

**IsiXhosa storytelling (iintsomi) as an alternative medium for
maternal health education in Primary Healthcare in the Eastern
Cape**

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Declaration

I the undersigned hereby declare that this thesis entitled: “isiXhosa storytelling (iintsomi) as an alternative medium for maternal health education in Primary Health Care in the Eastern Cape”, is my original work.

This thesis is being submitted for the first time to the university and has not been submitted to any other institution towards awarding a degree or any other qualification. All information sources of information used in the thesis have been acknowledged in text, citations and as listed references at the end of the thesis.

SIGNED:**DATE: October 2014**

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DEDICATION

I dedicate this work posthumously to the following persons:

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No size of open eyes matches your closed eyes; your wisdom; and your passion for education. Ndiyabulela *Tolo, Zulu, Mchenge, Dlangamandla*

ABSTRACT

The aim of this study is to explore the introduction of IsiXhosa (*iintsomi*) as an alternative method in the maternal health education in rural Primary Health Care in the Eastern Cape. An informal preliminary observation of a maternal health lesson by the researcher indicated a further need for maternal health educators to introduce storytelling into the health content themes. To re-inforce the maternal health educator lesson on the causes of teenage pregnancy, lifestyles for pregnant women, causes of miscarriage and termination of pregnancy, the Community Health Workers can undoubtedly use isiXhosa iintsomi in selected clinics and maternal waiting homes. As a readily available resource that cuts across all literacy barriers, iintsomi (isiXhosa) fosters a cross-cultural consultation which enables the healthcare worker to convey messages that make sense to the rural women. While the conventional methods of teaching have a tendency to create tension and lack of participation, use of folktale (*iintsomi*) have huge potential to bring lesson enjoyment; a meaningful interaction and story sharing by the maternal health educator, the pregnant women and greater community; access to important health messages; and strengthened utilisation of Primary Health Care. The study therefore suggests that there is a place for isiXhosa iintsomi: From the Fireplace into the Workplace.

'There is nothing strange or inappropriate about mixing drinks or making new blends or indeed of selling old-established tastes in new packaging to new customers for new kinds of profits.' (Finnegan in Sienaert, Bell and Lewis

1991:21)

ACRONYMS

| | |
|---------------|--|
| AOL | African Oral Literature |
| CHWs | Community Health Workers |
| CoMMiC | Committee on Morbidity and Mortality in Children |
| COPC | Community Oriented Primary Care |
| DoH | Department of Health |
| EC | Eastern Cape |
| MHE | Maternal Health Education |
| MWH | Maternal waiting Home |
| NCCEMD | National committee for the Confidential Enquiries into Maternal Deaths |
| OVC | Orphaned and Vulnerable Children |
| PHC | Primary Health Care |
| RDSP | Rural Doctors Support Program |
| SMSB | Saving Mothers Saving Babies |
| UNDG | United Nations Development Goals |
| UNESCO | United Nations Educational, Scientific, and Cultural Organisation |
| UNICEF | United Nations International Children's Emergency Fund |
| UNPFA | United Nations Population Fund |
| WHO | World Health Organisation |

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CHAPTER 1

BACKGROUND TO THE STUDY

1.1 Introduction

The purpose of the study is to explore the use of storytelling in maternal health education. This chapter gives an introductory background to traditional oral folktales in the past, the present and the future. While also alluding to the theoretical basis for the study, folktales in adult education; folktales as a tool for intercultural communication; and their significance in maternal health education at rural Primary Health Care (PHC) level will be presented. Secondly a preliminary case for maternal health education lesson from the researcher's previous experience will be presented. Lastly, ethical considerations and limitation of the study; the statement of the problem; research question; general objectives; specific objectives; and study structure will be outlined in the last part of this chapter.

1.2 Oral traditional folktales: The past, the present and the future

The Eastern Cape is one of South Africa's most rural provinces. Belonging with pride to the African continent, which Finnegan (2007:1) undoubtedly confirms has reason to be celebrated for being home of oral literature, ... and the inspiration of the voiced traditions of the great diaspora, this province can as well be regarded as home to the rich history of oral traditional literature which is enriched with dynamic cultures, customs, beliefs, values, traditions, and indigenous knowledge. Okpewho (1992:2) defines oral literature as simply literature delivered by word of mouth. As Kothari (2007: 4) recently explained, this was not just the word of mouth, it is indigenous knowledge information and wisdom that was conveyed orally, which emerged out of a medley of traditions and customs from various groups of local peoples; presented through folklore, rituals; art and traditional law. In the past, folktales were known to be used mainly by grandmothers to transfer moral lessons, to entertain and strengthen family bonds around the fireplace. Using folktale with animals, giants, and many other funny creatures, children and adults were engaged in informal lessons about imminent dangers of society while there was opportunity for fun and laughter which also strengthened family relations. As Finnegan (2007:121) also exemplifies through the Limba storytelling:

The evening was the usual time for stories. This meant that people had to come home to the village from working on their farms, often miles away, and be in a relaxed mood for enjoying story-telling.

Although Scheub (1975:12) describes the Xhosa storytelling as an essentially a private matter carried out among people who knew each other well, the researcher grew up at a time when folktales were openly narrated by grandmothers and shared with their grandchildren when everyone was back home: girls completed their house chores, boys back from cattle herding, grandparents back from the fields and the pot boiling from the fireplace. Because society evolves, folktales were not only enjoyed through narration in informal settings, they had moved into school classrooms where the focus was more on reading than on narration. As also stated in Ntuli (2011: 63) the most ancient forms of African literature that originated from the spoken word, transmitted orally by our predecessors were also recorded and written in text form by missionaries, hence their being dominated by what Ong (1982:42) terms written/ chirographic culture. The communication that was fostered through folktales (Manona 2002:408) between the grandparents and their grandchildren was thus affected as the generation and the literacy gaps increased.

Unlike its sister genres though, isiXhosa folktales today, have not yet enjoyed pleasing 'mingling with other media of expression like in so many situations today (Finnegan 2007:69). Their use has always been associated with educating and entertainment of children with seldom use for public performance and other contemporary contexts, more especially in the Eastern Cape. With oral poetry taking exciting position in the post-democratic era, for example in government orchestrated ceremonies, isiXhosa folktales still widely remain in books; which because of the hegemony of English; are mostly reduced into translated versions at times by non-mother tongue speakers and feature in media publications; narrated through radios; and television with less face-to face narration to either children or adults. Finnegan (2007:68) blames thus,

We are still, it seems, swayed by the tale of how true communication, development and individual self-fulfillment are brought by the written word and the wonders of modern technology, downplaying the fertile oral modes or suggesting that these, as 'pre-modern', pre-literate', 'traditional' or 'backward', and somehow incompatible with the contemporary world of today.

In order that contemporary society recognises the wealth in folktales as a source of communication, individual and community development, it is worth re-creating their action-oriented compatibility with today's state of the world. Scheub (1975:3) provides a more performance-oriented definition of isiXhosa folktales, thus:

(lintsomi) the Xhosa folktales should be understood as performance rather than as text. The Xhosa *ntsomi* (sing, *intsomi*; pl. *iintsomi*) is a performing art which has, as

its dynamic mainspring, a core-cliche (a song, chant, or saying) which is, during a performance, developed, expanded, detailed, and dramatized before an audience which is itself composed of performers, everyone in a Xhosa society being a potential performer.

Although Scheub describes *iintsomi* as stated above, the researcher feels that different contexts, particularly the rural PHC context, still lacks this understanding, as a result, they have not yet fully exploited *iintsomi* as performing art which according to Kaschula (2001:33) has potential to permeate different contexts. From this definition, the researcher also gathers that folktales (*iintsomi*) have always been historically embedded the isiXhosa language as its people are described as 'potential performers'. As emphasised in Bennie (1935: iii),

Le nto iyintetho yeSizwe ibalulekile. Ayifumane yabakho nje...Yinto ephilileyo, enobom bayo obendeleyo emabalini esizwe. Isingethe apha kuyo izimvo, neengcamango, namabali, namasiko, neenkolo, nohloni, nobuntu besizwe siphela-izinto ezo ezavela kumanyange...

The language of the nation is important. It did not just exist...it is alive; it has life deeply embedded in the stories of the nation. In it there are ideas, and thoughts, stories, rituals and beliefs; respect and Ubuntu for the entire nation- things inherited from ancestors...

With society also taking less pride in their own indigenous languages, the value of oral storytelling is constantly limited to particular functions while the ideas, the thoughts, the rituals, the beliefs and Ubuntu can still be restored in many contexts through continuous sharing of the stories for the same old purposes of educating and entertaining audiences in different contexts.

1.3 Folktales for adult education: A theoretical perspective

This study bases its significance to three aspects which the researcher views as crucial to define the relevance of folktales for adult education, namely:-

- a) The nature and the model for Primary Health Care
- b) The nature of the audience receiving maternal health lessons and the role of maternal health educators as facilitators of learning in the rural PHC context.
- c) The nature of communication between the rural women and educators in the PHC context.

