

**Factors contributing to self-referrals of antenatal women for  
delivery at Dilokong Hospital, Greater Tubatse Local Municipality**

by

**Salphy Mamoropo Magoro**

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**Supervisor:** Prof R. N. Malema

**Co-supervisor:** Prof M. E. Lekhuleni

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## **DECLARATION**

I declare that the “**Factors contributing to self-referrals of antenatal women for delivery at Dilokong Hospital, Greater Tubatse Local Municipality**” hereby submitted to the University of Limpopo, for the degree of Master of Curationis (MCur) has not previously been submitted by me for a degree at this or any other university, that it is my work in design and in execution, and that all materials contained herein have been duly acknowledged.

.....

**Magoro S.M**

.....

**Date Signed**

## **DEDICATION**

I dedicate this dissertation to:

- My parents; Moshita and Monene Magoro, Rabogale and Mahlako Mmusi; for their continual encouragement.
- My husband, Kgogo Thabo Mmusi, and my children; Diketso Keabetswe, Tshiamo Mahlako, and Khumanego Monene; for being understanding and patient with me when I was not available for you during the moments of intense concentration on my studies.
- The women of the Tubatse Local Municipality who participated in the study by contributing invaluable information for the study.

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## **ABSTRACT**

The purpose of this study was to determine the factors that were contributing to self-referrals of antenatal women at the Dilokong Hospital in the Tubatse Local Municipality. By employing a quantitative, non-experimental research method, 360 women completed and submitted a structured questionnaire. Validity and reliability were insured by pre-testing the data collection instrument on respondents who were not part of the main study. Data was analysed by using the SPSS and Excel computer programs with the assistance of a statistician. The age group between 21 and 30 years 197 (54.7%) was larger than the other age groups. Primigravida women represented less than half 147 (40.3%) of the respondents. These women were also supposed to be referred to the hospital for delivery; however, only 23.3% of the women were referred to the hospital for delivery. The choice of the delivery site was influenced by a lack of women's knowledge about the referral system and of services offered at the clinics, as well as the unavailability of doctors, midwives, food, equipment, enough space for delivery at the clinics, and the perceptions that nurses and midwives were rude. The government should ensure that the clinics are provided with adequate human resources and other resources that are needed for providing these health services. Pregnant women should be given referral letters and information with regard to where they are supposed to deliver.

Key concepts: Antenatal women, self-referral, referral system, and Primary Health Care (PHC).

## **DEFINITION OF CONCEPTS**

### **Antenatal women**

According to Sellers (2010), the term refers to pregnant women who are not yet ready to give birth. In this study, it refers to prenatal women who come to the hospital for delivery.

### **Self-referral**

It is defined by Oxford Dictionary (2010) as an act of self-recommendation for an appointment. In this study, it refers to all antenatal women who go to the hospital for delivery without referral letters.

### **Referral system**

Oxford Dictionary (2010) defines it as an organisational system for the act of recommending. In this study, it refers to the health system of the Department of Health for movement of patients from the lowest health system to the highest health system for the purpose of health care.

### **Primary Health Care (PHC)**

It is defined as non-specialised health services that are known as the first-line health services. Mainly, it is provided outside hospitals to people who are in the community (Sines, Appleby & Frost, 2005). In this study, it refers to services provided by all the clinics, mobile clinics, and gateway clinics.

## TABLE OF CONTENTS

DECLARATION .....	iii
DEDICATION .....	iv
ACKNOWLEDGMENTS .....	v
ABSTRACT .....	vi
DEFINITION OF CONCEPTS .....	vii
CHAPTER 1	
ORIENTATION TO THE STUDY .....	1
1.1 INTRODUCTION AND BACKGROUND .....	1
1.2 PROBLEM STATEMENT .....	3
1.3 LITERATURE REVIEW .....	3
1.4 AIM OF THE STUDY .....	5
1.5 RESEARCH QUESTION .....	5
1.6 OBJECTIVE OF THE STUDY .....	6
1.7 RESEARCH METHODOLOGY .....	6
1.8 STUDY SITE .....	6
1.9 STUDY DESIGN .....	6
1.10 POPULATION AND SAMPLING .....	6
1.11 DATA COLLECTION .....	7
1.12 DATA ANALYSIS .....	7
1.13 SIGNIFICANCE OF THE STUDY .....	7
1.14 CONCLUSION .....	7

## **CHAPTER 2**

<b>LITERATURE REVIEW .....</b>	<b>8</b>
<b>2.1 INTRODUCTION .....</b>	<b>8</b>
<b>2.2 Lack of resources at the closest PHC .....</b>	<b>8</b>
<b>2.3 Expectations of better quality service from high level facilities .....</b>	<b>8</b>
<b>2.4 Lack of confidence in PHC for dealing with complications .....</b>	<b>9</b>
<b>2.5 Failure of midwives / nurses to comply with referral indications .....</b>	<b>9</b>
<b>2.6 Women’s educational status .....</b>	<b>10</b>
<b>2.7 Women’s knowledge of the referral system and own perception of risks .....</b>	<b>10</b>
<b>2.8 THE MILLENNIUM DEVELOPMENT GOALS AND MATERNAL HEALTH</b>	<b>11</b>
<b>2.9 CONCLUSION .....</b>	<b>11</b>

## **CHAPTER 3**

<b>RESEARCH METHODOLOGY.....</b>	<b>12</b>
<b>3.1 INTRODUCTION .....</b>	<b>12</b>
<b>3.2 RESEARCH APPROACH.....</b>	<b>12</b>
<b>3.3 STUDY SITE .....</b>	<b>12</b>
<b>3.4 STUDY DESIGN.....</b>	<b>13</b>
<b>3.5 POPULATION .....</b>	<b>13</b>
<b>3.6 SAMPLING.....</b>	<b>14</b>
<b>3.7 INCLUSION CRITERIA.....</b>	<b>15</b>
<b>3.8 EXCLUSION CRITERIA.....</b>	<b>15</b>
<b>3.9 DATA COLLECTION METHOD.....</b>	<b>15</b>
<b>3.10 DATA ANALYSIS .....</b>	<b>17</b>
<b>3.11 MEASURES TO ENSURE VALIDITY AND RELIABILITY .....</b>	<b>17</b>
<b>3.12 ETHICAL CONSIDERATIONS.....</b>	<b>18</b>



<b>3.13</b>	<b>CONCLUSION .....</b>	<b>20</b>
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## **CHAPTER 4**

	<b>PRESENTATION OF RESULTS .....</b>	<b>21</b>
<b>4.1</b>	<b>INTRODUCTION .....</b>	<b>21</b>
<b>4.2</b>	<b>SECTION A: DEMOGRAPHIC INFORMATION .....</b>	<b>21</b>
<b>4.3</b>	<b>SECTION B: GYNAECOLOGICAL HISTORY .....</b>	<b>22</b>
<b>4.4</b>	<b>SECTION C: REFERRAL SYSTEM.....</b>	<b>30</b>
<b>4.5</b>	<b>SECTION D: REASON FOR SELF REFERRAL .....</b>	<b>34</b>
<b>4.6</b>	<b>THE RELATIONSHIP BETWEEN THE VARIABLES .....</b>	<b>43</b>
<b>4.7</b>	<b>CONCLUSION .....</b>	<b>51</b>

## **CHAPTER 5**

	<b>DISCUSSION OF MAJOR FINDINGS, LIMITATIONS, RECOMMENDATIONS, AND CONCLUSION .....</b>	<b>52</b>
<b>5.1</b>	<b>INTRODUCTION .....</b>	<b>52</b>
<b>5.2</b>	<b>RESTATEMENT OF THE PROBLEM STATEMENT .....</b>	<b>52</b>
<b>5.3</b>	<b>AIM OF THE STUDY .....</b>	<b>52</b>
<b>5.4</b>	<b>OBJECTIVE OF THE STUDY .....</b>	<b>52</b>
<b>5.5</b>	<b>DISCUSSION OF MAJOR FINDINGS .....</b>	<b>53</b>
5.5.1	Age .....	53
5.5.2	Parity.....	53
5.5.3	Delivery site .....	53
5.5.4	HIV status .....	54
5.5.5	Disclosure patterns .....	54
5.5.6	Information about clinic services .....	55
5.5.7	Availability of a doctor at the clinic .....	56

5.5.8	Availability of midwives / nurses at the clinic during the night .....	56
5.5.9	Availability of food at the clinic .....	57
5.5.10	Availability of sonar, instruments, space .....	57
5.5.11	Patients' perceptions of midwives / nurses at the clinic .....	57
<b>5.6</b>	<b>LIMITATIONS OF THE STUDY .....</b>	<b>58</b>
<b>5.7</b>	<b>RECOMMENDATIONS .....</b>	<b>58</b>
<b>5.8</b>	<b>CONCLUSION .....</b>	<b>59</b>
 <b>LISTS OF REFERENCES.....</b>		<b>60</b>
 <b>APPENDIX A: RESEARCH QUESTIONNAIRE .....</b>		<b>65</b>
<b>APPENDIX B: SEPEDI RESEARCH QUESTIONNAIRE .....</b>		<b>74</b>
<b>APPENDIX C: APPROVAL FROM MREC .....</b>		<b>83</b>
<b>APPENDIX D: APPROVAL FROM LIMPOPO PROVINCE DEPARTMENT OF HEALTH .....</b>		<b>84</b>
<b>APPENDIX E: PERMISSION TO CONDUCT STUDY FROM THE CEO OF DILOKONG HOSPITAL .....</b>		<b>85</b>
<b>APPENDIX F: EDITING CONFIRMATION .....</b>		<b>86</b>

## LIST OF TABLES

Table 4.1:	Age in years .....	21
Table 4.2:	Education level.....	22
Table 4.3:	Occupation.....	23
Table 4.4:	Number of children.....	24
Table 4.5:	Previous place of delivery .....	245
Table 4.6:	Previous mode of delivery.....	25
Table 4.7:	Duration of labour with the previous pregnancy .....	256
Table 4.8:	Admission with current pregnancy before onset of labour .....	267
Table 4.9:	Distance to the hospital.....	32
Table 4.10:	Availability of doctor at the clinic .....	334
Table 4.11:	Resources available at the clinic.....	36
Table 4.12:	The nurse at the clinic told me to come to the hospital when having labour pains .....	37
Table 4.13:	Knowledge of women about clinic services.....	38
Table 4.14:	Nurses at the clinic are rude .....	39
Table 4.15:	Women’s experience of a clinic delivery .....	40
Table 4.16:	Employment vs self-referral .....	413
Table 4.17:	Distance to the hospital vs self-referral .....	424
Table 4.18:	Transport fare vs self-referral.....	435
Table 4.19:	Availability of a doctor at the clinic vs self-referral.....	446
Table 4.20:	Availability of a midwife at the clinic during the night vs self-referral.....	457
Table 4.21:	Availability of food at the clinic vs self-referral .....	468
Table 4.22:	Knowledge of women about clinic services vs self-referral .....	479
Table 4.23:	Women’s knowledge about clinic deliveries vs self-referral .....	50

## LIST OF FIGURES

Figure 4.1:	Marital status.....	22
Figure 4.2:	Number of pregnancies including the current pregnancy.....	23
Figure 4.3:	Planned or unplanned pregnancies .....	26
Figure 4.4:	History of abnormalities in the family .....	27
Figure 4.5:	Diseases the pregnant women suffered from .....	278
Figure 4.6:	Pregnant woman on any chronic medication .....	28
Figure 4.7:	Pregnant woman agreeing to share their HIV status.....	29
Figure 4.8:	Pregnant women’s HIV status.....	29
Figure 4.9:	Knowledge of women about a referral system .....	290
Figure 4.10:	Women who were referred to the hospital for delivery .....	30
Figure 4.11:	Women who were given referral letters.....	301
Figure 4.12:	Women who had referral letters .....	31
Figure 4.13:	Women who were given information about referral letters .....	312
Figure 4.14:	Mode of transport.....	323
Figure 4.15:	Transport fare .....	33
Figure 4.16:	Availability of a nurse / midwife at the clinic during the night .....	34
Figure 4.17:	Ambulance (EMS) took me straight to the hospital .....	35
Figure 4.18:	Perception of women about the nurses.....	39
Figure 4.19:	Positive or negative experience of a clinic delivery .....	41

# CHAPTER 1

## ORIENTATION TO THE STUDY

### 1.1 INTRODUCTION AND BACKGROUND

The referral system is an essential component of health systems. It is particularly important in pregnancy care and childbirth for providing access to emergency obstetric care and for backing up antenatal and delivery care at first line facilities. However, referral patterns, as reported by referral hospitals in developing countries, show that the actual use of a referral system for obstetric care is inversely related to a professional needs assessment (Chenge & Askew, 2005).

A referral system is meant to complement the Primary Health Care (PHC) principle of treating patients as close to their homes as possible at the lowest level of care with the appropriate level of expertise. This back-up function of referral is of particular importance during pregnancy and childbirth, since a range of potentially life-threatening complications require management and skills that are only available at higher levels of care (WHO, 2011).

Hospitals are overcrowded with patients who could be more cost effectively treated at smaller facilities. Such overcrowding is a common feature of a poorly functioning referral system. While the primary function of hospitals is to provide complex clinical care to patients referred from lower levels, access to these hospitals should be through Primary Health Care Centres (PHCCs), except for emergency cases when patients may access the hospital directly via the emergency department at the hospital (Rasoulynejad, 2007).

A well-functioning referral system is a key element of any health system. In describing the health system, a pyramid is often used to emphasise that the provincial hospitals are the end point in a referral hierarchy that provides the most specialised care while the starting point of health care is the PHC facilities. Movements between the levels of the pyramid occur by means of referrals of and according to the needs from PHCCs to national hospitals (Low, Coeyere, Shivute & Brandt, 2007)

Health facilities are classified into PHC centres, district, secondary, and tertiary hospitals. In general, there are no doctors at the PHC facilities whereas district hospitals are staffed by doctors without specialist qualifications while secondary hospitals usually offer only the four most common specialties; namely general medicine, general surgery, paediatrics, and obstetrics. At tertiary hospitals, one would find less common specialists. Normally, the patient who requires health services will go to the nearest PHC. Only when that health facility lacks the skills and equipment to treat the patient will he or she be referred to a district hospital. In theory the same principle applies for referral from district to secondary tertiary hospitals (Low *et al.*, 2007).

According to Lyengar and Lyengar (2009) the effectiveness of a referral system depends on many factors, including the presence of significant financial barriers for patients' self-referral, the degree of differentiations in the medico-technical performance of the health facilities at the various levels, the effectiveness of the operational arrangements of the referral system, and the population's willingness to use PHC facilities as a point of entry into the health system. Patients should be treated at the appropriate level to improve access to health services and to make optimal use of available hours and human resources. If the pyramid system is ignored, patients are treated at higher than necessary costs while higher level facilities become overburdened while lower level facilities remain underutilised.

Overuse of hospitals is further aggravated by the low user fees for hospital care and no additional cost for non-referral cases. Since user fees at each hospital currently do not differ according to the functional complexity of hospitals, a graded system of user fees (financial disincentive) could be considered. If fees are increased for non-referral patients, more patients would use the referral system correctly, and more revenue would be raised from patients who are not referred (Omaha, Melendez, Vehara, & Ohi, 2008).