1.3.1 The nature and the model for Primary Health Care

According to Olver (2011:7) the PHC has been a core component of South African government health policy since 1994 and is enshrined as the centre piece of the Reconstruction and Development Programme's health policy, which states that:

“The whole National Health System must be driven by the Primary Health Care approach. This emphasises community participation and empowerment, intersectoral collaboration and cost-effective care, as well as integration of preventive, promotive, curative and rehabilitation services.”

Since maternal and child mortality is not a sectoral issue, it is important for society to realise different ways through which they can assist towards the ideals stated in the RDP as outlined above. The collaborative nature of the PHC model as illustrated in Pillay & Baron (2011/2012:4) also implies a need for other sectors like education, local government, environmental health, etc. to assist in systems strengthening. Without overemphasising the relevance of oral art performance in this model, the need to service schools, creches, and the entire community by the outreach teams is enough indication of the responsibility of the health practitioners to employ community mobilisation approaches, which appeal to the people who live in the rural PHC context. The interrelationship between the Department of Health and Education through the school health policy is further evidence to a responsive PHC system that aspires to provide quality access to maternal health messages through action-oriented and collaborative approaches. If in today's society the teenage pregnant woman is a 12 year old learner or a 16 year old drop-out, without any grandmother to tell stories at home during the evening, then maternal health educators have to be encouraged to pursue more collaborative strategies to disseminate effective maternal health messages for a variety of audience being serviced by the rural PHC system.

As the PHC system mostly relies on its Community Health Workers (CHWs) to disseminate health messages to pregnant adult and young rural women, the researcher strongly believes there is a reason to exploit the storytelling approach. Lehman (2007:4) mentions that the CHWs do not have professional qualifications enabling them to contribute effectively in the objective of the revitalization of the PHC. While the Department of Health still engages in efforts to empower this workforce, it is justifiable to allow for improvisation through a cost-effective way that suits adult audiences towards effective patient education. Tones (1990:6) describes effectiveness of health education, 'as one that produces changes in understanding or ways of thinking; bring about some shift or belief or attitude; influence or clarify values; facilitate acquisition of skills; or may even affect behavior or lifestyle'. For this reason as well,

more effort is required to ensure facilitation of learning in ways suitable for the rural PHC context.

1.3.2 The maternal health educators as facilitators of learning.

Research shows that speaking to adult learners with the purpose to transfer knowledge is different from speaking to children. The researcher chooses to use the term 'speaking' as she regards the selected context for study as one that should regard educating adults as first understanding the manner of speaking as a basis for how adults become educated. This is mainly dependent on the variety of the teaching strategies which the PHC context employs for its maternal health education.

Firstly while highlighting the key elements of interprofessional education (IEP), namely the learner, the educator and the learning context, Oandasan & Reeves (2005:25) emphasise that educational theory can influence the types of teaching strategies that can be used to create an enabling environment for effective adult learning. They further cite the classic theories of adult education (Knowles, 1980); reflection on practice (Schon, 1987); problem-based learning (Barrows & Tamblyn, 1980) and experiential learning (Kolb, 1984) as examples of approaches, which require consideration to create an informed curriculum for adult teaching and learning contexts.

With regards to adult education, Knowles (1980:43-47) defines adult learning as 'andragogy; an art and science of helping adults learn in an environment where they feel accepted, respected and supported; and also where a spirit of mutuality between the teachers and students as joint inquirers exists.' The study moves from a premise that as teachers in their context, the maternal health educators are dealing with young-adult females who are possible bringing different maternal health experiences into the new classroom, namely; lessons at the clinic or maternal waiting home or anywhere they access maternal health messages. While pregnancy is a reason to celebrate a new life, the high teenage pregnancy health risks and the blame accompanying such experience by mostly teenage girls, are some of the factors that are likely to attract feelings of rejection by families, friends and their partners. Their encounter with the new classroom, which is different from the one they have either left or no longer enjoy because of their situation, should be approached in a manner which motivates them to feel accepted so as to save a mother and a baby. Making them feel 'accepted' though, should at no stage be viewed as encouragement for wrongdoing but also as a platform to extend moral lessons about pregnancy related risks. Moreover, the elimination of high teenage pregnancy rates is also the desire of the health fraternity and society. As adult learners are also acquiring a new knowledge, Knowles et al (1998:150)

further suggests that it should not be enough for facilitators to achieve the desired outcomes. Individual learners should also find opportunity to transform their way of thinking about themselves and the world around them.

Given an environment where they are involved in the process of being mutual partners in seeking solutions to maternal health issues and as not only recipients of knowledge, teenage pregnant women; would gradually show interest in receiving maternal health messages. Furthermore, those women who are adult enough with, more maternal experience, would also feel respected and supported if they bring forth their knowledge in the lesson discussions. In view of the underlying reasons for strengthening maternal health education in PHC, a consideration of adult education theories would also contribute to save the mother and the babies as the methodologies used contribute to improved quality of primary care for rural pregnant women as envisaged in Pattinson (2010-2011:12) thus,

‘Quality of care depends on their being adequate resources at the facilities and staff with the right skills mix and knowledge to manage the patient. The health care providers have their own responsibilities to ensure they have the appropriate knowledge and skills and deal with their patients with empathy.’

Citing Knowles (1950), ‘Pedagogies for change’¹, emphasise that Knowles’s view of adult education was pointing to the ‘friendly and informal climate’ in many adult learning situations, the flexibility of the process, the use of experience, and the enthusiasm and commitment of participants (including the teachers!). Although the women approach the PHC in a state of haste, due to other issues challenging their antenatal care visits, like transport and distances, it is vital that they become orientated into an environment which requires them to engage with their nurses or health educators in a way that will assist in sharing of important information while they are also kept happily looking forward to bring healthy babies regardless of challenges. Since different women also bring along their individual anxieties about the quality of care and friendliness or the unfriendly environment usually anticipated while visiting a clinic or a hospital, Knowles, throughout his works (1984, 1998, 2001) suggest that where ‘facilitators of learning’ attempt to engage their learners in ‘actively constructing knowledge based on past experiences, interacting and exchanging ideas with others, and interpreting the information gained’(Blondy 2007:123), learning becomes meaningful and enjoyable.

This study considers the introduction of storytelling in maternal health education as an oldest form of informal education which can serve as a “framework” to help the health

¹ <http://infed.org/mobi/malcolm-knowles-informal-adult-education-self-direction-and-andragogy/>

educators introduce new content while they move from simple to complex and from known to unknown towards improved access to health messages (Knowles 2001:188). The researcher therefore regards (*iintsom*) folktales as a relevant childlike strategy which establishes an atmosphere of innocence, trust and readiness for rural women to receive new information while they culturally assimilate the important health messages delivered by maternal health educators as facilitators of learning.

It seems that use of storytelling to aid adult education theories is known to benefit different contemporary contexts. In explaining ways to apply active teaching methods in the courtrooms, Lopez (2014) clearly states that the practising attorneys have an obligation to utilise methods which will allow for clientele involvement in the process and thus suggests,

‘Lead them there, don’t just lecture, if all you do is just lecture, you are going to lose your jury. So, inject some storytelling in your opening and closing statements.’ (Ken Lopez on May 21, 2014 www.a21c.com/blog/bid/71309/5)

The above suggestion implies that when stories are used as icebreakers and as a way to summarise content, participants are likely to feel free to engage with information. With similar motivation which the practicing attorneys should approach their lecturing experience, this study therefore seeks to encourage maternal health educators; particularly the CHWs who are part of the Primary Health Care outreach teams, to also inject some storytelling in their teaching practices. As described in Pillay & Baron (2011:3) these teams comprise of health practitioners who require a variety of strategies in order to eliminate some of their challenges as a team. The CHWs are, for example, at a lower level of clinical experience from the doctors and nurses who are part of the team, as a result, a possibility of certain barriers to communication cannot be ruled out in this important relationship. When storytelling is introduced as a cultural vehicle to enable this communication between the health workers and their clients, CHWs could be enabled a rich opportunity to also assimilate more clinical information which can be mutually transferred to the rural women in a more user-friendly manner. The researcher further believes that this approach can promote sharing of patient stories as a way to facilitate a common ground for clinical discussions and a shared responsibility amongst outreach team members.

An important comment by Tones (1990:6) strengthens the researcher views on the relevance of storytelling for maternal health education. She encourages, not only theory-based but also value-concerned interventions for health education. This study also pursued to consider the real values and goals of maternal health education for the PHC context which guided the participants to face the real problems they encountered in their dissemination of health messages to pregnant women. As a result, an opportunity to teach lessons, observe

integration of folktales and reflect on their perceptions was considered as useful as supported in Oandasan & Reeves (2005:26) thus:

Such opportunities should be based on subject matter that relates to learners' immediate interests and concerns, as this has been shown to increase learner motivation (Schwenk & Whitman, 1987)

Selected folktales were therefore integrated in the lesson themes that the maternal health educators considered to be articulating their priority interests and concerns regarding pregnant women in their area. As a result selected maternal health educators identified teenage pregnancy risks as a major problem which the study should prioritise. As Barrows and Tamblyn (1980) in Kaufman (1998:1) also state,

Problem-based learning is the learning that results from the process of working toward the understanding or resolution of a problem. The problem is encountered first in the learning process.

While learning about the relevance of folktales in maternal health education, the study had to be taken as an opportunity for the educators to work towards a new understanding of the implications for methods used in the delivery of effective health messages to teenage pregnant women as they identified. Research cites lack of access to education and sexual and reproductive health including contraception and information as one of the underlying causes of adolescence and teenage pregnancy. Hence a further suggestion in Williamson (2013: viii) that,

'Because adolescent pregnancy is the result of diverse underlying societal, economic and other forces, preventing it requires multidimensional strategies that are oriented towards girls' empowerment and tailored to particular populations of girls, especially those who are marginalized and most vulnerable.'

While also arguing for the introduction of folktales in maternal health education, it is worth noting that the researcher is aware of how people differ in learning styles. According to McLeod (2010)², Kolb (1975) explained that different people naturally prefer a certain single different learning style. Various factors influence a person's preferred style, for example,

- a) social environment
- b) educational experiences, and
- c) basic cognitive structure of the individual.

² <http://www.simplypsychology.org/learning-kolb.html>

The researcher believes that rural health problems, at times, necessitate rural health solutions. Healthcare practitioners dealing with pregnant rural women would enjoy meaningful communication if they could use culturally appropriate communication in facilitation and dissemination of their health messages. They also need to be mindful of the diverse educational experiences which these women bring into their lessons. It is not common to find well educated women utilising rural clinics as they are probably working and have medical aids to go to private clinics or hospitals. Perhaps, a majority of the pregnant women attending antenatal in rural PHC are also likely to have incomplete academic qualifications or to be mostly teenagers who still attend or have dropped out from school because of their pregnancy. According to Williamson (2013:2), 'adolescence pregnancies occur with varying frequencies across regions and countries...what is common to every region however, is that girls who are poor, live in rural or remote areas and who are illiterate or have little education are more likely to become pregnant than their wealthier, urban, educated counterparts. As assumed by this study, the women identified as most vulnerable and needing access to more health information are also made different by their social environment which is mainly rural. Folktales, in this case, as further stated in Smyke (1991:140), undoubtedly match their socio-cultural make up and can be utilised for health education.

While strongly advocating for storytelling as a culturally appropriate way of dealing with maternal health problems, the researcher is also mindful of the fact that learning cannot be defined through a single method, hence this study presents integration of folktales into the existing maternal health lessons and not as an isolated strategy but as a way to encourage selected maternal health educators to facilitate a positive response to maternal health messages by pregnant women. Mezirow (1981:137) also emphasises that it is important to assist adults to learn in a way that enhances their capability to function as self-directed learners. When they get a chance to put their personal experiences within the folktale images, they also acquire more skills to do self introspection.

As pregnant women have also accumulated life experiences that are a rich resource for learning (Knowles 2001:8), it is likely that they would respond differently to lessons employing the storytelling approach than only the lecture or talk method which at times sounds judgemental or confrontational. Smyke (1991:140) states that one of the challenges facing nursing or midwifery personnel is reaching women, men, children, communities, and elders with information through culturally appropriate channels to change behaviour and strengthen family support systems. In addition, Bam et al (2013:2) describes primary care as also integrating research, teaching and learning into the practice of health care delivery while it considers the cultural and social characteristics of people who live in it. For these

reasons, this study therefore considers introduction of folktales as a teaching and communication strategy which can assist to facilitate a more culturally sensitive nature of communication between health educators and pregnant women in the rural PHC context.

1.3.3 Intercultural communication for maternal health education in the Primary Health Care context.

According to Ting-Toomey (1999:263), “when we act appropriately in a cultural scene, our culturally proper behaviours can facilitate communication effectiveness...By signalling to the other party that we are willing to adapt our behaviours in a culture-sensitive manner, we convey our respect for the other’s cultural frame of reference.” When maternal health educators use only the content from the prepared lessons, the knowledge gap affects communication and thus has potential to limit interaction with pregnant women in the audience. As also cited in Maseko & Kaschula (2009: 135) Ting-Toomey (1993) also argues that:

As part of her "identity negotiation theory," the more secure individuals' self-identification is, the more they will be open to interacting with people from other cultures. The more vulnerable they feel, the more anxiety they will experience in such interactions.

Rural women are mostly very respectful to people of a different educational background and status. Immediately a nurse appears, they have already put their mindset into believing that they are from too far apart backgrounds to start conversations of a common jargon. Although this is respect in their own way, it makes them more vulnerable and afraid to express themselves meaningfully; as a result, their interaction with the nurse or any health worker becomes limited. By suggesting storytelling as an alternative medium for maternal health education, the researcher also believes that rural women can easily identify with stories as they seldom visit a clinic without a story to tell. For example, a pregnant woman goes for antenatal care aware that she will be expected to tell the nurse about what she feels, eats or does while carrying the baby. It is the manner of communication between her and the health practitioner which determines how this information flows. If she is approached in a manner which makes her afraid or feel inferior or guilty as charged, her identity as a responsible adult who has a right to express her feelings and maternal health experiences is at risk, thus the poor communication becomes an additional ‘non-pregnancy related’ risk (Moodley et al 2008-2010: iii) to a multitude of the clinical risks which pregnant women already face these days.

Regarding pro-active communication approaches, Zeelan (2010:382-398) suggests that healthcare professionals have a responsibility to the public to ensure that they are able to understand what they need to do to address their healthcare needs. Those engaged in adult education should, in their use of words in teaching, seek to involve their respective audiences not only by giving information but by encouraging interaction, involvement and understanding of the messages for prevention of disease and promotion of health. This also depends upon their awareness of the immediate cultural environment and appropriate communication styles. As a natural way of engaging women to speak about their health problems and experiences, storytelling is undoubtedly suitable for the rural PHC model. As emphasised in Finnegan (2007:27) words are enacted in life and stories, thus speech is intertwined with its performative role and the social context. She further describes education as a creative and performative process, involving the interaction of specific individuals and specific occasions rather than some abstract transfer of formalized knowledge.

Lastly Schoeffel & Thompson (2007:8-9) emphasise that where a one way communication style is used, for example, the direct style which the researcher associates with the lecturing or talk method; the message is likely to come from the words used with no consideration of the surrounding context. Speakers prioritise on the content of communication. Where an indirect style, like storytelling is employed, the message is to be sought outside the words used, in a variety of elements: proverbs, metaphors, silence, and surrounding contexts. Speakers in this style tend to give priority to relationships and harmony among those present, hence the study exploring significance of folktales in the PHC context.

1.4 The significance of the study

The PHC context has duty to intensify education and training so as to save the mother; the neonate; the infant; the child; and eventually the nation. In the Department of Health Guidelines for Maternity Care in South Africa, Buchmann (2007:8) recommends that:

Women, families and communities at large must be empowered, involved and participate actively in activities, projects and programmes aiming at improving maternal and neonatal health as well as reproductive health in general.

This study presumes that any intervention identified as suitable for maternal health education should find relevance in Millennium Development Goal 4: *Reduce child mortality* and Millennium Development Goal 5: *Improve maternal health* simultaneously.

Various maternal and child health reports have cited patient oriented factors (Moodley *et al* 2008-2010; Pattinson *et al* 2010-2011; McKerrow *et al* 2011-2012) as playing a role in mortality and morbidity rates and therefore identified a need for improving access to health

messages by affected women and additional skills for the 'doers' to improve ways of dealing with pregnant women. In response to their suggestions, strengthening health education by using language and literature appropriate to both the health educator and the pregnant woman can definitely assist in promoting effective interventions at the clinics and maternal waiting homes. Folktales contain rich language and literature experiences which could bring in some creativity towards an innovative and responsive maternal health education. Depending on the ability of the storytellers, various folktales can be selected for use in healthcare lessons. Kehinde (2010:32) suggests that emphasis should be placed on folktales that can help in nation building, and those that can assist to address the situation whereby our esteemed values are steadily going towards disorder and disintegration.

To further contextualise not only the local but also a global significance of storytelling as important indigenous oral tradition for healthcare context, the study also highlights the works of the United Nations Permanent Forum on Indigenous Issues (UNPFII). As an advisory body to the Economic and Social Council (ECOSOC), the (UNPFII) is annually mandated to discuss indigenous issues related to economic and social development; culture; the environment; education; health; and human rights. Consequently, this forum has on its twelfth session report in 2013 called for strengthening of good practices that compliment public health through intercultural dialogues and discussions that ensure healthcare delivery in culturally specific ways.(UNPFII 2013:3). As a result, the United Nations Population Fund (UNFPA), which is a global partner to South Africa is strategically positioned in the Eastern Cape and other offices in the country so as to continuously support the 'Saving Mothers Saving Babies' (SMSB) program with capacity building of healthcare workers, women and youth on issues of sexual and reproductive health, family planning and safe motherhood. (UNPFA 2011:14-25)

Given this opportunity, would it not be an advantage for the Eastern Cape Primary Health Care to sustain the collective global and local efforts to achieve MDG 4&5 by also exploring oral traditional storytelling as a viable tool to facilitate intercultural dialogues and maternal health specific discussion by health practitioners and rural women? Perhaps, the most relevant answer to that question could be derived from a further exploration thus,

How is oral literature adapting and functioning in the modern world?" (Kaschula 2001: xii)

The researcher thinks that it is through action that solutions to similar questions as quoted above could yield to possible solutions. Through this study, the researcher curiosity on the future of folktales in contemporary modern workplace began with a preliminary informal

observation of maternal health lessons where folktales were first explored in teaching of pregnant women.