In many developing countries, access to intrapartum care may be poor due to transport problems. In addition, the capacity of dealing with intrapartum complications at a PHC may be limited by insufficiently skilled manpower and resources. Therefore, it is important to reduce the number of women who will need referrals. Women at risk of complications

need to be identified and referred to a hospital for evaluation and delivery (Majoko, Nystrom, Manjaja & Lindmark, 2005).

According to Murray and Pearson (2006), since the advent of PHC in developing countries, the referral system has been considered to be an important component of the health system. In this study, the factors contributing to self-referrals of women for delivery at the Dilokong Hospital were determined.

## **1.2 PROBLEM STATEMENT**

There are a high number of self-referrals of antenatal women for delivery at the maternity ward of the Dilokong Hospital in the Limpopo Province. In the 2010 / 2011 financial year, there were 3 737 antenatal women were delivering at the Dilokong Hospital. Only 1 550 of these women were referred from other health facilities and that seemed to suggest that antenatal women did not go to the nearest PHC facilities for delivery. The health care institutions seem not to have a specific strategy that is used for guiding antenatal women about the referral system. The CEO of the Dilokong Hospital has indicated that there was a need for conducting this study (Department of Health, 2011b).

## **1.3 PRELIMINARY LITERATURE REVIEW**

A study by Low *et al.*, (2007) shows that bypassing of the primary level of health care facilities and going directly to the hospital is a common practice, especially for most women who have started with labour at home.

There are more than 50% of self-referrals, whereas institutional referrals are around 30% and emergency referrals are less than 5% of women. Known variables contributing to the choice of obstetric care include distance, cost, perceived quality of obstetric care, health workers' attitude and respect for women's social needs, perceived aetiology of complications, and socio-cultural preferences (Low *et al.*, 2007).

The first nationwide study of the patient referral system in Kenya demonstrates low referral rates at secondary and tertiary hospitals, as well as at health centres. Common referrals flow from PHC directly to the tertiary hospitals, bypassing district and secondary

hospitals. The study also indicates a lack of a registered list of referred patients. There is also an extremely low rate of reply to referral letters and an insufficient supply and duplication system of the referral forms (Omaha *et al.*, 2008).

According to Pembe, Carlstedt, Urassa, Nystom and Dari (2010), the Ministry of Health and Social Welfare in Tanzania have guidelines for referrals of pregnant women to the hospital. The guidelines do not distinguish between the historical risk factors and actual complications during the present pregnancy but stipulates that all the PHC facilities are supposed to refer woman based on the indications for referral.

A study conducted by Pembe *et al.* (2010) in Tanzania evaluates the appropriateness of the referral indication, reasons for non-compliance to the referral guidelines, and also to establish whether compliance to referral guidelines makes a difference to the perinatal outcomes. Most demographic and histological referral indications have been shown to poorly predict occurrence of complications and delivery outcomes. Moreover, if all PHC facilities have complied with the referral guidelines, hospitals would not be overburdened with uncomplicated normal vaginal deliveries (NVDs), the misuse of hospital resources would be reduced, and the proper quality of maternal care to women who needed emergency care would be enhanced (Pembe *et al.*, 2010).

According to Dlakavu (2012), self-referred women at the Baragwaneth hospital in South Africa are more likely not to have received any antenatal care. Antenatal care at the midwife obstetric units includes information about where to give birth and it is likely that these women do not know where to go when labour starts. The absence of antenatal care, therefore, is likely to be a contributory factor to self-referral, with the hospital being the easiest option for women who have not received advice on where to deliver.

A study by Mashishi (2014) revealed that among 394 women who delivered at Dilokong Hospital, South Africa in 2008, the majority (85%) were self-referred which means they did not start at a PHC facility but went directly to the hospital for delivery without a referral. Of those women who self-referred to the Dilokong Hospital, 49% were low risk pregnancies and they could have delivered at clinics and CHCs. Only 51% were high risk pregnancies that required hospital delivery. The practice of women with low risk



pregnancies delivering at an inappropriate level of care (hospitals rather than PHCs) needs to be investigated because it potentially affects the workload of the maternity care staff at the hospital; it causes the inefficient utilisation of hospital resources.

Furthermore, Mashishi (2014) reports that 67% of these women uses an ambulance to get to the hospital because paramedics often take them directly to the hospital and not to a clinic. The study suggests that there may be a problem of non-compliance by the users and the health care providers.

Direct self-referral to the hospital may indicate a lack of confidence in PHC for dealing with complications (Majoko *et al.*, 2005). Direct self-referral deviation from the textbooks' referral system pyramid is common. Non-compliance with referral advice and bypassing of PHC to the hospital are common. Such bypassing is often initiated by the user, but sometimes by the lower-level health care providers. Self-referral may result in underutilisation of lower-level facilities and congestion of hospitals. However, self-referral reflects a justifiable lack of confidence in the quality of care available and in remote settings where transportation is difficult and health system are unsatisfactory. Self-referral to hospital may be the most realistic and speediest option when obstetric complications are suspected (Murray & Pearson, 2006).

#### **1.4 AIM OF THE STUDY**

The aim of the study was:

- To determine the factors that are contributing to self-referrals of antenatal women for delivery at the Dilokong Hospital, Greater Tubatse Local Municipality.

#### **1.5 RESEARCH QUESTION**

The following question guided the researcher throughout the period of conducting this study:

- What are the factors contributing to self-referrals of antenatal women for delivery at the Dilokong Hospital?

## **1.6 OBJECTIVE OF THE STUDY**

The objective of this study was:

- To describe the factors contributing to self-referral of antenatal women for delivery at the Dilokong Hospital.

## **1.7 RESEARCH METHODOLOGY**

The study was conducted in the postnatal high risk clinic of the Dilokong Hospital, Greater Tubatse Local Municipality, Sekhukhune District, in the Limpopo Province of South Africa. A quantitative research approach was used to determine factors contributing to self-referral of antenatal women for delivery at the Dilokong Hospital.

## **1.8 STUDY SITE**

This study was conducted in the maternity ward of the Dilokong Hospital, Greater Tubatse Local Municipality, Sekhukhune District, in the Limpopo Province of South Africa.

## **1.9 STUDY DESIGN**

A non-experimental descriptive research design was chosen to enable the researcher to determine the factors that were contributing to self-referrals of antenatal women for delivery.

## **1.10 POPULATION AND SAMPLING**

The study population were all postnatal women who came to the maternity ward of the Dilokong Hospital for delivery. Simple random sampling was used to select the respondents.

### **1.11 DATA COLLECTION**

A self-developed questionnaire was used to collect data from the postnatal women. The questionnaire comprised closed-ended questions and was divided into four sections; namely Section A that addressed the demographic and socio-economic information, Section B that addressed women's gynaecological and obstetric history, Section C that addressed women's knowledge about value for money, and Section D that addressed the factors that were contributing to self-referrals.

### **1.12 DATA ANALYSIS**

Data were analysed using the Statistical Package for Social Sciences (SPSS) and Excel computer programs with the assistance of the University of Limpopo statistician.

### **1.3 SIGNIFICANCE OF THE STUDY**

The findings of this research study could help to improve public health care facilities and develop programmes that would increase and enhance behavioural changes of antenatal women with regard to referral for delivery.

Professional nurses / midwives in public health may benefit from the study, since guidelines and recommendations pertaining to a referral system would update their knowledge and skills in relation to this phenomenon.

### **1.13 CONCLUSION**

Chapter 1 gives an orientation to this study. This includes a background to the research problem, the research problem, aim and objectives of the study, research methodology and design, population and sampling, data collection and analysis, and the significance of the study.

Chapter two discusses the literature review conducted for this study.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

The purpose of Chapter 2 is to provide an in-depth review of the literature related to the research topic. The purpose of reviewing literature for this study was to obtain relevant information that had been available about the research topic. A literature review provides essential background knowledge about similarities and differences between the present study and prior research studies done that are relevant to this topic. It is also a systematic identification, location, scrutiny, and summary of related published works to gain about a thorough understanding of the research topic (Burns & Grove, 2009).

#### **2.2 LACK OF RESOURCES AT THE CLOSEST PHC**

Omaha *et al.* (2008) explain that in Kenya, referral rates of each hospital were less than 25%, even at tertiary hospitals that provide the most specialised medical services. This implies that many patients visit these hospitals without consulting at any other health service institutions (self-referral). In addition, at regional and area hospitals, which are considered to be the main institutions that are receiving surgical or complicated medical cases from health centres, the average referral ratios are less than 5%. These low referral rates indicate underuse of peripheral facilities and overuse of hospitals. In Kenya, a lack of drugs at the closest clinics and expectations of better quality service from higher-level health facilities are the two most commonly mentioned reasons for bypassing the nearest health facilities to higher level health facilities.

#### **2.3 EXPECTATIONS OF BETTER QUALITY SERVICE FROM HIGH LEVEL FACILITIES**

In Namibia, district hospitals in the north-east, central, and south are thought to be referring cases directly to the Kututura Hospital (KH) and Windhoek Central Hospital (WCH) complex which functions as the National Hospital, instead of referring health service seekers to secondary hospitals. Patients are bypassing the referral system and

self-referring themselves to the Windhoek Hospital Complex. The pattern of patients going directly to the hospital outpatients departments (OPDs) in the hope of 'best' treatment without first visiting the PHC facilities and the intermediate hospitals has been observed in Namibia, partly because patients know that the WCH has better facilities and doctors with specialised skills (Low *et al.*, 2007).

#### **2.4 LACK OF CONFIDENCE IN PHC FOR DEALING WITH COMPLICATIONS**

Tanzania has a national referral system in place for the management of obstetric complications; however, patients often bypass referring facilities in favour of higher level hospitals. A study was done at the Kilimanjaro Christian Medical Centre (KCMC) to compare caesarean section rates among formally referred women versus the ones who were self-referred. From a registry of approximately 21 000 births, 80% were self-referrals while only 20% were formally referred (Kyomuhendo, 2003).

According to Abrahams (2001), the secondary outcome of that study indicates the assessment of risk of both maternal and neonatal outcomes after caesarean section according to referral status. Not surprisingly, formally referred patients have a higher caesarean section rate and they suffered more adverse outcomes; such as low birth weight, low Apgar scores, and neonatal admissions. Of interest, it is noted that those patients who are referring themselves lack confidence in PHC for dealing with complications and thus prefer delivering at a tertiary hospital, since patients are able to pay the contribution towards their hospital accounts that is required.

#### **2.5 FAILURE OF MIDWIVES / NURSES TO COMPLY WITH REFERRAL INDICATIONS**

The self-referral group, as in the case of the Gutu District in Zimbabwe, includes women with antenatal risk factors or complications that are overlooked by the nurses / midwives. There are high rates of non-compliance with indications for referrals by nurses / midwives. There is evidence that 59% of women with previous complications recommended for hospital evaluation are not referred because of the failure of a nurse / midwife to comply with referral indications (Majoko *et al.*, 2005).

## **2.6 WOMEN'S EDUCATIONAL STATUSES**

Education seems to play a role but even those women with higher education have a poor knowledge of referral channels in the health care system. Many patients do not necessarily know the differences between the difference levels of health care. Patients may also lack confidence in the quality of care available at primary health care level and may perceive hospitals as providing better care, with doctors who are regarded as more capable than nurses or midwives at managing their medical problems efficiently and effectively (Graham, Bell & Bullough, 2001).

## **2.7 WOMEN'S KNOWLEDGE OF THE REFERRAL SYSTEM AND OWN PERCEPTION OF RISKS**

High numbers of self-referrals amongst the obstetric population highlight women's own perception of risk, and the inappropriate use or over-utilisation of higher level hospitals may be viewed as helping to ease patients' anxiety. Self-referrals result in lower levels of care being underutilised, and hospitals being over-utilised, congested, and overburdened, which lead to an escalation in health care costs. Due to large patient loads, human and physical resources are stretched to capacity which results in hospitals compromising the care that they provide to patients who genuinely and correctly deserve to be managed in a specialised care setting (Abrahams, 2001).

According to Kowalewski, Jahn and Kimotta (2000), the high number of self-referrals highlights women's own perception of risk. There is a high utilisation of PHC for antenatal care but not for delivery. A qualitative investigation to elucidate why women shun PHC for delivery is required. Similar patterns of high antenatal and low delivery utilisation of PHC services have been reported in other African settings, and there is a suggestion that the access to health facilities is not the only barrier. There is a need to motivate women to use modern facilities for delivery / labour and to make the facilities sensitive to women's needs (Kowalewski *et al.*, 2000).

According to Majoko *et al.*, (2005) women frequently present to a hospital without a PHC referral, either because of perceived risks or logistical problems of accessing the PHC.

Among 993 self-referrals, 320 (32%) had a risk factor that had not been acted upon by the nurses / midwives. Among women who were not referred during their antenatal period, the risk of perinatal death was elevated for women referred when in labour when compared to the group of PHC deliveries.

## **2.8 THE MILLENNIUM DEVELOPMENT GOALS AND MATERNAL HEALTH**

During 2001, 189 United Nations Member States convened for the United Nations Millennium Summit. Together they adopted eight interlinked Millennium Development Goals (MDGs). These goals were unprecedented efforts to meet the needs of the poor countries in the world for better health of their people by the year 2015. The fifth goal aimed at improving maternal health, with the objective of reducing by three quarters the ratio of women dying during childbirth by 2015. To monitor the progress towards achievement of this goal, Maternal Mortality Ratio (MMR) as the outcome indicator and the number of births attended to by skilled personnel as the process indicator were to be assessed. The fourth goal focused on the reduction of child mortality by two thirds by 2015. These two goals are somehow interrelated, since healthy children need healthy mothers (UNICEF, 2010).

## **2.9 CONCLUSION**

This chapter reviews literature that relates to this study. Literature that was reviewed formed a better understanding of the study topic. It also formed a basis upon which the study findings were evaluated in order to ensure validity and reliability of the research findings.

The next chapter describes the methodology used for the research, study site, research method, research design, population, sampling, inclusion criteria, exclusion criteria, data collection, data collection tool, data analysis, and ethical considerations.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

The purpose of Chapter 3 is to describe the research design and method of data collection that were used to determine the factors that were contributing to self-referral of antenatal women for delivery at the Dilokong Hospital.

#### **3.2 RESEARCH APPROACH**

The research approach is described as the general research plan for obtaining answers to the research questions and for testing the research hypotheses. The research design directs the strategies that a researcher adopts to develop information that is accurate, objective, and interpretable (Polit & Hungler, 1995)

Quantitative research approaches are essential to develop the body of knowledge needed for evidence-based practice. It is defined as a formal, objective, and systemic process in which numerical data is employed to obtain information about the world (Burns & Grove, 2009). It involves the systematic collection of numerical information under conditions of considerable control, and the analysis of that information by using statistic procedures (Claire, Graig & Smith, 2006). The researcher considered this approach because it was ideal for this study.

#### **3.3 STUDY SITE**

This study was conducted at the postnatal high risk clinic of the Dilokong Hospital. The postnatal high risk clinic of Dilokong Hospital is divided into two sections, namely a labour ward and a postnatal ward. The postnatal ward has subsections that are a normal delivery section, a post caesarean section, a neonatal section, a kangaroo section, and a high risk clinic. The high risk clinic is a well-furnished open space and it is only used on Thursdays between 8:00 and 16:30 for high risk clinic consultations, therefore, it is available for use most of the time.