1.5 A preliminary case: An informal lesson observation at a maternal waiting home in 2011

Besides being inspired by the works of prominent scholars as mentioned above, this study was foremost driven by the researcher's desire to share the skill of storytelling to the health workers in rural Primary Health Care (PHC) so as to learn further about its ability to work or 'permeate our lives at every level in the modern context (Kaschula 2001: xii).

This desire came as a result of the researcher preliminary exposure to a maternal health education lesson which took place at a Maternal Waiting Home in the Joe Gqabi District in September 2011. Maternal Waiting Homes are high priority in the World Health Organisation agenda as a strategy to reduce maternal deaths in rural hospitals. Moreover, health education in the homes is regarded as very important to continuously strengthen the SMSB campaign by all maternal healthcare practitioners.

One of the researcher's roles was to encourage doctors in the Rural Doctors Support Program (RDSP) to engage in other non-clinical activities, like participating in the district management call to support health literacy campaign at hospital and clinic level.

On the day the researcher and her team visited the maternal waiting home, they were incidentally invited to observe a lesson which was facilitated by one of the senior nurses to the pregnant women awaiting delivery.

The subject of the lesson was sexual reproductive health which covered different themes including teenage pregnancy; family planning (also called Women Year Protection); and lifestyles for pregnant teenagers and adult women. The lesson started well and continued for about 20-25 minutes. The researcher observed the lesson to be centrally delivered through the traditional method of teaching which Broughton et al (1994:22) described as "teacher-dominated interaction" where the educator had to carry a burden of trying to involve her audience in the lesson. The educator rendered a prepared talk for a long time before asking questions from the audience, as a result the lesson was tension dominated. The researcher perceived the lesson as an example of Broughton's description above.

Understandable that this was not a school classroom but an interaction which was supposed to be an informal opportunity for pregnant women to access important health messages, the researcher viewed the method of teaching as not suitable for that immediate context.

Consequently, the researcher observed that a majority of the pregnant women in the audience were teenage girls (*The youngest was confirmed by the accompanying official to be 16 years old and was often nick-named by the educator as Mancane, which means, 'The Small One'*) who displayed signs of being shy; lacking confidence and unable to answer questions freely. The researcher observed that the educator often pleaded the teenage pregnant women to respond to some questions during the lesson. Even when they managed giving limited answers, they were not as bold as the few middle aged women who were also part of the audience.

Although the researcher was not sure how adults, particularly pregnant women, doctors and the nurses present, would respond to a folktale she offered her storytelling service to assist in the lesson. The nurse allowed the researcher to narrate a folktale of the jackal and the wolf (*intsomi kadyakalashé nomvolofu*). The researcher; as an experienced storyteller, did not go outside to plan which folktale to use, she just selected that particular iintsomi from a list of others she normally used with children.

After the storytelling session, participation improved and the educator continued to teach using not only from her preparation but also using the folktale as a stimulus to ignite audience participation in discussions of her lesson theme.

The researcher could not conclude whether the teenage pregnant women were afraid of the visitors or the nurse; had anxiety of their pregnancy or were uncomfortable discussing an issue affecting them directly. As all this experience was on the basis of an informal observation, the researcher became interested to undertake a formal study so as to learn more about the role of folktales in maternal health education lessons in Primary Health Care context.

1.6 The statement of the problem

It is a fact that the conventional ways of teaching mostly rely on use of other media forms with less or absolutely no use of indigenous storytelling. It is not uncommon for lessons in the health and other classroom contexts to be based on no stories at all or on foreign stories written on pamphlets, posters or narrated on radio and television. The researcher considered this as detaching society from re-experiencing and re-imagining the rhythm, style, and cultural images which the beauty of a face-to-face storytelling approach has potential to bring in any teaching and learning context.

Given the socio-cultural make up of rural women attending maternal health lessons in primary health care contexts, continuous use of teaching methods foreign to rural

women; undoubtedly deprives both the health educator and her audience an opportunity to interact meaningfully through a more performance-based approach. On the other hand, the fact that health educators are not exposed to storytelling as a method of teaching limits their creativity in delivering effective lessons and therefore their audiences do not enjoy accessing maternal health education lesson.

1.7 Research question

As the Eastern Cape rural Primary Health Care revitalises, can the integration of isiXhosa (*iintsomi*) as an alternative medium of education in maternal health education assist in creating an enabling environment for improved access to crucial maternal health messages by rural women?

Although the study employed a natural ethnographic action research approach (Burns 2000; Wolcott 1988; Koshy 2001; Cohen 2007), it was necessary further split the main question into specific questions which guided my methodology, for the study:

- a) To what extent are *iintsomi* relevant for maternal health education in the PHC context?
- b) What teaching practices and methods are currently used by maternal educators?
- c) What happens when *iintsomi* is integrated in the lesson by the health educator?
- d) How is the introduction of *iintsomi* perceived by the health educators and their audience?

1.8. General study objectives

The general objective of this study is to promote access to maternal health information by using isiXhosa storytelling (*iintsomi*) in selected primary healthcare clinics and a maternal waiting home. With particular reference to maternal health education reports, (Moodley 2008-2011:43-59), a need for action through an integration of indigenous issues into existing training opportunities and also for operational activities and programs at country level as advocated by The United Nations Permanent Forum (UNDG 2013) necessitates a study that shall:-

- i. Promote natural, healthy relations between the healthcare workers and the pregnant women for ease of access to information towards health promotion.
- ii. Promote a positive integration of indigenous ways of teaching and learning in the current maternal health themes towards a more patient-based approach; sharing of experiences and stories; participatory learning and collaborative health education.

- iii. Revitalize innovativeness in maternal health education by encouraging health educators to re-conceptualise and utilise 'a range of information, education and communication activities to reach communities, women, men, boys and policy-makers through the media and all culturally appropriate channels' (Smyke 1991:64)

1.9. Specific objectives

In view of the concerns about challenges still affecting maternal health education in rural Primary Health Care contexts the specific objective of this study is to promote access to maternal health information through introduction of (iintsomi) folktales in selected primary healthcare clinics and a maternal waiting home by:

1. Exploring relevance of storytelling (iintsomi) folktales for maternal health education in rural Primary Health Care.
2. Integrating (iintsomi) folktales in already existing maternal health education lessons.
3. Evaluating perceptions and views of participants regarding introduction of storytelling (iintsomi) in selected maternal health education lessons.

1.10. Ethical considerations

As Schutt (2012:353-354) emphasised, qualitative researchers should negotiate the approach that will be taken to protect privacy and maintain confidentiality with participants early in the study. To this effect, the researcher, having obtained permission from the University to undertake the study, engaged in a process of approaching all relevant stakeholders responsible for maternal health education in the target district. Thorough discussions on the nature of the study, the topic and the envisaged approach were conducted with all relevant stakeholders. Written requests and permission letters were obtained from the management. During the first focus group meeting, a written consent³ to be involved in the study was explained, provided and signed by all selected participants. Permission to record, take pictures and video of lessons was requested from each site visited from all women and other community members who attended the observed maternal health lessons at each clinic. Participants were acknowledged to have a right to participate or not participate in the study where they considered the proceedings as violating or infringing their rights.

Although the selected participants were involved as researchers as well, the researcher ensured that confidentiality in activities such as interviewing the pregnant women was maintained. The hospital where the pregnant women were first consulted was

³ Consent form appended.

approached for permission to undertake lessons and to interview the pregnant women who volunteered for such. All expectations for participation in the study were explained clearly verbally in isiXhosa and Sesotho where applicable. Although the researcher targeted a health context, the nature of the study was not medical and therefore no physical bodily interaction was envisaged to occur between the patients, thus, the pregnant women and the researcher. Furthermore, the researcher observed strict privacy where the lessons to be observed occurred near examining rooms, more especially in those clinics which were challenged by space. No clinical records were requested from the clinics or hospital, as the study was mainly concerned with the activities of the maternal health educators in their teaching environment.

The researcher also observed protection of participants' identity by giving them the codes Participant Practitioner Researcher (PPR) 01-10. All participants, including the management had expressed no fear of the names of the clinics and the hospital visited to appear on report but the researcher further respected the state property and referred the sites as Clinic A-G. The maternal waiting home has been retained as such and has been mentioned in the preliminary case study as the hospital granted written permission for the researcher to use it as her motivation for the study. Lastly, the management names only appeared from the permission letters but not the content of the study as those engaged in maternal health education have been coded as MHEMs (Maternal Health Education Managers).

1.11 Limitations of the study

This study contributes to the limited access to other ways of teaching and learning for contexts best understood by the educator, thus it was necessary that crucial information generated through the study be shared through action research but without compromising validity and reliability of the study.

The nature of the study did not confine responses regarding storytelling to the sampled participants as it was difficult to control flow of secondary evidence in action research. Data collected, the results and the recommendations are based on the views of the respondents but without generalisations to the maternal health education fraternity in the entire rural PHC Eastern Cape context. The study was also limited to observation of lessons for those women available to attend the classes whose views on maternal health education have been captured voluntarily without intention to generalise to all teenage or adult pregnant women in the entire rural PHC context.

The nature of their visit to their local clinics was also not compatible with the study timing as they utilise different transport modes and are affected by other systemic and structural realities of the clinics, for example, their antenatal date coinciding with general visit of other patients which limits space for special educational interaction with the entire constituency of pregnant women in some of the sites selected for study. Lastly, the study time limitations and other study seasonal constraints did not allow for a broader study area, hence the study was undertaken in only 8 sites in one PHC sub-district of one Eastern Cape district.

1.12 Summary

This chapter presented the history of oral folktales in the past, the present and the future. Widely known as one of the poor provinces, the richness of the Eastern Cape in terms of its oral traditional indigenous knowledge systems has been juxtaposed to the inability of the different contemporary contexts to fully exploit the oral art forms like isiXhosa iintsomi for the benefit of the present generation. Folktales, having functioned and continue to be used as a didactic tool for transferring wisdom, to foster communication and to entertain children and adults, have been identified in this chapter as having potential to permeate new contexts. As compared to its sister genres, it seems that folktales have not yet permeated the public performance platforms as they should be, the researcher has outlined how; supported by the scholastic theories of adult education; the model for Primary Health Care and the demands of the intercultural communication orientedness of the rural health context: folktales are relevant in the maternal health education at clinics and maternal waiting home.

A thorough significance of storytelling in healthcare has been outlined while a preliminary case study was used as motivation for further study; statement of the problem, the goals and the study objectives. Lastly the chapter clearly highlighted the study ethical considerations and limitations of the study.

1.13 Breakdown of study chapters

The study is structured as follows:

Chapter 1: Background to the study, research questions (broad and specific), study objectives (general and specific), ethical considerations, limitations, and study structure

Chapter 2: Literature Review: To provide a theoretical base for the study in relation to the three objectives outlined in Chapter 1.

Chapter 3 Methodology in relation to the three objectives as outlined in Chapter 1

Chapter 4 Data Analysis as per objectives, research questions and methods used.

Chapter 5: Summary of Findings

Chapter 6: Recommendations and Conclusion

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Chapter one generally gave a background to the Primary health care context and explored the relevance of storytelling in maternal health education. The aim of this chapter is to review literature in relation to folktales a teaching method. The chapter will discuss the following issues:-

2.2. Maternal health education challenges in Primary Health Care

2.3. The advantages of storytelling for adult teaching and learning.

2.4. Creating awareness on the characteristics of folktales

2.5. Presenting other storytelling studies.

2.2. Maternal health education challenges in Primary Health Care context

In order to recognise a need for collective input, there should always be critical challenges that necessitate more effort. As maternal health education has been one of top priorities for rural healthcare, previous Saving Mothers Saving Babies reports indicate some of the challenges which call for strengthening of maternal health education. Woods (2002:8) cites the social problems in the community; ignorance; fear of revealing the pregnancy; unfriendly service at the clinic; laziness; poor education of women and traditional taboos as some underlying social factors to patient related problems of maternal morbidity and mortality.

While there is health education via other media, for example, availability of pamphlets, information on radios and television, newsletters and newspaper, women are still regarded as ignorant about their maternal health problems. On the other hand, women are also regarded as not showing enough interest in finding out about their health because of being lazy or being afraid to express their thoughts due to an unfriendly service at the clinic or because their culture does not allow them to talk freely about sexual reproductive health issues. Although there are these other ways of creating maternal health awareness, Moodley (2008-2010:49) blames the ineffectiveness of current health messages; minimal community education; and lack of diverse ways to empower rural and young women as further challenges facing maternal health education. As a result, these challenges contribute to, among other things, as Moodley further states,

- a) Not booking for antenatal care

- b) Not recognizing important warning signs
- c) Not seeking help when warning signs were present

Teenage pregnant women are often blamed for being victims of the above problems as a result they become categorised as 'high risk when it comes to maternal mortality and morbidity' (Moodley 2008-2010:5).

Regarding the CHWs, 'the backbone' (Olver 2011:11) of the PHC system, who have to reach out to these women before the clinic nurse or the doctor becomes to their clinical condition, Lehman (2007:4) complains that they do not have professional qualifications enabling them to contribute effectively in the objective of the revitalization of the PHC. Nonetheless, Day (2009: Manuscript 6) comments that healthcare professionals have a responsibility to the public; to ensure that they understand what they need to do to address their healthcare needs and that they can begin to assume a new role of being artists and storytellers to execute their role (Zeelan 2010:382-398). To mix their experience, knowledge and skills towards effective maternal health education, this study suggests they can use folktales, (iintsomi) as another medium for maternal health education in rural PHC.

2.3. Advantages of storytelling in adult teaching and learning

Various folklorists cite advantages of storytelling as a method for adult teaching while prominent theorists also account for their relevance in the health context:-

2.3.1 Folktales provide a relaxing environment for adult learners

The World Health Organisation comments that, "motherhood, though a positive experience, is for many women associated with pain, suffering, illness or death due to a list of pregnancy related and non-pregnancy related factors". Harris (2005:4) states that many experts on storytelling emphasize the importance of telling stories that help your listeners experience strong feelings and emotions about a subject *first* before telling them facts and figures. It is definitely saddening for pregnant women to face the information about the likelihood of a mother dying while giving birth while confronted with the statistics of how many died in the same hospital they anticipate delivering their healthy babies.

Kehinde (2010:38) also suggests that folktales perform therapeutic functions in easing emotional tensions and expressing, dissolving and resolving repressed anti-social passion of anger, hatred and jealousy which currently bedevil the nation. Many times, young women come to face their pregnancy with feelings of regret, dismay over broken dreams, thoughts about the challenges of motherhood and other emotional anxieties they encounter. It is

therefore important for maternal health educators to devise means to assist them to cope with these anxieties. Theoretically, Eck (2006:28-31) attributes this to Caine et al (2005) theory of brain-based learning significant for adult learners where it is claimed that when learners are relaxed they are easily immersed in learning which leads to them to digest, think and reflect on the learning experience. When lessons, for example, go straight to the risks of pregnancy, listeners will not get a chance to positively connect with their personal stories.

Maternal health educators are also human, “they are also affected by the ‘pressures of the contemporary working life’ (Okpewho 1992:109). When women are pregnant, health workers worry about saving lives, for example, where there are high risk pregnancies and deliveries, they become afraid of possible maternal deaths. Their stories of success and those of disappointment are universal. Therefore, Okpewho (1992:106-109) further suggests that:

...oral literature helps to keep up the spirits and relieve the worker of boredom...providing an avenue for emotional and psychological release in day-to-day relations between members of the society, oral literature promotes the basis for social harmony, which I view as crucial for creating enabling platform for women to communicate and interact meaningfully.

2.3.2 Folktales enhance oracy, performance and audience entertainment

Moodley (2008-2010:49) recommends involvement; empowerment and active participation of women in activities designed to enhance their maternal health education Whereas expectant young women may still find it difficult to communicate their experiences when approached through talks; speeches or lectures; using (iintsomi) can eliminate ignorance and any fears to discuss issues of pregnancy with health workers. Bukenya (2001:33) in Kaschula (2001) states that one of the most important functions of oral literature in contemporary contexts is to empower women and improve their oracy and further defines oral literature as:

...holistic communication. It is attitude, it is posture, and it is voice, expression, gesture, movement. It is also access to, and entitlement to contexts, discourses and technologies

Storytelling can surely become an exciting way to transmit learning to teenage pregnant girls. It can also assist towards behavioural change and elimination of the cited patient related causes of maternal, neonatal and child mortality and morbidity rates. As Dienslage (2001:47) in Kaschula also states:

Nevertheless, in order to transmit traditional moral codes and patterns of behaviour to younger generation. They can still be passed off as an educational tool and a pedagogic instrument...