### **3.4 STUDY DESIGN**

The researcher considered this design; which includes a structural approach, a formal instrument to collect data, and the procedures followed to analyse data; since it was ideal for this study. It assisted with the discovery of new meaning while determining what existed and how often a phenomenon was occurring and categorising the information (Burns & Grove, 2009). A descriptive study provides detailed information about the variable under study.

- **Descriptive research design**

A descriptive design is concerned with gathering information from a representative sample of a population. A descriptive design is used in studies that require more information in a particular field through the provision of a picture of the phenomenon as it occurs naturally (Brink, 2009). These studies also generate precise measurements of phenomena being studied that can be explained by the accumulation of statistical data (Burns & Grove, 2009). Hence, the descriptive research design was chosen, since it was found to be appropriate for a study that intended to determine the factors that were contributing to self-referrals of antenatal women for delivery.

### **3.5 POPULATION**

Population means the entire group of persons or objects that are of interest to the researcher, in other words, the ones that meet the criteria for the phenomena which the researcher wishes to study (Brink, 2009). The study population comprised all postnatal women who came to the maternity ward at the Dilokong Hospital for delivery.

For the 2010 / 2011 financial year, 3 728 antenatal women delivered at the Dilokong Hospital. The study population was calculated from 3 728 which was the number of deliveries at Dilokong Hospital for the financial year 2010/2011.

### 3.6 SAMPLING

Sampling describes the researcher's process of selecting the sample from a population in order to obtain information with regard to a phenomenon in a way that represents the population of interest (Brink, 2009). Simple random sampling was chosen to select the respondents for this study. This type of sampling is the easiest of the sampling methods where each individual case in the population theoretically has an equal chance of being selected for the study (De Vos, Strydom, Fouché & Delport, 2011).

The sample size was calculated by using Slovin's Formula (George, 2000). For a confidence level of 95%, the sample size of 360 respondents was calculated as follows:

The calculations:

$$\begin{aligned} S &= N \div (1 + Ne^2) \\ &= 3\,737 \div (1 + 3\,728 \times 0.05^2) \\ &= 3\,728 \div (1 + 3\,728 \times 0.05 \times 0.05) \\ &= 3\,728 \div 10.32 \\ &= \mathbf{361.24} \end{aligned}$$

The researcher visited the postnatal ward of the Dilokong Hospital. Population was converted to 360 because the researcher to have equal number of 10 respondents per day. A total of 360 paper pieces were cut. Three hundred and sixty of those pieces of paper were assigned numbers. All the pieces of papers were put in a bowl. The respondents were asked to draw a paper from the bowl. If the respondent picked a paper with a number on, then the respondent was an eligible member of the sample to participate in the study. Each drawn number was recorded. The process was repeated until 360 respondents were selected.

### **3.7 INCLUSION CRITERIA**

The inclusion criterion for the study was all postnatal women who delivered in the maternity ward at the Dilokong Hospital.

### **3.8 EXCLUSION CRITERIA**

The exclusion criterion for the study was all women who were residing in the Driekop village because Dilokong Gateway Clinic was their only PHC facility and the clinic did not offer maternity services. Therefore, they were not required to be referred for delivery at the Dilokong Hospital.

### **3.9 DATA COLLECTION METHOD**

A self-developed structured questionnaire was employed to collect data for this study. See (**Appendix A**).

- **Data collection instrument**

A self-developed structured questionnaire was used to collect data for this study. A questionnaire is a printed self-report form designed to elicit information that can be obtained from a subject's written responses (Burns & Grove, 2009). A structured questionnaire is a data collection instrument that comprises a set of questions or items in which the wording of both the question and response alternatives are predetermined. Respondents either complete the instrument themselves in a paper-and-pencil format or an interviewer asks questions orally but relies on the respondents to answer some questions in writing (Polit & Hunger, 1999).

Katzellenbogen, Joubert and Abdool-Karim, (2002) view a questionnaire as a list of questions that are answered by a respondent, and that give direct measures of the variables under investigation. According to Creswell (1994), if a researcher wants to obtain information about attitudes, feelings, beliefs, or any other information that cannot be observed, then the most appropriate way is to ask questions and receive answers from respondents. However, questionnaires have the disadvantages of being time consuming,

expensive, interpersonal dynamics might interfere with data collection, and interviewer variation might affect reliability. On the other hand, they have the advantages that they are less expensive to administer, respondents feel free to express their views, and they answer questions at their own pace after considering each point carefully (Kambaza, 2005).

Based on the information gathered from the literature review and with due consideration of the aforementioned about advantages and disadvantages of questionnaires, a research instrument was developed for this study. The questionnaire used in this study comprised of closed-ended questions only. The data collection instrument was divided into four sections.

- **Section A** addressed the demographic and socio-economic information (6 items).
- **Section B** addressed women's gynaecological and obstetric history (12 items).
- **Section C** addressed women's knowledge on referral system (7 items).
- **Section D** addressed the factors contributing to self-referrals (21 items).

The questionnaire was translated into the local language (Sepedi) for respondents who were not comfortable to answer the English questionnaires see (**Appendix B**). Data was collected over a period of eight weeks starting from 06 May 2013 to 30 June 2013.

- **Pre-test**

A pre-test that is using a similar population is a straightforward way of determining whether the research questions are understandable to the respondents (De Vos *et al.*, 2011). Pre-testing was done with 35 antenatal respondents who were admitted at the Dilokong Hospital maternity ward for delivery. Those 35 respondents who participated in the pilot study were not included in the main study. The purpose of the pre-test was to evaluate whether the answers to the questions would yield appropriate responses in order to reach the objective of the research project. The results from the pre-test assisted with validating the questionnaire. Respondents who took part in the pre-test were not included in the main study. After the respondents had completed the questionnaire, the researcher

made minor additions to the questions and did not change the format of the questionnaire. The format was kept the same to maintain uniformity in the major study.

- **Data collection process**

The researcher secured an appointment with the Chief Executive Officer (CEO) of the Dilokong Hospital to ask permission to collect data in relation to factors contributing to self-referrals for delivery by antenatal women. The CEO granted the researcher permission to collect data from the postnatal high risk clinic after the respective unit manager and maternity staff had been informed. The shift manager in maternity ward assisted by gathering the postnatal women who drew numbers during sampling, at the high risk clinic. The women were assembled in a vacant consultation room. They were provided with chairs and pens to fill in the questionnaires. The researcher and two professional nurses who assisted the researcher with the distribution and collection of the questionnaires introduced themselves to the women. Thereafter, the researcher explained the purpose of the study. Those who agreed to participate in the study signed a consent form. Questionnaires were then distributed to the respondents. They were given 30 minutes to complete the questionnaire. All mothers were able to complete the questionnaire as it was translated in the local language. The researcher minimised bias by positioning herself away from the respondents while they were completing the questionnaires but she remained within reach to clarify possible uncertainties (Burns & Grove, 2009). A total number of 360 questionnaires were distributed and completed.

### **3.10 DATA ANALYSIS**

According to Burns & Grove (2009), quantitative data analysis is a diverse and complex process. However, it has become relatively easier with clear step-by-step processes and the aid of computerised data analysis software.

Data was analysed using the SPSS Statistic Software version 18 and Excel computer program. Inferential and descriptive statistics were used. The findings and the results are presented using figures, bar graphs, frequency distribution tables and percentages.

### **3.11 MEASURES TO ENSURE VALIDITY AND RELIABILITY**

Validity refers to the extent to which an empirical inquiry adequately reflects the real meaning of the concept under consideration. It was ensured by basing the questionnaire on current scientific knowledge in relation to the research theme that was obtained from the literature review and from a panel of experts in the field who validated the appropriateness and accuracy of the questionnaire (Burns & Grove, 2009).

Reliability occurs when an instrument measures the same thing more than once and results in the same outcome. It was ensured through a self-designed questionnaire in consultation with the supervisor, co-supervisor, and the University of Limpopo statistician. All questions that the review panel regarded as unclear were corrected according to their recommendations. The researcher pre-tested the tool by conducting a pilot study with 35 respondents who were not included in the main study. Their assistance made it possible to rectify all mistakes in the tool.

### **3.11 ETHICAL CONSIDERATIONS**

Polit & Beck (2004) define ethics as a system of moral values concerned with the degree to which research procedures adhere to professional, legal, and social obligations towards respondents.

- **Ethical clearance and permission to conduct study**

The research proposal and the questionnaire for this study were submitted to the University of Limpopo for clearance. A clearance certificate was issued by the Medunsa Research Ethics Committee. That clearance certificate was presented to the authorities of the Limpopo Provincial Department of Health and Social Development. Permission to conduct the study was obtained from the Limpopo Department of Health and Social Development, from the Chief Executive Officer of the Dilokong Hospital and from the respondents who took part in the study.

Prior to the process of distributing the questionnaires, the researcher and two professional nurses who were assisting with data collection established rapport (Mouton, 2002).

- **Informed consent**

Written informed consent had been obtained from each of the respondents before they completed the questionnaire. Informed consent means that respondents have adequate information about the research, are capable of comprehending the information, and have the power of free choice; enabling them to consent voluntarily to participate in a research project or to decline participation (Polit & Beck, 2004). Thus, the principles of autonomy and respect for persons were upheld.

The respondents were given detailed information about the study to be conducted, which included the type of study and the reasons why the study should be conducted. Information pertaining to all the risks and benefits were made available to the respondents before the commencement of the study. All the information was made available in the language that was well understood by the respondents (Brink, 2009; Burns & Groove, 2009).

- **Principle of justice**

The researcher treated the respondents fairly by selecting them for reasons directly related to the study problem. The researcher also respected the rights of the respondents by letting them determine the extent to which their private information would be shared with other people (Brink, 2009; Burns & Groove, 2009).

- **Respect of participants**

The researcher handed out written consent forms to all the respondents before they were allowed to participate. The researcher allowed the respondents to decide whether or not they wanted to take part in the study, without the risk of any penalty / prejudice. She also explained to them that they had the right to withdraw from the study at any time, to refuse to give information, and to ask for clarification about the purpose of the study. The researcher did not use any form of coercion (Brink, 2009; Burns & Groove, 2009).

- **Autonomy and confidentiality**

To ensure anonymity, respondents were assured that they were not required to write their names on the questionnaires. That ensured that the respondents remained anonymous. The researcher labelled the questionnaires by using numbers. The researcher kept collected data in a secure place in a safe. When seeking respondents' informed consent, the researcher also made them aware of the possibility that the research report would be published for the benefit of other researchers (Brink, 2009; Burns & Groove, 2009).

- **Beneficence**

The researcher avoided harming the respondents by carefully structuring the questions and monitoring the respondents for any signs of distress. If any respondent during the process presented with any signs of distress was to be referred for counselling (Brink, 2009; Burns & Groove, 2009)

### **3.12 CONCLUSION**

This chapter describes the research design and methodology that was used in the study. It highlights aspects of sampling, data collection tools, the data collection process, ethical issues, and data management.



## CHAPTER 4 PRESENTATION OF RESULTS

### 4.1 INTRODUCTION

In this chapter, the researcher presents the results of the research.

The questionnaire was arranged in the following sections and the results are presented in the same order.

- Section A: Demographic information.
- Section B: Gynaecological history.
- Section C: Women's knowledge of referral system.
- Section D: Factors contributing to self-referral.

### 4.2 SECTION A: DEMOGRAPHIC INFORMATION

Table 4.1 indicates that 197 (54.7%) of the respondents were between the age of 21 and 30 years. Seventy (19.4%) and Sixty six (18.3%) were between the age 31-40 and 11-20 years respectively. The smallest age group (27; 7.5%) were above 40 years old.

**Table 4.1: Age in years**

Age in years	Frequency	Per cent
11 – 20	66	18.3
21 – 30	197	54.7
31 – 40	70	19.4
40	27	7.5
Total	360	100.0

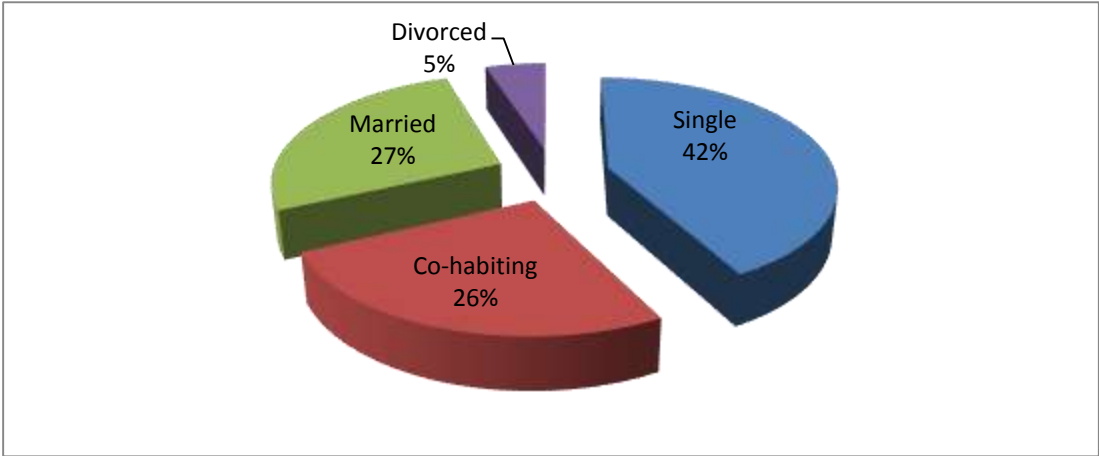
N = 360

Table 4.2 shows that almost half of women (175; 48.6%) had tertiary education, (152; 42.2%) had secondary school education, (28; 7.8%) had primary education, and (5; 1.4%) never went to school.

**Table 4.2: Education level**

Educational level	Frequency	Per cent
Never been at school	5	1.4
Primary	28	7.8
Secondary	152	42.2
Tertiary	175	48.6
Total	360	100.0

N = 360



N = 360

**Figure 4.1: Marital status**

Figure 4.1 indicates 42% of the women were single. Almost the same percentages (26% and 27%) were either co-habiting or married. Five per cent of the respondents were divorced.

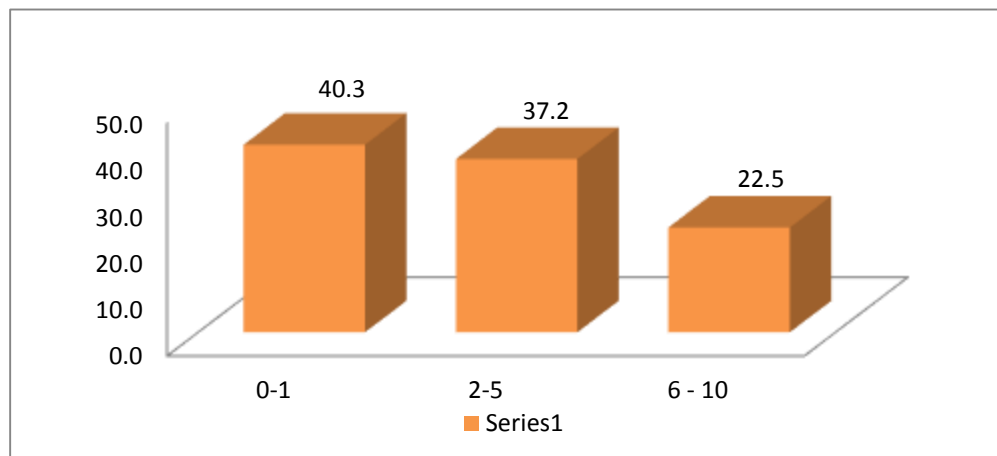
Table 4.3 shows that less than half 146 (40.6%) of the respondents were unemployed, 119 (33.1%) were employed, 80 (22.2%) were still at school, and 15 (4.2%) were self-employed.