When translated to English, the term '*ukuhlukuhla*' means to 'shake. This implies that besides the clinical examination of the mother and state of her unborn baby, there is supposed to be some activity or exercise involved. That is why health workers also make the pregnant women sing health related songs like; *Ndinosana lwam, Ndinebhongo ngosana lwam; Ndachol'uNodoli ngasemlanjeni, Nompilo sinik'icebo*; and many others. If song functions to enhance women involvement, storytelling has potential to do the same as iintsomi often integrate singing. The 'shaking' of the body, the mind and spirit can therefore be achieved through a combination of songs and beautiful aesthetic storytelling which uses familiar language, gestures and body language. As also confirmed by many folklorists, the art of oral storytelling performance does not only provide the words but also foster innovativeness and manipulation (Okpewho 1992: 45) of the materials external and personal to the performer (Scheub 1975:44-89) while access to the information is improved.

According to Scheub (1975:50) spoken words alone do not sufficiently communicate the feelings the artist is attempting to project. As also a tool for entertainment, storytelling is generally a humorous, friendly way of doing things for it breaks any existing tensions and any possible power relations towards collaborative conversations between adult learners and their educators during the lessons. Though society largely associates use of (iintsomi) with only entertaining children, and quickly dismiss the narration as just an 'intsomi' (*sarcastically that which is not real*); adults also need to be invited to see things differently through imagination and fantasy in the world of animals and giants. As described by Okpewho (1992:109),

"The fact that the tales are set in a fantastic, nonhuman world helps to lift the minds of both the performer and the audience away from the limitations of human life to a world of blissful wish fulfillment".

Where motherhood carries stress (WHO); bringing fun and humor in the health context through stories restores relaxation to patients. Finnegan (2012:9) also believes that the humour of the delivery adds drama and meaning to the relatively simple and straightforward wording of folktales. Though a childlike activity, there is andragogic sense for using storytelling with adult learners. Stories bring back memories which enable adults to reconnect with their past while carrying forward their present and the future, as a result when a story is told, an atmosphere of innocence and trust is established.

2.3.3 Folktales for cross-cultural communication in Primary Health Care

The ability for women to respond to maternal health education largely depends on their cultural relationship with their educators. As Saville-Troike (2003:14) commented:

“Ultimately, all aspects of culture are relevant to communication, but those that have the most direct bearing on communicative forms and processes are the social and institutional structure, the values and attitudes held about language and ways of speaking, the network of conceptual categories which results from experiences, and the ways knowledge and skills (including language) are transmitted from one generation to the next and to new members of the group”

Although Moodley (2008-2010:49) suggests a variety of ways to involve and empower women to participate actively in activities aimed at improving maternal and neonatal health as well as reproductive health, the social problems experienced by rural women are too diverse to be addressed only through videos, radios, booklets and community theatres, which are all script-based. Culture as defined in Kaschula, Mostert & Ralarala (2008:47) serves as a combined state and process that affects people as they respond to others, to events and to the environment.

The health education lesson can also be viewed as a “communicative event” (Saville-Troike 2003:19) wherein culture and language play a crucial role. Language does not only refer to the *metalinguistic* (reference to language itself) function in this case but also an extent to which it is also,

“*expressive* (conveying feelings or emotions), *directive* (requesting or demanding), *referential* (true or false propositional content), *poetic* (aesthetic), *phatic* (empathy and solidarity).” (Saville-Troike 2003:13)

When health workers demonstrate an understanding of a holistic approach in their delivering of health messages, the quality of care can improve. Citing Langer (1989) Kaschula, Mostert & Ralarala (2008:47) also remind us that where intercultural communication is required, the aspect of ‘mindfulness’ should always prevail as there is always some kind of ‘cultural noise’. To align their viewpoint with the maternal health education, the health educators also need to possess language skills and knowledge to create new categories of information; to be open to new information, and to be aware of more than one perspective. For example, health educators, particularly Community Health Workers who work at grassroots level in the communities, have a responsibility to impart knowledge which carries sensitive language. Different ways of communicating to the women produce different responses which have effect on interaction between “the sender and the receiver” (Kaschula & Ralarala 2004: 253) of the health messages.

The researcher has used the following example from a personal experience of listening to maternal health education lessons. The purpose is to compare a language specific to the content to that which begins from an *intsomi* perspective:

Scenario1

*“Namhlanje ndifuna ukunixelela
ngeengxaki
enigaxeleka kuzo ngenxa
yokumitha nibancinci.
“Okokuqala niyaqhathwa
ngala madoda madala
nisoloko nithene nca nawo.”
Ningayihamba ke loo ndlela yenu!
Okanye ubonwe ngath’uyathandwa
Kodwa niba nedwa ke
xa nikhulelwe!*

Today I want to tell you about
the problems
you face because of
being pregnant while still young.
Firstly you are being deceived
by these old men you
are always clinging to”.
You can travel your route!
or think be seen as loved
whereas you are alone
when you fall pregnant

Scenario 2

*Kwathi ke kaloku ngantsomi!
Chosi Ntsomi!
Kwakukho uDyakalashé noMvolofu
Babengabahlobo abakhuluuulu,
abathandana Kunene,
nditsho kwakungangeni kwamoya
phakathi kwabo!
Ngaminazana ithile
UDyakalashé wacela uMvolofu
Ukuba amkhaphe baye ebukhweni bakhe
Nangona wayengathandi ncam uMvolofu
Ngale mini, wamcenga umhlobo wakhe
Hayi ke bagqiba ukuba bahambe ekuseni

Bahamba! Bahamba! Bahamba!
Bahamba! Bahamba! Bahamba!
Kwala xa bephi-phiii-phi!*

Once upon a time!
Yes to the intsomi! (Audience)
There was a Jackal and a Wolf
They were great friends
who loved each other very much
I say not even the wind
could separate them
One day
the Jackal asked the Wolf
to accompany him to his in-laws
Although the Wolf was not really keen
on this day, his friend begged him.
and so they agreed to leave very early
in the morning
The walked and walked and walked
The walked and walked and walked
It happened that when they were
somewhere, further away!

(See Appendix G for the complete folktale version)

The point in relation to the above scenarios is that some rural women still shy away from openly discussing sexual reproductive health issues. Teaching them only through talks, speeches and lectures, as scenario 1 illustrates, has potential to limit the instruction to the

language specific to the lesson content while it isolates the beauty of those language devices which are found in folktales (Scheub 1975:62). For example, idiophones and exaggeration: *kwala xa bephi-phiii-phi; omkhuuulu*: foster imagination while repetition: *bahamba, bahamba, bahamba* calls for action which immediately exposes the audience to the aesthetic experience of storytelling (Okpewho 1992: 71-104). The health educator also has advantage 'to take the risk of audience participation for both educational and artistic purposes. She cannot ignore her audience: she must bring its members along with her other elements of production into her creation (Scheub 1975:100)

Another tool which the health educator can exploit is the euphemistic nature of the folktale language. It is understandable that health workers need to encourage women to speak out and call a spade a spade when discussing sexual reproductive health issues. African culture respects certain words, unlike how words in English are thrown out with their advantage of sounding perfect with a less insulting tone. For example, in a novel by Guybon Sinxo, uNojayiti Wam, Nojayiti chose the name 'cannibal' for her baby because of how it sounded not really concerned about what it meant. On the other hand some rural women, more especially teenagers, might feel embarrassed, shy and not free to talk to health educators about sex problems. Also because of their cultural stance, most married adult women do not feel at ease to say or share any information about issues of sexuality. What the educator considers as a straight forward direct approach might be culturally considered 'ubukrwada' rudeness, for example, when telling them about sexual intercourse:

'Xa niza kutsib'iziko notat' ekhaya sounds respectful than when the health educator says, *'xa uza kulalana nendoda yakho'*

Because folktales beautifully employ 'ukuhlonipha', euphemistic language; it can be used by educators to close that cultural gap; to prepare them to trust her, the environment and the information, even before getting into the lesson content. Finnegan (1967:67) emphasises that,

'On some occasions, a story is made more effective by bringing in some oblique and unstated reference to the actions or situation of one of the listeners, Though not direct...but the listeners may recognize the resemblance between the acts of, say, one of the animal characters and one of themselves. In this way the audience is closely involved in the narration.'

When adult learners trust the cultural appropriateness of the environment; the sender of the message; and the media resource, there is opportunity for transparent interaction as they move from known to unknown. Yackley (2007:6) associates this with Jung (1968)'s theory of 'collective unconsciousness' stating that adult comprehension of messages passed through

a story is due to 'a common understanding of certain ideas, thoughts, and concepts among all people, regardless of race, culture and ethnicity. Therefore, using folktales will not make the content lose the focus on health but will function as an encouragement for women to discuss, exercise their right to ask questions and to express their beliefs and attitudes about health (Smyke 1991: 186).

A further theoretical account for the above distinction is given in Saville-Troike (2003:14) where he cites (Hymes 1972c):

The difference between the functional intent of the speaker and the actual effect on the hearer is part of the notion of functional relativity.

She further concludes that, "the social functions or practices of language provide the primary dimension for characterizing and organizing communicative processes and products in a society; without understanding why a language is being used as it is, and the consequences of such use, it is impossible to understand its meaning in the context of social interaction." (2003:14)

2.3.4 Folktales enhance the quality of care

It seems that the effectiveness of health messages revolves around the quality of verbal communication which takes place between the health worker and the pregnant women. An expert in maternal and child health (UNFPA: 1990) as quoted in Smyke (1991: 148) commented thus:

"If you put information in a form relevant to women, it will be picked up and used... you don't have to wait for generations to become literate before you can do this."

The quality of care is not only dependent on getting the correct medicines: how one is treated also depends on the way information is disseminated about the clinical issues at hand. Maternal health education is thus a stepping stone to servicing the patient, in this case, those who have to receive health messages. In this regard, Saohatse (1998:1) explains that:-

Many people tend to only associate health care with medicinal cures or drug therapy. This obscures the powerful and complementary role that verbal communication plays in medical procedures; for example, history –taking and establishing a diagnosis is part of the process. Therefore good quality care can be compromised by inexperienced use of language or by inadequate communication between patients and health care professionals.

From the above assertion, there is an indication of the relevance of storytelling as some way for diagnosing patients in a culturally conversational way towards pleasing clinical outcomes. Buchman (2007: 9) further stated that,

Health workers administering care to pregnant women must demonstrate respect and a genuine interest in their clients, and avoid an arrogant, rude or judgmental attitude.

Folktales facilitate mutual respect and a sense of belonging for both the health educators and their audiences. Dederen (2012:86) asserts that folktales foster some code of elementary morals which dominates both the communicative efforts of the narrators and the didactic purpose of the indigenous narratives. He further described folklore as part and parcel of the “indigenous curriculum” of the wider processes of enculturation.

A certain doctor, herein referred to as Dr X for confidentiality purposes, once narrated a story of teaching a rural woman about family planning to the researcher as follows;

While working in one of the rural districts of the Eastern Cape, a middle-aged woman whose husband worked in the mines came to me for consultation about her sixth pregnancy. I was very angry at her ignorance of becoming pregnant while she constantly claimed to be raising the children without her husband. I suggested that she speaks to her husband so that they consider serious family planning, whether she chooses ukuvala (sterilisation) or to use contraceptives (I mentioned all types including condoms). She seemed interested in the condom part and I advised her by saying;

‘Uyabona ke, xa eqina umyeni wakho, wena khawulezisa ufake icondom kwinduku le...

(You see, when your husband’s penis is hard and ready, she must put a condom on it)

I further demonstrated to her with a broomstick as I had no other readily available resource for this emergency lesson. Little did I know that she will come back pregnant a year later! Because I wrote notes on her folder, I remembered her and confronted her for disappointing me after such an effort to teach her about how to use a condom. She honestly told me that she did all I taught her,

“Gqirha, ndikuxelel’ungakuxokisi, ibithi yakuma nditsibe ndiye kwintong’omtshayelo, ndiyithi gangxa le khondomi, ndibuye ke ndimnike.” Yena azange afune nokulongopha ngaloo shi yakho yokuvala, hayi ke naku ke ndaphinda ndanzima!”

“Doctor, I am telling you the honest truth, when the penis is hard, I would jump to the broomstick and insert the condom, and come back to sleep with my husband. He did not even want to talk about your thing of family planning, so I am now here pregnant again.”

I was disappointed, and felt my lesson was not understood (Dr X and Researcher, February 2012)

The above story is an illustration that Dederen’s views folklore as part and parcel of the “indigenous curriculum” of the wider processes of enculturation are very relevant to assist in improving communication between the health educator and the women. That the doctor speaks isiXhosa and the woman speaks the same language does not mean they understand each other as there are other underlying societal values that govern their communication. As stated in Mupa et al (2013: 58):

Information sharing with parents, community leaders and even with school teachers is highly limited. Culture plays a significant role in discussing issues about sexuality among young people. Sexual behavior is rarely discussed in public in African countries (Amuyunzu-Nyamongo, 1999). Parental care may be lacking and parents are not invariably good role models themselves (Mmbaga et al., 2007). Some cultures disapprove of sexual intercourse before marriage, which militates against young people seeking information about sex and HIV and AIDS. It is a taboo for mothers and sons or fathers and daughters to discuss issues relating to sex (Manda, 2006).

Churchill et al 1982, in Hunter (2008:12) therefore suggest that stories can help the doctors and other health workers to prepare the ground for more complex discussions of women health problems. Folktales, as a readily available resource for rural communities, have been selected to be explored alongside maternal health themes.

To conclude, the relevance of (iintsomi) folktales, as a society’s art can begin to be viewed as not just as a once-off form of cross-cultural communication but as a vital component of ethnomethodology (Saville-Troike 2003) through which the attitudes and behaviors of audiences in health context can be continuously studied. When storytelling is integrated as a face-to-face approach alongside other existing media forms, like English booklets, radio, television, pamphlets; mutual respect and the value of the health messages can be revived. Moreover, a collaborative approach, which Scheub (1975:59) calls ‘integratedness, towards prevention of possible patient related maternal and child health risks can be strengthened. However, integratedness depends on availability of a model for storytelling as well as

creating awareness about the value of folktales for health care worker professional and personal development.

2.4. A collaborative approach for maternal health education

McKerrow et al (2011:xii) envisages; a better patient education; effective delivery of key child promotion activities; enhanced linkages between home and healthcare; and strengthening of a community based health service through Community Health worker programs. Pattison (2010-2011:iv) further states that the model favoured by Saving Mothers Saving Babies is '*action orientated*' as it gives the level (community/individual, health care manager and health care provider) that should be targeted when developing strategies for improving the health system.

According to the Health and Welfare Seta (2011)⁴, health promotion and prevention is at the core of recommendations of PHC revitalization where the outreach teams are expected to work together towards effective community participation. Professional nurses and the Community Health Workers have their stipulated roles as members of the PHC outreach team (Pillay & Baron 2011) Though not all CHW roles are the subject of the study at hand, this study cites them as an indication of the broad nature of their role as health educators and relevance of folktales (*iintsomi*) in their 'context of interaction' (Lehman 2007:4) thereof. The HWSETA (2011) outlines the roles and responsibilities of the CHWs as follows:-

- a) Health promotion and prevention (Maternal and child health)
- b) Provide health related information (immunisation, ante-natal and post natal care, HIV, TB and chronic diseases)
- c) Provide supportive counseling
- d) Assist with conducting Support Groups
- e) Participate in specific health days in the community
- f) Attend community meetings
- g) Assist with School health
- h) Support and promote health at crèches, ECD institutions and other institutions like old age homes.

The rural nature of the health education context and its diverse constituency is added advantage for folktales, as oral narratives and performance to be re-experienced by the

⁴ Source: <http://www.hwseta.org.za/upload/re.pdf>

health educators and their audiences. Citing Benjamin (1969), Bauman (1986:2) observes that “the storyteller takes what he tells from experience- his own or that reported by others. And he in turn makes it the experience of those who are listening to the tale”. For example, when health workers teach by methods limiting interaction with their audiences, rich experiences about those “human vices disrupting their social order and those desires, seeking equilibrium of some kind” (Scheub 1975:83) will not be discovered and thus the data collected about patients will be limited to specific clinical inquiry. However, the skill of the health educator to encourage community participation becomes crucial, hence Moodley (2008-2010:309) emphasis on action-oriented approaches to improve maternal health as illustrated in the diagram below:-



Source: Saving Mothers (2008-2010:309) Fifth Comprehensive Report on Confidential Enquiries into Maternal Deaths in South Africa

2.5. Creating awareness of folktales as a health education method

Bringing an iintsomi into a new context can be a very exciting but a challenging experience as well. Iintsomi is largely used for teaching children at home and in schools thus using them with adults in healthcare can bring them back to a new life. Although it may be a challenge for those educators who are not familiar with (iintsomi), it is rare to encounter an audience that has never experienced iintsomi. Scheub (1975:93) calls it a ‘creative process’ and suggest that:

The first step in the creative process, taken within the context of the theme, is a process of cueing and scanning, during which the performer explores her mental repertory of remembered core-images, and recalls and selects the various raw materials from the remembered tradition which she will, in performance, combine

with contemporary materials to create her work of art. This process occurs at great speed, no doubt.

2.5.1 Suitable folktales for healthcare workers

Finnegan (1967:89) states that there is no fixed or correct form; each performance is unique to the individual narrator and the occasion. Health educators teach from readily outlined themes as stipulated in Moodley (2008-2010) in the previous section. As women themselves, Community health Workers have experience of the challenges facing pregnant women in the society. So, using *iintsomi* in her lessons brings a mutual opportunity for recalling the images suitable for their immediate environment: the community; the clinic; or the waiting homes where they deliver their health lessons. Therefore, it is not possible to prescribe a folktale for any potential narrator. Already, the health educators deliver their lessons from prescribed written preparations, so *iintsomi* comes natural from one's previous experience.

Scheub (1975: 61) states that the core images of the inherited tradition are given life not by means of written word, but with the body and the voice, imaginatively and rhythmically utilized. This means that *iintsomi* is readily available as a tool for teaching.