**Table 4.3: Occupation**

Occupation	Frequency	Per cent
Scholar	80	22.2
Employed	119	33.1
Self-employed	15	4.2
Unemployed	146	40.6
Total	360	100.0

N = 360

#### 4.3 SECTION B: GYNAECOLOGICAL HISTORY



**Figure 4.2: Number of pregnancies including the current pregnancy**

Figure 4.2 indicates that 40.3% of the women were pregnant for the first time. The percentage of 37.2% had 2-5 pregnancies before while 22.5% had 6-10) pregnancies before.

Table 4.4 shows that 150 (41.7%) had 2-5 children as the 147 (40.8%) who had 0-1 children. Sixty of the women (16.7%) women had 6-10 children. The smallest number of 3 (0.8%) of the women had more than 10 children.

**Table 4.4: Number of children**

Number of children	Frequency	Per cent
0-1	147	40.8
2-5	150	41.7
6 – 10	60	16.7
Above 10	3	0.8
Total	360	100.0

N = 360

Table 4.5 indicates that 146 (65.4%) of the women had previously delivered at a public hospital, 30 (13.5%) at a clinic, 26 (11.7%) at a private hospital while 21 (9.4%) previously had delivered at home.

**Table 4.5: Previous place of delivery**

Place of delivery	Frequency	Per cent
Home	21	9.4
Clinic	30	13.5
Private Hospital	26	11.7
Public Hospital	146	65.4
Total	223	100.0

N = 223

Table 4.6 indicates that the largest number 113 (50.7%) of women delivered normally, 60 (26.8%) women delivered through caesarean section, 22 (9.9%) were assisted deliveries, and 28 (12.6%) were self-deliveries.

**Table 4.6: Previous mode of delivery**

Mode of delivery	Frequency	Per cent
Self-delivery	28	12.6
Normal delivery	113	50.7
Assisted delivery	22	9.9
Caesarean-section (operation)	60	26.8
Total	223	100.0

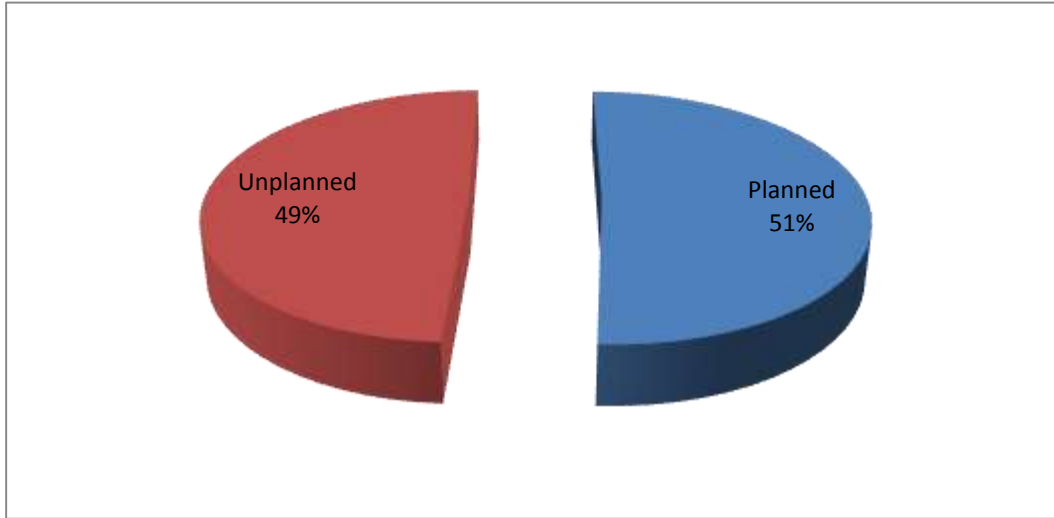
N = 223

Table 4.7 shows that 93 (41.7%) of women had labour pains for a few hours, 59 (26.5%) of the women did not know how much time they had labour pains with their previous deliveries, 54 (24.2%) had labour pains for a day, and 17 (7.6%) of them had labour pains for a week.

**Table 4.7: Duration of labour with the previous pregnancy**

Duration of labour	Frequency	Per cent
Few hours	93	41.7
A day	54	24.2
A week	17	7.6
Do Not know	59	26.5
Total	223	100.0

N = 223



N = 360

**Figure 4.3: Planned or unplanned pregnancies**

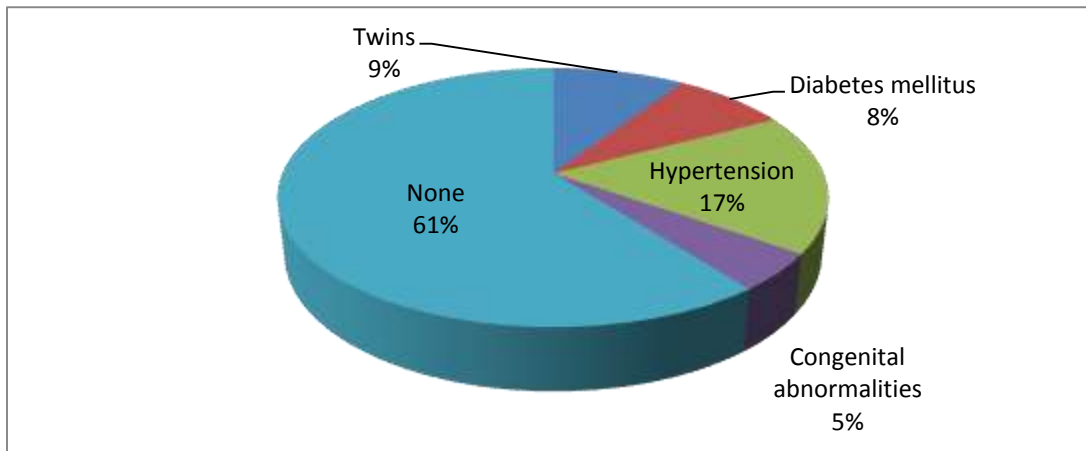
Figure 4.3 indicates that 51% of pregnancies were planned while 49% of pregnancies were unplanned.

Table 4.8 indicates that 291 (80.9%) of the women were never admitted with the current pregnancies before onset of labour and 69(19.2%) of them were admitted with the current pregnancies before onset of labour.

**Table 4.8: Admission with current pregnancy before onset of labour**

Admitted	Frequency	Per cent
Yes	69	19.2
No	291	80.9
Total	360	100.0

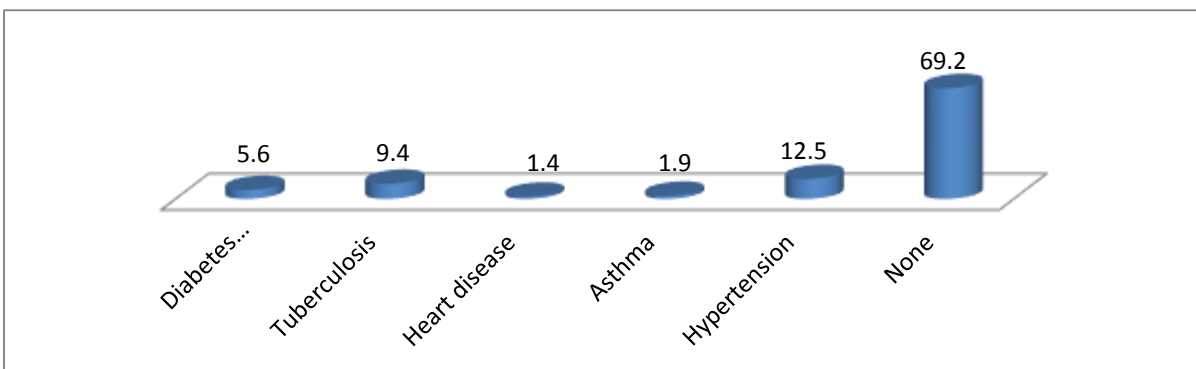
N = 360



N = 360

**Figure 4.4: History of abnormalities in the family**

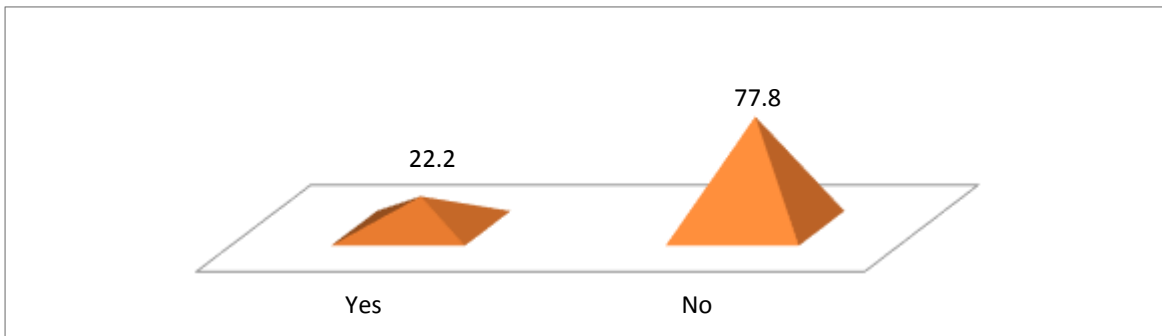
Figure 4.4 indicates that the largest percentage (61%) had no history of abnormalities in the family. Seventeen percent (17%) had a family history of hypertension whereas (9%) had a family history of twins, (8%) diabetes mellitus while (5%) reported congenital abnormalities.



N = 360

**Figure 4.5: Diseases the pregnant women suffered from**

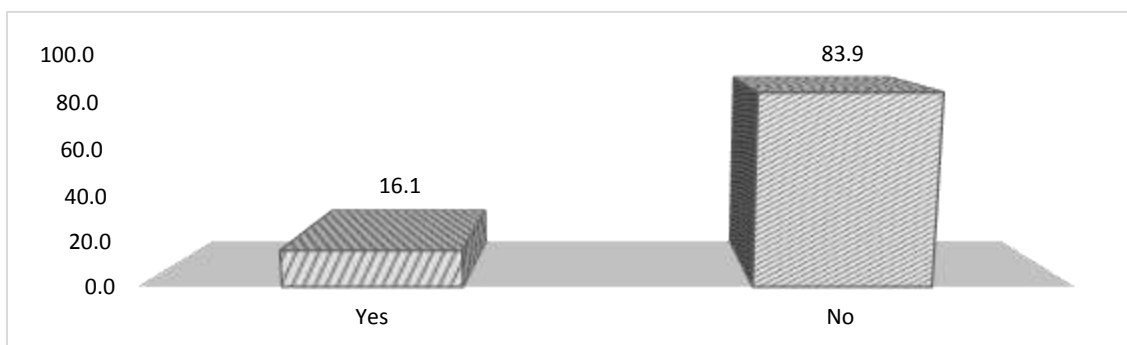
Figure 4.5 indicates that the largest number of women (69.2%) did not suffer from any diseases, 12.5% had hypertension, 9.4% had TB, and 5.6% had diabetes mellitus. Almost the same smallest percentages had asthma (1.9 %) and heart diseases (1.4%).



N = 360

**Figure 4.6: Pregnant woman on any chronic medication**

Figure 4.6 indicates that 77.8% of the women were taking chronic medication and 22.2% of them were not taking chronic medication.

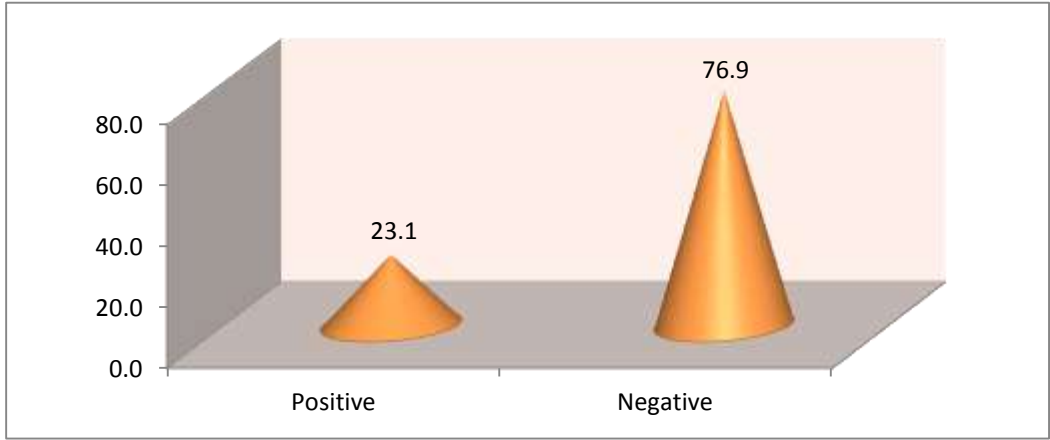


N = 360

**Figure 4.7: Pregnant woman agreeing to share their HIV status**

Figure 4.7 indicates that 83.9% of the respondents did not mind sharing their HIV status while 16.1% preferred not to share their HIV status.



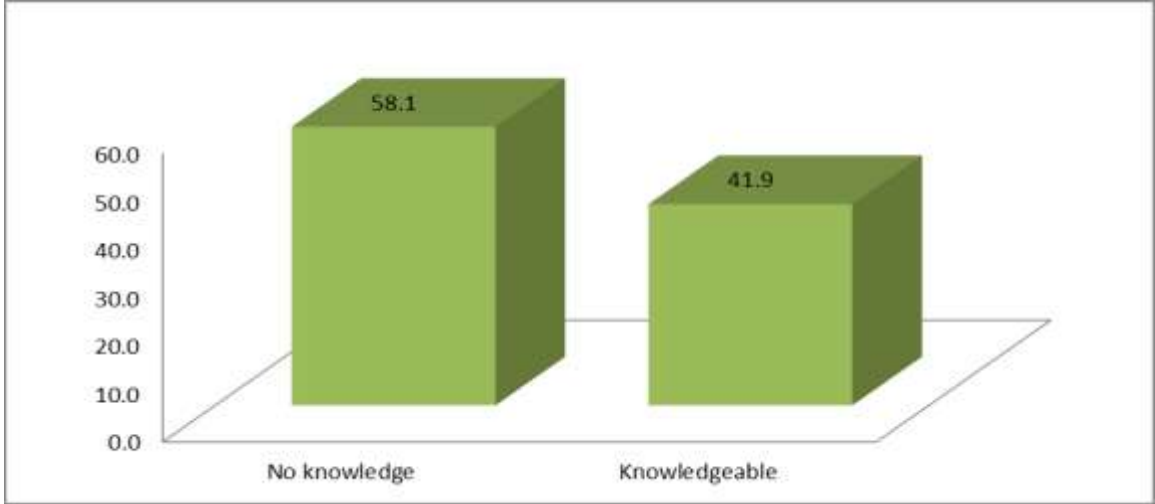


N = 302

**Figure 4.8: Pregnant women’s HIV status**

Figure 4.8 indicates that 76.9% of the women were HIV negative while 23.1% were HIV positive.

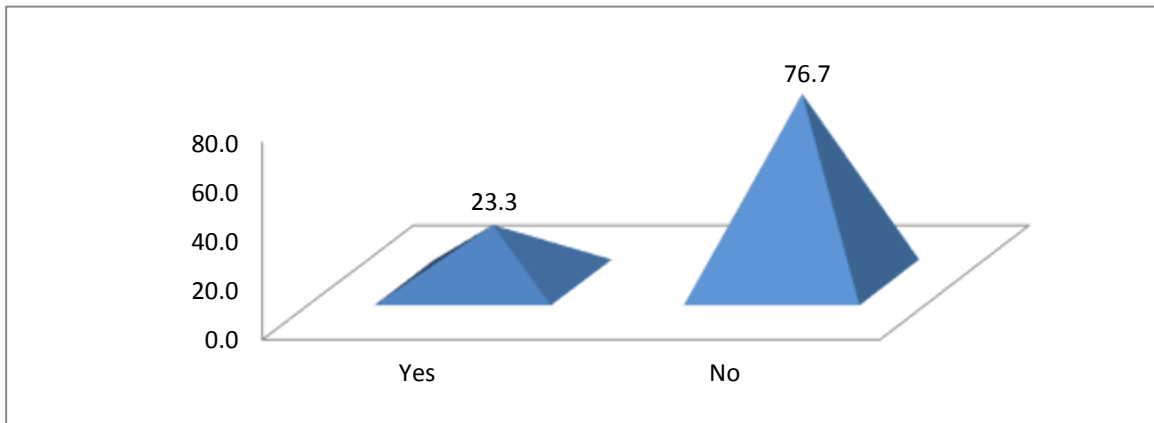
**4.4 SECTION C: REFERRAL SYSTEM**



N = 360

**Figure 4.9: Knowledge of women about a referral system**

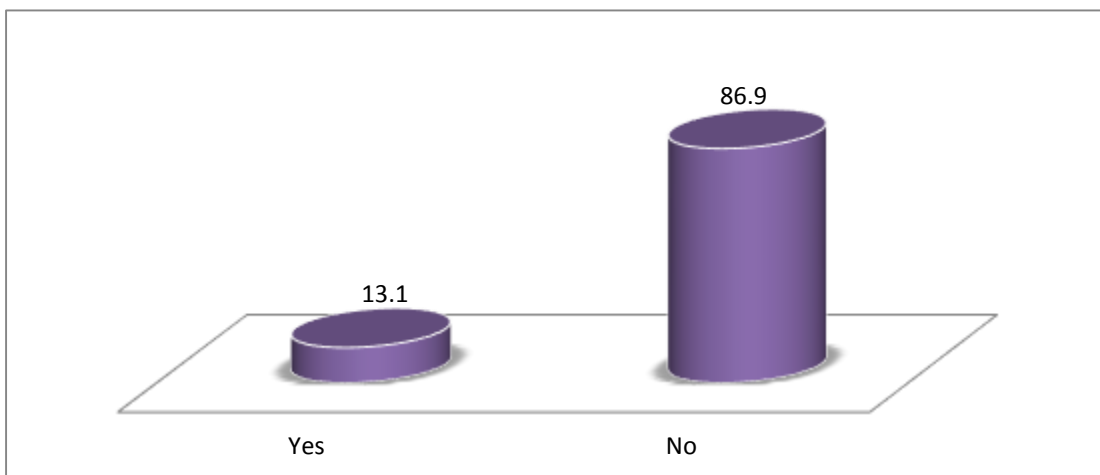
According to Figure 4.9, 58.1% of the responding women did not have knowledge of a referral system while 41.9% of them knew about a referral system.



N = 360

**Figure 4.10: Women who were referred to the hospital for delivery**

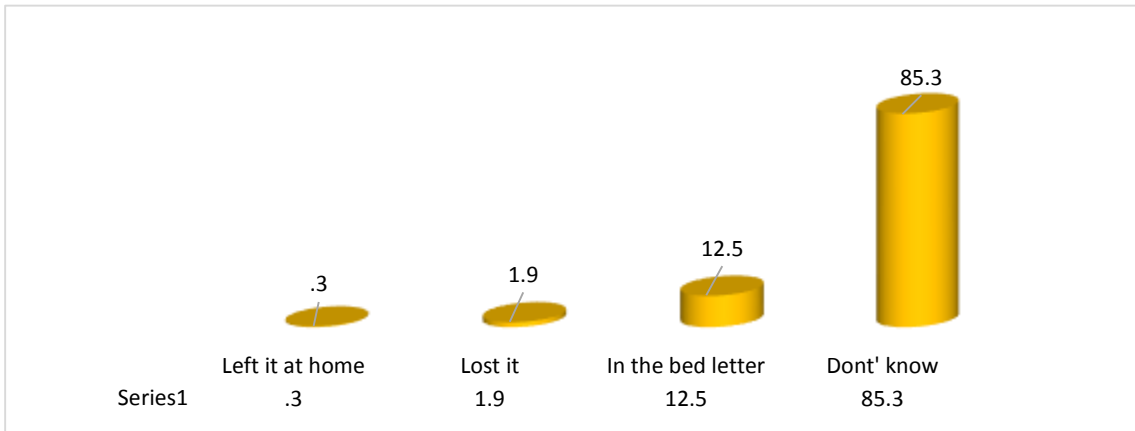
Figure 4.10 indicates that 76.7% were not referred and 23.3% were referred.



N = 84

**Figure 4.11: Women who were given referral letters**

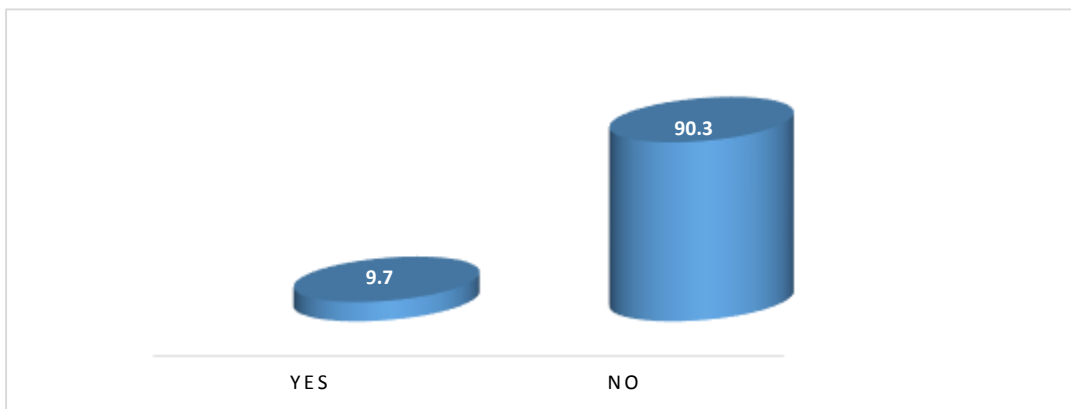
Figure 4.11 indicates that 86.9% of the respondents did not receive referral letters while a small minority (13.1%) were given referral letters.



N = 84

**Figure 4.12: Women who had referral letters**

Figure 4.12 indicates that the largest percentage (85.3%) of the women who had referral letters did not know where the referral letters were. Twelve and a half per cent had the referral letters in their bed letters while 1.9% of them lost their referral letters and 0.3% left their referral letters at home.



N = 84

**Figure 4.13: Women who were given information about referral letters**

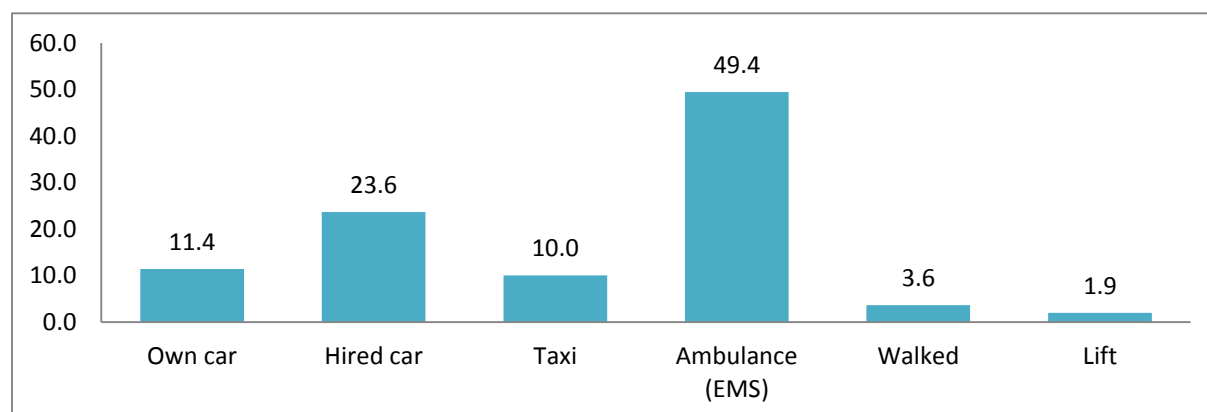
Figure 4.13 indicates that 90.3% of the responding women were not informed about the use and the importance of the referral letter while only 9.7% of them were informed about the use and the importance of referral letter.

Table 4.9 indicates that the largest percentage 60.8% of respondents were staying more than 10km from the hospital, 30.3% were staying 5 – a 10km from the hospital while a small minority (8.9%) were staying 5km or closer from the hospital.

**Table 4.9: Distance to the hospital**

Distance to the hospital	Frequency	Per cent
5km or less	32	8.9
5km – 10 km	109	30.3
More than 10 km	219	60.8
Total	360	100.0

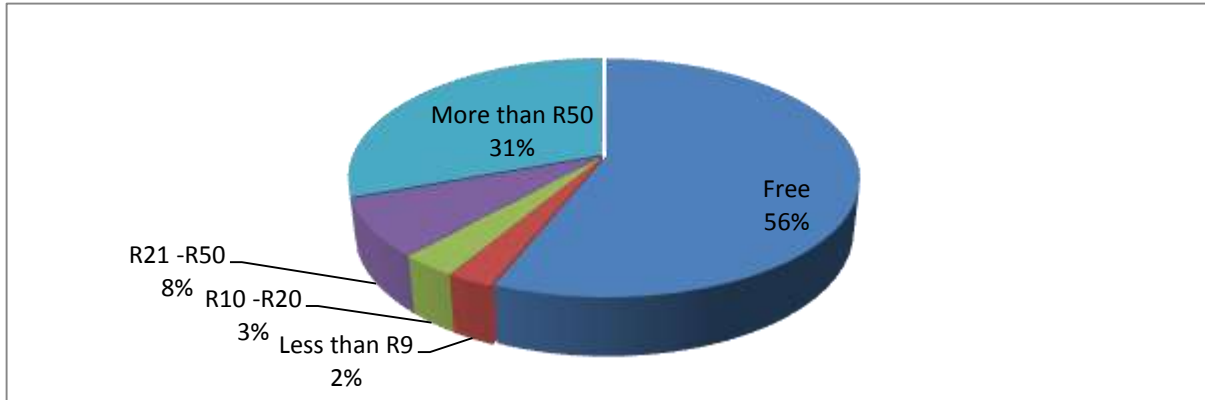
N = 360



N = 360

**Figure 4.14: Mode of transport**

Figure 4.14 shows that almost half (49.4%) of the respondents used ambulance services. More than a quarter (23.6%) used hired cars, (11.4%) used their own cars while (10.0%) used taxis. The smallest percentages (3.6%) walked to the hospital whereas (1.9%) asked other people to give them a lift to the hospital.



N = 360

**Figure 4.15: Transport fare**

Figure 4.15 shows that the largest percentage (56%) did not pay for transportation to the hospital. Nearly a third (31%) paid more than R50, 8% paid R21 – R 0, 3% paid R10 – R20, and 2% paid R9 or less.

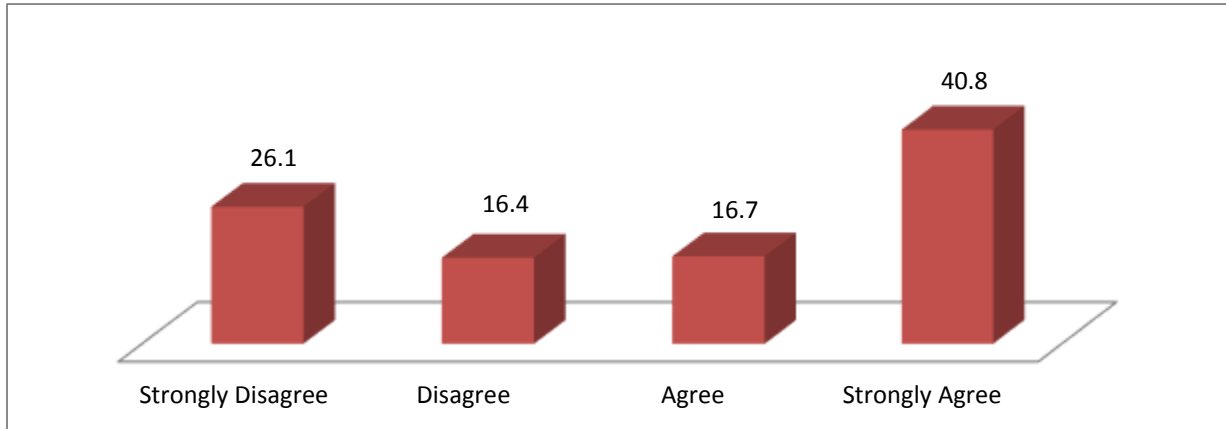
#### 4.5 SECTION D: REASONS FOR SELF-REFERRAL

Table 4.10 indicates that 169 (46.9%) of the respondents strongly agreed that there was no doctor at the clinic, 124 (34.4%) agreed that there was no doctor at the clinic, 37 (10.3%) disagree that there was not doctor at the clinic, and 30 (8.3%) women strongly disagree that there was no doctor at the clinic.

**Table 4.10: Availability of doctor at the clinic**

No doctor at the clinic	Frequency	Percent
Strongly Disagree	30	8.3
Disagree	37	10.3
Agree	124	34.4
Strongly Agree	169	46.9
Total	360	100.0

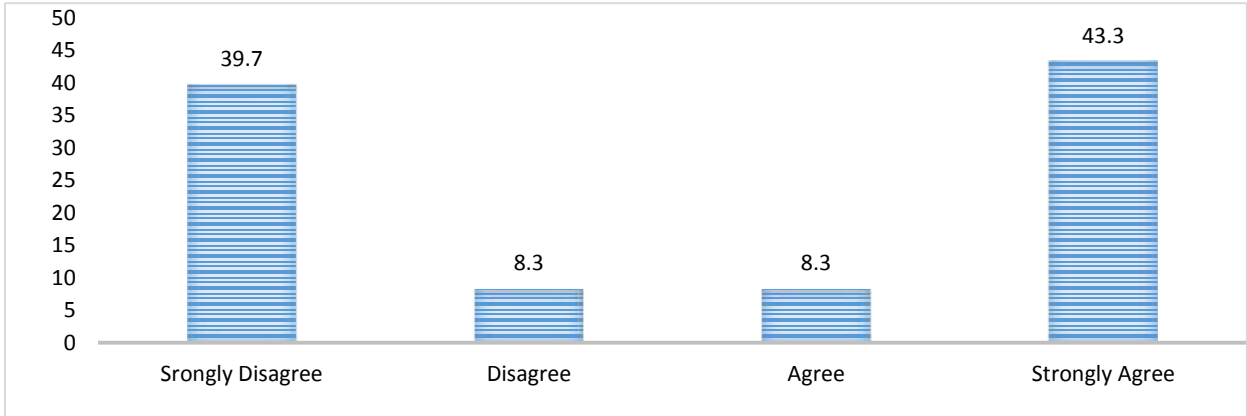
N = 360



N = 360

**Figure 4.16: Availability of a nurse / midwife at the clinic during the night**

Figure 4.16 shows that 40.8% of the responding women strongly agreed that there was only one nurse / midwife at the clinic during the night, 26.1% of them strongly disagreed that there was a nurse / midwife at the clinic during the night, 16.7% agreed that there was only one nurse/midwife at the clinic during the night, and 16.4% women disagreed that there was a nurse / midwife at the clinic during the night.



N = 360

**Figure 4.17: Ambulance (EMS) took me straight to the hospital**

Figure 4.17 indicates that 43.3% of the women strongly agreed that the ambulance took them straight to the hospital, 39.7% of them strongly disagreed that the ambulance took them straight to the hospital and an equal number of women agreed and disagreed (8.3%) that the ambulance took them straight to the hospital.

Based on results in Table 4.11 about resources available at the clinic, on issue of no sonar at the clinic, 63.8% of the respondents strongly agreed, 31.4% agreed, 3.1% strongly disagreed, and 2.5% disagreed there was no sonar at the clinic.

On issue of no instrument to assist with delivery, 57.8% of the respondents strongly agreed, 33.6% agree. 4.7% disagree, and 3.3% strongly disagree that there are no instruments to assist in delivery at the clinic.

For issue of adequate space and enough rooms for delivery at the clinic, 51.7% of the respondents strongly agreed, 24.7% strongly disagreed, 19.2% agreed, and 4.7% disagreed that there was not adequate and enough rooms for delivery at the clinic.

Lastly, on the issue no food served at the clinic after delivery, the largest percentage (89.2%) of the respondents strongly agreed, 10.0% agreed, 0.8% strongly disagreed while none of the respondents disagreed that there was no food served at the clinic after delivery.

**Table 4.11: Resources available at the clinic**

<b>Resources available at the clinic</b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>
There is no sonar at the clinic. (n = 360)	63.80%	31.40%	2.50%	3.10%
There are no instruments to assist with delivery at the clinic. (n = 360)	57.80%	33.60%	4.70%	3.30%
There is no adequate space and enough rooms for delivery at the clinic. (n = 360)	51.70%	19.20%	4.70%	24.70%
There is no food served at the clinic after delivery. (n = 360)	89.20%	10.00%	0.00%	0.80%



According to Table 4.12, 196 (54.2%) of the respondents strongly agreed that the nurse at the clinic told them to go straight to the hospital when having labour pains, 90 (25.0%) agreed that the nurse at the clinic told them to go straight to the hospital when having labour pains, 68 (18.9%) strongly disagreed that the nurse at the clinic told them to go straight to the hospital when having labour pains, and 6 (1.7%) disagreed that the nurse at the clinic told them to go straight to the hospital when having labour pains.

**Table 4.12: The nurse at the clinic told me to come to the hospital when having labour pains**

<b>The nurse at the clinic told me to go to the hospital when having labour pains.</b>	<b>Frequency</b>	<b>Percent</b>
Strongly Disagree	68	18.9
Disagree	6	1.7
Agree	90	25.0
Strongly Agree	196	54.2
Total	360	100.0

N = 360

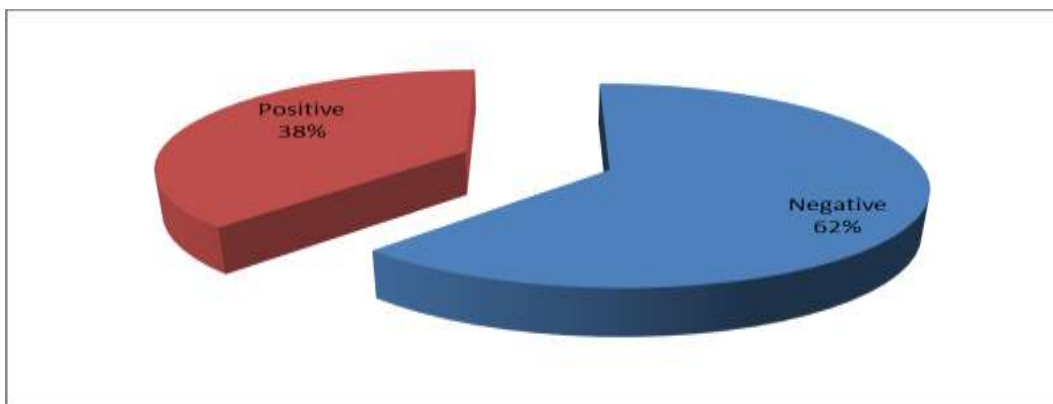
According to this study the knowledge of women about clinic services as shown in Table 4.13, on issue of the clinic that operated during the day only, 54.7% of the respondents strongly agreed, 17.5% agreed, 13.3% disagreed, and 14.4% strongly disagreed. On the issue of women having an idea that they could deliver at the clinic, 55.3% of the respondents strongly agreed, 23.6% agreed, 12.2% disagreed, and 8.9% strongly disagreed. For issue of women receiving more urgent assistance at the hospital than at the clinic, 48.6% of the respondents strongly agreed, 27.2% agreed, 18.60% strongly disagreed, and 5.6% disagreed. On the issue of women being told by someone that it was not safe to deliver at the clinic, 48.9% of the respondents strongly agreed, 26.4% agreed, 13.3% strongly disagreed and 11.4% disagreed.

**Table 4.13: Knowledge of women about clinic services**

<b>Knowledge of women about clinic services</b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>
The clinic operates during the day only. (n = 360)	54.7%	17.5%	13.3%	14.4%
You have no idea that you can also deliver at the clinic. (n = 360)	55.3%	23.6%	12.2%	8.9%
You will get assistance more urgently at the hospital than at the clinic. (n = 360)	48.6%	27.2%	5.6%	18.6%
Someone told you it is not safe to deliver at the clinic. (n = 360)	48.9%	26.4%	11.4%	13.3%

N = 360

According to Figure 4.18, nearly two thirds of the women 223 (62%) reported that nurses at the clinics had a negative attitude towards pregnant women whereas 137 (38%) reported that nurses at the clinics had a positive attitude towards pregnant women.



**Figure 4.18: Perception of women about the nurses**

Table 4.14 shows that 236 (65.6%) of the responding women strongly agreed that nurses at the clinics were rude, 99 (27.5%) of them agreed that nurses at the clinics were rude, 20 (5.6%) strongly disagreed that nurses at the clinics were rude, and 5 (1.4%) women disagreed that nurses at the clinics were rude.

**Table 4.14: Nurses at the clinic are rude**

Nurses at the clinic are rude	Frequency	Percent
Strongly Disagree	20	5.6
Disagree	5	1.4
Agree	99	27.5
Strongly Agree	236	65.6
Total	360	100.0

N = 360

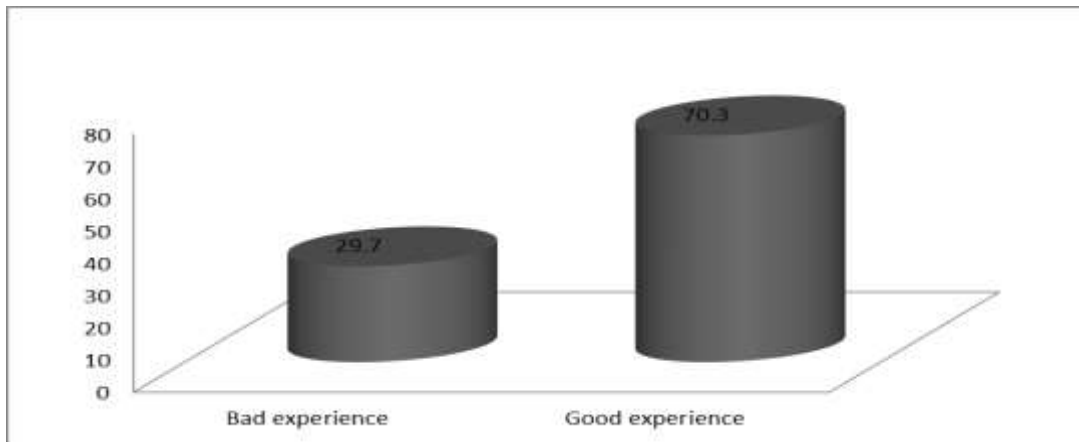
### Women's experience of clinic delivery

Based on the results shown in Table 4.15 about women’s experience of clinic delivery; on the issue of standing in long queues at the clinic, 38.6% of the respondents strongly agreed, 26.1% disagreed, 17.2% agreed and 17.8% strongly disagreed. On the issue of the nurse / midwife at the clinic taking time to attend to them, 39.4% of the respondents strongly agreed, 26.1% agreed, 20.0% strongly disagreed, and 14.4% disagreed. About the issue of a bad experience during a previous delivery at the clinic, 63.6% of the respondents strongly agreed, 21.7% agreed, 11.4% strongly disagreed, and 3.3% disagreed. On the issue of respondents knowing someone who had complications with a previous delivery at the clinic, 61.9% of them strongly agreed, 21.1% agreed, 14.2% strongly disagree, and 2.8% disagreed. Lastly, on the issue about women not being embarrassed to be seen screaming by the nurse / midwife they saw more often while in labour, 40.3% of respondents agreed, 33.9% strongly disagreed, 15.6% strongly agreed, and 10.3% disagreed.

**Table 4.15: Women’s experience of a clinic delivery**

<b>Women’s experience of a clinic delivery</b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>
You cannot stand in long queues at the clinic. (n = 360)	38.6%	17.2%	26.1%	17.8%
Nurse / midwife at the clinic takes time to attend to you. (n = 360)	39.4%	26.1%	14.4%	2%
You had complications with your previous delivery at the clinic. (n = 360)	63.6%	21.7%	3.3%	11.4%
Someone you know had complications with her previous delivery at the clinic. (n = 360)	61.9%	21.1%	2.8%	14.2%
You are embarrassed to be seen screaming by a nurse / midwife you see often when in labour. (n = 360)	15.6%	40.3%	10.3%	33.9%

**Bad or good experience of a clinic delivery**



N = 360

**Figure 4.19: Bad or good experience of a clinic delivery**

According to Figure 4.19, 70.3% of the responding women had a good experience of clinic services and 29.7% of them had a bad experience of clinic services.

## 4.6 THE RELATIONSHIP BETWEEN THE VARIABLES

**Table 4.16: Employment vs self-referral**

Employment			Total
	Referred	Self-referred	
Scholar	22	58	80
	6.1%	16.1%	22.2%
Employed	30	89	119
	8.3%	24.7%	33.1%
Self-employed	0	15	15
	0.0%	4.2%	4.2%
Unemployed	32	113	145
	8.9%	31.4%	40.3%
Total	84	276	360
	23.3%	76.7%	100.0%
Chi-Square Tests			
	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.010 <sup>a</sup>	4	.198
Likelihood Ratio	9.611	4	.048
Linear-by-Linear Association	1.038	1	.308
N of Valid Cases	360		

Using the Chi-Squared test in Table 4.16,  $P = 0.198$  is more than the required value. Therefore, the  $P$  value is insignificant, meaning that employment does not have an impact on self-referral.

**Table 4.17: Distance to the hospital vs self-referral**

Distance to the hospital			Total
	Referred	Self-referred	
5km or less	12	20	32
	3.3%	5.6%	8.9%
5km -10 km	36	73	109
	10.0%	20.3%	30.3%
More than 10 km	36	183	219
	10.0%	50.8%	60.8%
Total	84	276	360
	23.3%	76.7%	100.0%
Chi-Square Tests			
	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	15.136 <sup>a</sup>	2	.001
Likelihood Ratio	14.795	2	.001
Linear-by-Linear Association	13.966	1	.000
N of Valid Cases	360		

According to the Chi-Square test results in Table 4.17,  $P = 0.01$  is less than the required value. Therefore, the  $P$  value is significant, meaning that distance to the hospital has an impact on self-referral.

**Table 4.18: Transport fare vs self-referral**

Transport fare	Referred	Self-referred	
Free	52	150	202
	14.4%	41.7%	56.1%
Less than R9	0	9	9
	0.0%	2.5%	2.5%
R10 - R20	4	7	11
	1.1%	1.9%	3.1%
R21 - R50	16	12	28
	4.4%	3.3%	7.8%
More than R50	12	98	110
	3.3%	27.2%	30.6%
Total	84	276	360
	23.3%	76.7%	100.0%
Chi-Square Tests			
	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	31.822 <sup>a</sup>	4	.000
Likelihood Ratio	32.258	4	.000
Linear-by-Linear Association	2.997	1	.083
N of Valid Cases	360		

According to the Chi-Squared test results in Table 4.18,  $P=0.00$  is less than the required value. Therefore, the P value is significant, which indicates that the transport fare has an impact on self-referral.

**Table 4.19: Availability of a doctor at the clinic vs Self-referral**



Availability of a doctor at the clinic			Total		
	Referred	Self-referred			
Not available	10	57	67		
	2.8%	15.8%	18.6%		
Available	74	219	293		
	20.6%	60.8%	81.4%		
Total	84	276	360		
	23.3%	76.7%	100.0%		
Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.953 <sup>a</sup>	1	.001		
Continuity Correction <sup>b</sup>	2.001	1	.170		
Likelihood Ratio	3.521	1	.061		
Fisher's Exact Test				.079	.046
Linear-by-Linear Association	3.244	1	.072		
N of Valid Cases	360				

In the Chi-Squared test results in Table 4.19,  $P = 0.01$  is less than the required value. Therefore, the  $P$  value is significant; this means that the availability of doctors at the clinic has an impact on self-referral.

**Table 4.20: Availability of a midwife at the clinic during the night vs self-referral**

Availability of a midwife at the clinic			Total		
	Referred	Self-referred			
Count	26	127	153		
%	7.2%	35.3%	42.5%		
Count	58	149	207		
%	16.1%	41.4%	57.5%		
Count	84	276	360		
%	23.3%	76.7%	100.0%		
Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.979 <sup>a</sup>	1	.014		
Continuity Correction <sup>b</sup>	5.378	1	.020		
Likelihood Ratio	6.129	1	.013		
Fisher's Exact Test				.017	.010
Linear-by-Linear Association	5.962	1	.015		
N of Valid Cases	360				

According to the Chi-Squared test results in Table 4.20,  $P = 0.014$  is less than the required value. Therefore, the  $P$  value is significant, meaning that the availability of nurses / midwives at the clinic during the night has an impact on self-referral.

**Table 4.21: Availability of food at the clinic vs self-referral**

Availability of food at the clinic			Total		
	Referred	Self-referred			
Not available	2	1	3		
	0.6%	0.3%	0.8%		
Available	82	275	357		
	22.8%	76.4%	99.2%		
Total	84	276	360		
	23.3%	76.7%	100.0%		
Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.576 <sup>a</sup>	1	.015		
Continuity Correction <sup>b</sup>	1.003	1	.273		
Likelihood Ratio	2.360	1	.110		
Fisher's Exact Test				.137	.137
Linear-by-Linear Association	3.167	1	.075		
N of Valid Cases	360				

According to the Chi-Squared test results in Table 4.21,  $P = 0.15$  is less than the required value. Therefore, the  $P$  value is significant, implying that the availability of food at the clinic has an impact on self-referral.

**Table 4.22: Knowledge of women about clinic services vs self-referral**

Knowledge of women about clinic services	Were you referred?		Total		
	Referred	Self-referred			
Not aware	57	203	260		
	15.8%	56.4%	72.2%		
Aware	27	73	100		
	7.5%	20.3%	27.8%		
Total	84	276	360		
	23.3%	76.7%	100.0%		
Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.041 <sup>a</sup>	1	.308		
Continuity Correction <sup>b</sup>	.776	1	.378		
Likelihood Ratio	1.020	1	.313		
Fisher's Exact Test				.331	.188
Linear-by-Linear Association	1.038	1	.308		
N of Valid Cases	360				

Using the Chi-Squared test in Table 4.22,  $P = 0.308$  is more than the required value. Therefore, the  $P$  value is insignificant; it means that knowledge of women about clinic services does not have an impact on self-referral.

**Table 4.23: Women's knowledge about clinic deliveries vs self-referral**

Women's knowledge about clinic deliveries			Total		
	Referred	Self-referred			
Not aware	65	219	284		
	18.1%	60.8%	78.9%		
Aware	19	57	76		
	5.3%	15.8%	21.1%		
Total	84	276	360		
	23.3%	76.7%	100.0%		
Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.150 <sup>a</sup>	1	.699		
Continuity Correction <sup>b</sup>	.055	1	.815		
Likelihood Ratio	.148	1	.701		
Fisher's Exact Test				.760	.402
Linear-by-Linear Association	.149	1	.699		
N of Valid Cases	360				

The Chi-Squared test results in Table 4.23 indicate that the  $P = 0.198$  is more than the required value. Therefore, the  $P$  value is insignificant; knowledge of women about clinic deliveries does not have an impact on self-referral.

## **4.7 CONCLUSION**

The findings of this study are presented in this chapter by using tables and figures. A discussion of the major findings of the study, limitations, and recommendations are presented in the next chapter.

## **CHAPTER 5**

### **DISCUSSION OF MAJOR FINDINGS, LIMITATIONS, RECOMMENDATIONS, AND CONCLUSION**

#### **5.1 INTRODUCTION**

The major findings of this study, limitations, recommendations, and conclusions are presented.

#### **5.2 RESTATEMENT OF THE PROBLEM STATEMENT**

There was a high number of self-referrals of antenatal women for delivery at the maternity ward at the Dilokong Hospital in the Limpopo Province. In the 2010 / 2011 financial year, there were 3 737 antenatal women deliveries at the Dilokong Hospital. Only 1 550 of these women were referred from other health facilities and that seemed to suggest that antenatal women did not go to the nearest PHC facilities for delivery. The health care institutions seemed not to have a specific strategy that is used for guiding antenatal women about the referral system. The CEO of the Dilokong Hospital has indicated that there was a need to conduct the study (Department of Health, 2011b).

#### **5.3 AIM OF THE STUDY**

The aim of the study was:

- To determine the factors contributing to self-referral of antenatal women for delivery at the Dilokong Hospital, Greater Tubatse Local Municipality.

#### **5.4 OBJECTIVE OF THE STUDY**

The objective of this study was:

- To describe the factors contributing to self-referral of antenatal women for delivery at the Dilokong Hospital.

## **5.5 DISCUSSION OF MAJOR FINDINGS**

The findings of this study are compared with findings of other researchers with regard to the research phenomenon.

### **5.5.1 Age**

Most women in this study were between 21-30 years, which concurs with the age categories that are associated with more pregnancies than the other age categories (Department of Health, 2007).

### **5.5.2 Parity**

The findings indicate that 146 (40.3%) of the respondents in the study were primigravidae and were supposed to deliver at the hospital. Only 84 (23%) of them were referred to the hospital for delivery. This contradicts the guidelines of maternal care because according to the guidelines, all primigravidae are expected to deliver at the hospitals and not at the clinics. Therefore, these women are supposed to produce referral letters from their nearest clinics at the hospitals that they are referred to (Department of Health, 2011a).

### **5.5.3 Delivery site**

Women in this study previously either delivered at the public hospitals, clinics, or private hospitals under the supervision of skilled health care workers at these health facilities. It is encouraging that most women delivered at a health facility and only a small number of 21 (5.8%) delivered at home. According to NDoH, (2011a), institutional delivery under the guidance of a skilled health worker with midwifery skills prevails at 40%. During the 5<sup>th</sup> National Health Assembly that was held in October 2007, it was resolved that in order to improve maternal health, stakeholders should encourage using skilled attendants for deliveries (NDoH, 2011a and NDoH 2011c).



#### **5.5.4 HIV status**

According to the latest South African Survey, one in two HIV positive people is a woman of child-bearing age. Of the 5.258 million South Africans living with HIV, KwaZulu-Natal has the highest proportion of 15%, followed by the Free State, Mpumalanga, and the North West Province at 13%. The Western Cape has the lowest proportion at 5% (UNAIDS World AIDS Day Report, 2012).

The Antenatal Care (ANC) survey, indicate that the HIV prevalence rate in the Limpopo Province is estimated at 21.4% in 2010 and 22.1% in 2011 (Department of Health Budget Vote Speech, 2012/13). According to the Actuarial Society of South Africa (ASSA) provincial modelling, there were 409 161 people living with HIV in the Limpopo Province in 2011 (Department of Health, 2012). HIV prevalence amongst ANC attendees in the Limpopo Province declined significantly from 21.5% in 2007 to 20.7% in 2008, but increased to 21.4% in 2009, 21.9% in 2010, and 22.1% in 2011 (Department for Public Service and Administration Annual Report, (2009/10).

The Limpopo Province remains the third-lowest province affected by the HIV epidemic, after the Western Cape (18.2%), and the Northern Cape (17.0%) (Department of Health, 2011b). In this study, 76.9% of women tested HIV negative and 23.1% tested HIV positive. The percentage of women who had tested HIV positive in this study was slightly more than the percentage in the Limpopo Province.

#### **5.5.5 Disclosure patterns**

Although 16.1% of women did not share their HIV status and their HIV status was not known, 83.9% of women did not mind sharing their HIV status. Women should be continually encouraged to disclose their HIV status. According to the Prevention of Mother-to-Child Transmission (PMTCT) programme, it is encouraged that pregnant women disclose their HIV status to the nurse because when they disclose, they will access health services with regard to the PMTCT programmes (Department of Health, 2007).

### **5.5.6 Information about clinic services**

Almost 80% of the women did not know that they could deliver at a clinic. The majority believed that they would get more urgent assistance at the hospital than at the clinic. It is surprising that more women reported that they received good service at the clinic in comparison to the hospital. It is also surprising that more women reported that they were told to go to the hospital when having labour pains when only primigravidae and women with complications are supposed to deliver at the hospital. According to Kkonde (2010), midwives at the PHC facilities are in the best position to empower pregnant women by giving them adequate information about all services and choices that are available to them in order for them to make informed decisions about where to deliver. However, women are not always given enough information to assist them with making the correct decisions.

The “Mother-baby package: Implementing safe motherhood in countries” (WHO, 2006) suggests the antenatal care should be used to help women and their families to develop an appropriate delivery plan (including place of delivery) based on the women's history and health status. The (Safe Motherhood Initiative) emphasises that women's choices should be respected and ensured. This adds another dimension to the discussion about antenatal risk assessment and referral, because it implies involving the mother in defining the need for referral and shifts the focus from predictive power of risk factors to the risk as perceived by the individual mother.

For any woman to make an informed decision about choice of delivery site and also to be able to recognise complications or illness, she needs adequate information that is normally provided by the health worker. The health worker at the clinics wields influence in women's decision making. The lack of exercising that influence could possibly be the reason why women bypass clinics and why there is an underutilisation of PHC facilities for delivery (Kkonde, 2010).

### **5.5.7 Availability of a doctor at the clinic**

Doctors visit the primary health care (PHC) clinics once a week during the day. They usually treat patients who are referred by the nurses. A study conducted by Low *et al.* (2007) confirms that there are no doctors at the PHCs. In this study, the unavailability of doctors at the PHC facilities influenced the pregnant women to refer themselves to the hospital. Normally, the patient who is requiring health services will go to the nearest PHC clinic. Only when that health facility lacks the skills and equipment to treat the patient will they then be referred to a district hospital. The pattern of patients going directly to the hospital in the hope of best treatment while bypassing the PHC facilities has been observed in Namibia, partly because patients know that the hospital has better facilities and doctors with specialised skills (Low *et al.*, 2007).

### **5.5.8 Availability of midwives / nurses at the clinic during the night**

There was a correlation between the availability of midwives / nurses and self-referral. Those who referred themselves to the hospital did so because they believed that there were no midwives / nurses at clinic at night.

A study by Danilina and Gorelup (2014) indicates that 65.4% of their respondents pointed out that they preferred to go directly to the hospital, while 34.6% preferred to go to PHC centres. More than 65% of clients were satisfied with the services at the PHC centres and less than 11% of them were dissatisfied with its services, 74% of respondents believed that the services at hospitals were better than at PHC centres. On the other hand, nearly 60% of the respondents indicated that there is shortage of staff at PHC centres, especially during the night while less (45%) indicated that there is shortage of staff during the night at hospitals.

### **5.5.9 Availability of food at the clinic**

PHCs and clinics do not provide food to the patients. If a patient delivers at a clinic, the relatives are supposed to bring food to the patient. In this study, availability of food at the clinic played an important role in relation to self-referral. Women referred themselves to the hospital because there was no food provided at the clinic.

### **5.5.10 Availability of sonar, instruments, space**

More women reported that there were no sonar, instruments for assisting women to deliver, and space at the clinic. A similar study by Danilina & Goreluv, (2014) indicates that infrastructure deficits, such as not well equipped rooms for delivery, are reported to have significant effects on pregnant woman and make it very difficult for women to choose to deliver at a clinic. Another study by Mbatha and Lutge (2007) explains the physical environment or infrastructure with regard to the health care facilities as the state of maintenance of the buildings, the availability of basic services (such as water and electricity), the availability of and access to the necessary technology (for example, communication systems and laboratory data information systems), and the availability of functional medical and non-medical equipment. Infrastructure, such as viable surrounding roads and a transport system, is also important in facilitating patients' access to health care facilities.

### **5.5.11 Patients' perceptions of midwives / nurses at the clinic**

The majority (93.1%) of women in this study believed that midwives / nurses at the clinic were rude. In Ghana, managers of health services looked at how midwives' behaviour affected pregnant women's choice of health care. Women who participated in that study highlighted serious neglect and abuse by midwives. Midwives at the PHC facilities often shouted at them, they were rude and refused to offer assistance. Those women, who were mistreated, were looking elsewhere for care the next time that they became pregnant (Amooti & Nuwaha, 2000). A similar study by Adam & Salihu, (2002), that was conducted in Nigeria notes that the behaviour of midwives at the clinics is often reported to be inappropriate. Some midwives are accused of shouting at and humiliating their

patients for screaming in labour, for taking too long to deliver, or for refusing to show their genitals. Abbey (2008) further reports that women who are badly treated would not recommend other women to make use of the services of those midwives. In this study, women were not asked to describe the type of rudeness they experienced and whether they would not recommend other women to deliver at the clinic.

Dr Aaron Motswaledi made the public aware of the procedure to follow when lodging a complaint about nurses who have a negative attitude towards them (NDoH, 2011b).

## **5.6 LIMITATIONS OF THE STUDY**

Though the study was successfully conducted and concluded, there were some limitations that were encountered during the study period. They included the following;

- The population of the study were women who had just delivered. Due to tiredness, they might have selected answers without reading simply to get the questionnaire completed.

## **5.7 RECOMMENDATIONS**

The following recommendations are intended to form a basis for future studies and also a platform for informed evidence-based planning for health system improvement by the Tubatse Municipality planners, as well as by the Ministry of Health as the overall policy formulation centre. It is recommended that:

- There is need to develop health programmes and more community engagements with the health workers in order to sensitise the community and give correct information about services offered at the clinics, the referral system, and messages to guide women in their decision making processes.
- A study should be conducted to evaluate the causes of unethical and unprofessional behaviour of health workers at public health facilities in order to suggest appropriate ways and means of effectively dealing with the unethical and unprofessional behaviour.

- Efforts should be made to improve the image of health workers in the eyes of the public by initiating programmes that continually monitor the health workers' professional conduct, with mechanisms to address identified inefficiencies.
- Government should ensure that the clinics are well equipped with personnel, resources, and equipment needed for services offered at the clinics.

## **5.8 CONCLUSION**

There is an underuse of clinic services in the Tubatse Municipality for delivery while the Dilokong Hospital is overstretched. The majority of women who deliver at the hospital are not high risk patients and may well deliver at a PHC facility. Choice of site of delivery by women is mainly a personal decision and preference that is significantly influenced by a lack of knowledge about the referral system, health workers conduct, and availability of supplies. The conduct of health workers need to improve.

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## APPENDIX A: RESEARCH QUESTIONNAIRE

Questionnaire number: \_\_\_\_\_

PLEASE ANSWER THE FOLLOWING QUESTIONS BY PUTTING A TICK (✓) SIGN ON THE APPROPRIATE BLOCK.

### SECTION A: DEMOGRAPHIC INFORMATION

1. Age?

11-20 years	1.
21-30 years	2.
31-40 years	3.
Above 40 years	4.

2. Educational level?

Never been at school	1.
Primary	2.
Secondary	3.
Tertiary	4.

3. Marital status?

Single	1.
--------	----

Co-habiting	2.
Married	3.
Divorced	4.
Widowed	5.

4. Occupation?

Scholar	1.
Employed	2.
Self-employed	3.
Unemployed	4.

5. Religion?

Christian	1.
Non-Christian	2.
Other	3.

6. Race group?

African	1.
White	2.
Indian/Asian	3.
Coloured	4.

## SECTION B: GYNAECOLOGICAL HISTORY

7. Number of pregnancies including the current pregnancy?

0-1	1.
2-5	2.
6-10	3.
Above 10	4.

8. Number of children?

0-1	1.
2-5	2.
6-10	3.
Above 10	4.

9. If having children, where did you deliver your children?

Home	1.
Clinic	2.
Private hospital	3.
Public hospital	4.

10. How did you give birth to your last baby?

Self-delivery	1.
Normal delivery	2.

Assisted delivery	3.
Caesarean-section (Operation)	4.

11. How long did you have labour pains before delivery with your last pregnancy?

Few hours	1.
A day	2.
A week	3.
Do not know	4.

12. Was the pregnancy?

Planned	1.
Unplanned	2.

13. Have you been admitted with current pregnancy?

Yes	1.
No	2.

14. Which of the following abnormalities do you have in your family?

Twins	1.
Diabetes mellitus	2.
Hypertension	3.

Congenital abnormalities	4.
None	5.

15. Which of the following diseases do you suffer from?

Diabetes mellitus	1.
Tuberculosis	2.
Heart disease	3.
Asthma	4.
Hypertension	5.
None	6.

16. Are you on any medication?

Yes	1.
No	2.

17. Do you mind sharing your HIV status?

Yes	1.
No	2.

18. If yes, what is your HIV status?

Positive	1.
Negative	2.



## SECTION C: KNOWLEDGE OF REFERRAL SYSTEM VERSUS VALUE FOR MONEY

19. Were you referred?

Yes	1.
No	2.

20. If yes, were you given referral letter?

Yes	1.
No	2.

21. If yes, where is the referral letter?

Left it at home	1.
Lost it.	2.
In the bed letter	3.
Don't know.	4.

22. Were you informed about the use / importance of referral letter?

Yes	1.
No	2.

23. How far is your home from the Dilokong Hospital?

5km or less	1.
5km-10 Km	2.
More than 10Km	3.

24. Which means of transportation have you used to come to the hospital?

Own car	1.
Hired car	2.
Taxi	3.
Ambulance (EMS)	4.
Bus	5.
Walked	6.
Lift	7.

25. If transport / own car used, how much have you spend?

Free	1.
Less than R 9	2.
R 10-R 20	3.
R 21-R 50	4.
More than R 50	5.

#### SECTION D: FACTORS CONTRIBUTING TO SELF-REFERRAL

Keywords: 1. Strongly disagree **SD**

2. Disagree **D**

3. Agree **A**

4. Strongly agree **SA**

<b>Did you bypass the clinic because of the following?</b>	<b>SD</b>	<b>D</b>	<b>A</b>	<b>SA</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Services and resources</b>				
26. There is no doctor at the clinic.				
27. There is only one nurse / midwife at the clinic on duty during the night.				
28. There is no sonar at the clinic.				
29. There are no instruments to assist with delivery at the clinic.				
30. There is no adequate space and enough rooms for delivery at the clinic.				
31. There is no food served at the clinic after delivery.				
32. The nurse at the clinic told me to come straight to the hospital when having labour pains.				
33. You were at town / visited when started having labour pains.				
34. Ambulance (EMS) took me straight to the hospital.				
<b>Knowledge of women</b>				
35. The clinic operates during the day only.				
36. You have no idea that you can also deliver at the clinic.				
37. You will get assistance urgently at the hospital than in the clinic.				

<b>Did you bypass the clinic because of the following?</b>	<b>SD</b>	<b>D</b>	<b>A</b>	<b>SA</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
38. Someone told you it is not safe to deliver at the clinic.				
<b>Attitude</b>				
39. You do not prefer to be assisted when giving birth by a nurse/midwife you see often.				
40. Your culture / religion does not allow you to deliver at the clinic.				
<b>Experience</b>				
41. You cannot stand long queue at the clinic.				
42. Nurse / midwife at the clinic takes time to attend to you.				
43. You had complications with your previous delivery at the clinic.				
44. Someone you know had complications with her previous delivery at the clinic.				
45. Nurses at the clinic are rude.				
46. You are embarrassed to be seen screaming when in labour by a nurse / midwife you see often.				

N.B: Thank you for your time and cooperation. I really appreciate your participation.

## APPENDIX B: SEPEDI RESEARCH QUESTIONNAIRE

Questionnaire number: \_\_\_\_\_

ARABA DIPOTŠIŠO TŠE DI LATELAGO KA GO NGWALA LESWAO LE (√) KA  
LEPOKISANENG LA MALEBA

KAROLO A: TSEBO KA SETLOGO SA GAGO.

1. Mengwaga?

11-20 mengwaga	1.
21-30 mengwaga	2.
31-40 mengwaga	3.
Above 40 mengwaga	4.

2. Boemo bja dithuto?

Ga se ka tsena sekolo	1.
Phoraimari	2.
Sekondari	3.
Unibesithi / kholetšhe	4.

3. Boemo bja tša manyalo?

Ke nnoši	1.
Ke dula le molekani	2.

Ke nyetšwe	3.
Ke hladile	4.
Ke mohlologadi	5.

4. Tša mešomo?

Ke tsena sekolo	1.
Ke a bereka	2.
Ke a ipereka	3.
Ga ke bereka	4.

5. Tumelo?

Ke tsena kereke	1.
Ga ke tsene kereke	2.

6. Mohlobo?

Mothomoso	1.
Lekgowa	2.
LeIndian / LeAsian	3.
LeColoured	4.

KAROLO B: BOEMO BJA TŠA SESADI

7. O imile ga kae ge re bala le mpa ye ya gonabjale?

0-1	1.
2-5	2.
6-10	3.
Ka godimo ga 10	4.

8. O na le bana ba bakae?

0-1	1.
2-5	2.
6-10	3.
Ka godimo ga 10	4.

9. Ge o na le bana, ngwana wa mafelelo o mmelegetše kae?

Ka gae	1.
kliniking	2.
Sepetleleng sa private	3.
Sepetleleng sa mmušo	4.

10. Ngwana wa gago wa mafelelo o tšile bjang?

Ke ipelegišitše	1.
Ke belege gabotse	2.
Ke belege ka thušo ya ditšhipi	3.

Ke belege ka opareišene	4.
-------------------------	----

11. O tšere nako e kae o šokwa ka pelego ya mafelelo?

Diiri	1.
Letšatši	2.
Beke	3.
Ga ke tsebe	4.

12. O imile ka maikemišetšo?

Ee	1.
Aowa	2.

13. Sa le wa robala sepetlela o imile mpa ye?

Ee	1.
Aowa	2.

14. Ke bofe bogolofadi bjo bo lego gona ka lapeng?

Matwins	1.
Bolwetši bja swikilri	2.
Bolwetši bja madi a magolo	3.
Bogole bjoo o belegwang le bjona	4.



Ga bo gona	5.
------------	----

15. Ke afe malwetši ao o nago le ona?

Bolwaetši bja swikiri	1.
Bolwetši bja mafahla/ TB	2.
Bolwetši bja pelo	3.
Bolwetši bja mafahla / asma	4.
Bolwetši bja madi a magolo	5.
Ga a gona	6.

16. Go na le dihlare tseo o di tšeago?

Ee	1.
Aowa	2.

17. Ga o na bothata bja go bolela ka boemo bja gago bja HIV?

Ee	
Aowa	

18. Ge o dumela, boemo bja gago bja HIV ke eng?

E gona	
Ga e gona	

KAROLO C: TSEBO YA MOKGWA WA GO ROMELWA SEPETLELA LE BOLENG BJA TŠHELETE

19. Ba go referile?

Ee	1.
Aowa	2.

20. Ge ebane ba go referile, ba go file lengwalo la referale?

Ee	1.
Aowa	2.

21. Ge ebane ba go file lengwalo referale, le kae lona?

Ke le šeile gae	1.
Ke le timeditše	2.
Le ka gare ga faele	3.
Ga ke tsebe	4.

22. Sa le wa tsibišwa ka bohlokwa bja bja lengwalo la referale?

Ee	1.
Aowa	2.

23. O dula bokgole bjo bokae le sepetlele sa Dilokong?

5km or less	1.
5km-10 Km	2.
Go feta 10Km	3.

24. O šomišitše senamelwa sa mohuta mang go tla sepetlele?

Koloi ya ka	1.
Ke hirile koloi	2.
Thekisi	3.
Ampulanse (EMS)	4.
Pese	5.
Ke tlile ka maoto	6.
Ke kgopetše lift	7.

25. Ge ebane o šomišitše senamelwa, le ge e le koloi ya gago o šomišitše bokae?

Mahala	1.
Ka fase ga R9	2.
R10-R20	3.
R21-R50	4.
Ka godimo ga R50	5.

KAROLO D: DINHLE TŠEO DI GO HLOHLOLETŠANG GO KE REFERA

Keywords: 1. Ke gana ka kudu **SD**

2. ke a gana **D**

3. ke a dumela **A**

4. ke dumela ka kudu **SA**

<b>O fetetše sepetlele ka mabaka ao a latelago?</b>	<b>SD</b>	<b>D</b>	<b>A</b>	<b>SA</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Ditirelo le dišomišwa</b>				
26. Ga go ngaka kliniking.				
27. Go šoma mooki ka o tee kliniking bošego.				
28. Ga go motšhene wa sonar kliniking.				
29. Ga go ditšhipi tša go thuša go ntšha ngwana kliniking.				
30. Ga go sekgoba le dikamora tšeo di lekanego tša go belegela kliniking.				
31. Ga o fiwe dijo kliniking ge o fetxa go belega				
32. Mooki wa kliniking o go boditše gore o ye bookelong ge o ekwa lešoko.				
33. O be o le toropong/ o etile ge o thoma go šokwa.				
34. Ampulanse (EMS) e go tlišitše sepetlele.				
<b>Tsebo ya mosadi</b>				
35. Kliniki e bulwa mosegare feela.				
36. Ga o tsebe gore o ka belegela kliniking.				

<b>O fetetše sepetlele ka mabaka ao a latelago?</b>	<b>SD</b>	<b>D</b>	<b>A</b>	<b>SA</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
37. O thušega ka tšhoganetšo bookelong go feta kliniking.				
38. O boditšwe gore ga goa bolokega go belegela kliniking.				
<b>Maitshwaro</b>				
39. Ga o kgotsofalele go belegišwa ke mooki wo o mmonago mehle.				
40. Setšo/ tumelo ya gago ga e dumele o belegela kliniking.				
<b>Maitemogelo</b>				
41. O ka se kgotlelele go ema mothaladi o motelele ka kliniking.				
42. Mooki o tšea nako go go thuša ka kliniking.				
43. O bile le mathata ka pelogo ya go feta yeo o belegetšego kliniking.				
44. Motho wo o motsebago o bile le mathata ka go belegela kliniking.				
45. Baaki ba kliniking ga ba bolele le rena gabotse.				
46. O jewa ke dihlong go bonwa o hlabile lešata ge o šokwa ke mooki wo o mmonago mehle.				

N.B: ke leboga tirišano le nako ya lena.

## APPENDIX C: APPROVAL FROM MREC

Prof GA Ogunbanjo  
Chairperson MREC  
P.O.Box 163  
University of Limpopo  
Medunsa Campus, 0204

☎: (012) 521-5617/5671  
Fax: (012) 521-3749  
E-mail:lorato.phiri@ul.ac.za



SM Magoro  
Department of Nursing & Human Nutrition  
University of Limpopo  
Turloop Campus, 0727

Dear Sir/Madam

**RE: FACTORS CONTRIBUTING TO SELF REFERRAL OF ANTENATAL WOMEN FOR DELIVERY AT DILOKONG HOSPITAL, TUBATSE MUNICIPALITY, LIMPOPO PROVINCE.**

Your protocol received was considered at the MREC meeting held on 11 October 2012.

The committee **PROVISIONALLY APPROVED** and **RECOMMENDED** that the researcher must still address the following recommendation before the clearance certificate is issued:

- (i) **Sampling & Pre-test:** Why was the number of respondents required per day put at 10? How many respondents will be used for the pre-test? It is recommended that a statistician be consulted prior to data collection.

MREC awaits your response to above recommendations and submission of a revised protocol that addresses all these concerns

Yours Sincerely



PROF GA OGUNBANJO  
CHAIRPERSON MREC

11 October 2012

Cc.: Dr RN Malema

## APPENDIX D: APPROVAL FROM LIMPOPO PROVINCE DEPARTMENT OF HEALTH



**LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

### DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald

Ref:4/2/2

Magoro SM

Segopje

Polokwane

0744

Dear Ms Magoro

**Re: Permission to conduct the study titled: Factors contributing to self-referral of antenatal women for delivery at Dilokong hospital, Tubatse Municipality, Limpopo Province.**

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
  - Further arrangement should be made with the targeted institutions.
  - In the course of your study there should be no action that disrupts the services.
  - After completion of the study, a copy should be submitted to the Department to serve as a resource.
  - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.

General Manager: Strategic Planning, Policy and Monitoring

Date 27/11/2012

**APPENDIX E: PERMISSION TO CONDUCT STUDY FROM THE CEO OF DILOKONG HOSPITAL**



**LIMPOPO**

**PROVINCIAL GOVERNMENT**  
REPUBLIC OF SOUTH AFRICA

**DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT**  
**DILOKONG HOSPITAL**

PRIVATE BAG X9119 DRIEKOP 1129  
TEL. NO.: 013 214 7265/9  
FAX NO.: 013 214 7281/7201

29 April 2013

ENQ: Mrs. Mashishi M.M  
Tel: 013214 7265/ 083 443 5332  
Fax: 013 214 7201

**To: Ms. Magoro S.M**

**RE: PERMISSION TO CONDUCT RESEARCH PROTOCOL**

Permission is hereby granted for you to conduct research at Dilokong hospital.

Hoping that you will benefit at your time of conducting the research at the institution.

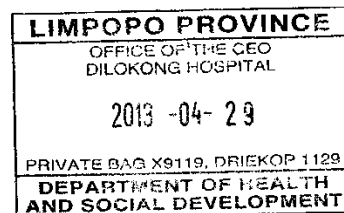
You are also reminded that the results should be made available

Regards

*M. Mashishi* .....

**CHIEF EXECUTIVE OFFICER**

29/04/2013  
DATE





## APPENDIX F: EDITING CONFIRMATION



\* The stars that tell the spade when to dig and the seeds when to grow \*

\* Isilimela – iinkwenkwezi ezixelela umhlakulo ukuba mawembe nembewu ukuba mayikhule\*

P O Box 65251  
Erasmusrand  
0165

31 May 2014

Dear Ms Mamoropo Magoro

**CONFIRMATION OF EDITING THE THE MINI-DISSERTATION WITH THE  
TITLE FACTORS CONTRIBUTING TO SELF-REFERRALS OF ANTENATAL  
WOMEN FOR DELIVERY AT DILOKONG HOSPITAL, GREATER TUBATSE  
LOCAL MUNICIPALITY**

I hereby confirm that I have edited the abovementioned dissertation as requested.

Please pay particular attention to the editing notes AH01 to AH28 for your revision.

The tracks copy of the document contains all the changes I have effected while the edited copy is a clean copy with the changes removed. Kindly make any further changes to the edited copy since I have effected minor editing changes after removing the changes from the tracks copy. The tracks copy should only be used for reference purposes.

Please note that it remains your responsibility to supply references according to the convention that is used at your institution of learning.

You are more than welcome to send me the document again to perform final editing should it be necessary.

Kind regards

A handwritten signature in black ink, appearing to read 'André Hills', is enclosed in a rectangular box.

André Hills  
083 501 4124