As confirmed by many folklorists, there have been so many *iintsomi* which adults have heard from their grandparents; as a result, it could be challenging to choose which ones are relevant for a particular teaching context. Nonetheless, Kehinde (2010:32) suggests that the emphasis should be placed on folktales that can help in nation building, and those that can assist to address the situation whereby our esteemed values are steadily going towards disorder and disintegration.

Maternal Health educators need to be aware of the types of folktales which can be selected for the purpose of entertaining while also educating women about the risks associated with pregnancy, more especially for teenagers. For an informed choice of a folktale suitable for different contexts, Okpewho (1992: 182-225) explains the different categories of oral narratives. There are fables which are mostly dilemma tales posing a problem which at the end the audience has to tackle and where questions are left to the audience to tackle. These are further categorized into two types; the explanatory tales which probe the background to a community's code of conduct of values and beliefs and the trickster tales which involve tricking and deceit, a breach of faith which perhaps leads to an end of a relationship. This type of tales mostly uses animals.

These animals, according to Scheub (1975:85) have a very important metaphoric role to play:-

Since natural harmony (in the artistic development of the theme) is a metaphor of the ideal human society, then the elements from that world of nature (birds, oxen, jackal, wolf etc) enter the human society to put things right. Certain animals become teachers. If a man seeks to pattern his own society after the order that he sees in the natural world, his best instructors are those very creatures that are an integral part of that natural order. And these creatures, as they instruct by their own words and actions, affirm and honour the time-sanctioned customs of men as the best means of achieving harmony.

The above assertion by Scheub indicates that by choosing to use a folktale in the healthcare teaching context, the educator is bringing an additional educator in the form of the characters in the tale hence most common questions after the narration are, for example:

| | |
|---|------------------------------------|
| <i>Inifundisa ntoni le ntsomi?</i> | What does this folktale teach you? |
| <i>Nifunda ntoni apha kuDyakalashé?</i> | What do you learn from the Jackal? |
| <i>Nibona ntoni apha kuMvolofu?</i> | What do you see from the Wolf? |

In a normal talk or presentation the questions will, for example, range from:

| | |
|---------------------------------|-------------------------------|
| <i>Nivile?</i> | Do you understand? |
| <i>Niyayiqonda ke ingozi</i> | You now understand the |
| <i>yokukhulelwa nibancinci?</i> | dangers of teenage pregnancy? |
| <i>Ayikho imibuzo?</i> | Are there any questions? |

2.5.2 A suitable environment for using folktales in maternal health education

The National Development Plan, vision for health 2030 states that:

Given that the core business of the health sector is clinical services that are both preventative and curative, it is important to provide the necessary environment for this to take place (2011:302).

The educator's environment and the goal of teaching also determine the choice of the core images suitable for selection. The clinic environment is readily frustrating to a pregnant woman, it is therefore necessary to create an enabling environment for teaching by selecting stories which will help the women become stimulated to think about their own experiences.

Leo Widrich⁵ writes, “Whenever we hear a story, we want to relate it to one of our existing experiences. That’s why metaphors work so well with us. Whilst we are busy searching for a similar experience in our brains, we activate a part called insula, which helps us relate to that same experience of pain, joy, disgust or else.” When that experience of taking an inappropriate advice about contraceptives from a friend, a boyfriend or a husband is relayed through the folktale of the Jackal and the Wolf, there is opportunity for women to engage in the lesson.

To emphasise the fact that storytelling is not just simple narration but an important tool to trigger thoughts and action, Scheub (1975: 95) speaks of “cueing and scanning” terms which clearly indicate that storytelling is action and performance. It is therefore the maternal health educator contextual knowledge and understanding of the health messages that assists her to select appropriate core images which are appealing to pregnant women thoughts and imagination.

Scheub (1975:74) further calls for “the juxtaposition and manipulation of the ancient materials in the contemporary settings and situations”. The researcher views this as an invitation for health workers, in their endeavor to achieve the desired health outcomes as stipulated in MDG 4 and 5, to also look into oral traditional narratives as alternative media for their lessons at the clinic; the community; and the maternal waiting homes while also considering their immediate purpose for the narration.

2.5.3 The role of the audience in storytelling sessions

Besides the choice of a folktale, the narrators need to be aware of the important role played by the audience in the performance of (iintsomi) folktale. Firstly, it is important to realise that the oral performance is always intended for a specific occasion (Finnegan 2012:4). Awareness about the context makes it easy to prepare to appeal to the audience, more especially if the narrator is familiar with the context. On the other hand, the role of the audience is always very different than when the lessons are presented on the basis of the prepared talk or speech as the folktale enables the listeners to pay attention, participate very soon in the lesson and join the narrator’s actions or singing easily. As explained by Finnegan (2012:12-13), in oral performance, the audience,

....as is not the case with written forms, is often directly involved in the actualization and creation of a piece of oral literature. An audience of some kind is normally an

⁵ <http://blog.bufferapp.com/science-of-storytelling-why-telling-a-story-is-the-most-powerful-way-to-activate-our-brains>

essential part of the whole literary situation. Sometimes he chooses to involve his listeners directly, as in story-telling situations where it is common for the narrator to open with a formula which explicitly arouses his audience's attention; he also often expects them to participate actively in the narration and, in particular, to join in the choruses of songs which he introduces into the narrative.

An intsoni is always introduced in a way which captures the interest and calls for immediate attention from the audience.

Narrator: *Kwathi ke kaloku ngantsomi!* Once upon a time!

Without doubt, the audience will know what to say without being asked as this goes with their traditional understanding of the intsoni pieces and their rules of performance.

Audience: *Chosi Ntsomi!*

Yes to the folktale!

Phondo phum'aph'ungaphum'apha! Horn grows here not here!

Immediately the educator shifts to become a storyteller or a narrator; the listeners are tuned into the 'capturing' tradition of intsoni (Okpewho 1992: 222-223); that of being removed from the real world of men, to participate in or observe the events; the readiness to be part of the lesson by being bound by the traditional rules of the newly created context of storytelling either than their normal way of starting a lesson, for example,

Mholweni boomama!

Greetings women

Namhlanje ndiza kunifundisa

Today I am going to teach you

ngeengozi zokukhulelwa niselula.

about teenage pregnancy risks

It is also important to note that from the above example the lesson plot and theme are explicitly given to the audience right from the beginning of the lesson whereas in a (intsoni) folktale narration "Plot, like theme, is revealed only in performance, through the externalization of the core-images of combination of core-images" (Scheub 1975:83). This approach has potential to keep the listeners on suspense while they engage in active listening with curiosity and anticipation for involvement in the events and the entire moral lesson of the folktale. Unlike when someone renders a speech or a talk, during a folktale narration, the audience is also not formally obliged to listen from the beginning to the end without interruption thus Finnegan (2012:13) says:

Members of the audience too need not confine their participation to silent listening or a mere acceptance of the chief performer's invitation to participate they may also in

some circumstances break into the performance with additions, queries, or even criticisms.

The above is also an indication of the relaxed environment which a folktale brings along. When women are free to express themselves, health educators will also be interested to exchange ideas rather than only deliver health messages from charts, posters, and their expertise but from a mutual collaborative perspective as envisaged by the strategic model for effective delivery of maternal health (Moodley 2008-2010:309). Although an audience of adults may initially be skeptical and doubtful of the narrator's intention for using a folktale, the manner in which the performer handles the performance is key to changing any looming perceptions from the audience, which without even being invited, find itself part of the narration.

2.5.4 A storytelling model for Community Health Workers

As Lehman (2007:4) mentioned, Community Health Workers do not have professional qualifications enabling them to suit the objective of the revitalization of the PHC. However the HWSETA (2011) suggested 'development of models for work-based vocational training programmes for certain categories of health workers, namely the Community Health Workers and Counselors. Storytelling, as an indigenous oral art performance which has historically been used for education of society can be used as a model to enhance work-based Community Health Worker maternal health education skills.

However threatened; pressured and endangered is indigenous knowledge and its oral forms of literature (Kothari 2007:7), Scheub (1975:74)

Though emphasis is on imagination, change and shifting from the ntsomi tradition takes place gradually... such conservatism is no doubt related to the educational function of the ntsomi, and it is also the result of the needs of the artists in creating their images in bringing their images into a meaningful relationship with the contemporary life, the aesthetic values of the tradition being found not in the development of wholly new plots and images but in the re-creation and reshaping, the remoulding and re-forming, the juxtaposition and manipulation of the ancient materials in the contemporary settings and situations

Scheub (1975) devoted time to explain various ways through which the oral narrator manipulates symbols and images within the tales. Some performers have acquired the skill by watching others while some share stories which they learned as children, for example, Makhuphula (1988) as mentioned in Jenkins (2004:13). Although the 'core images' might be the same, different narrators use different styles depending on their age; era; context;

audience; social issues; and their skill. Gcina Mhlophe's style completely differs from Nongenile Zenani as described in Scheub (1969). Telling an iintsomi to children differs from telling it to adults. Okpekwho (1992:16) points out that:

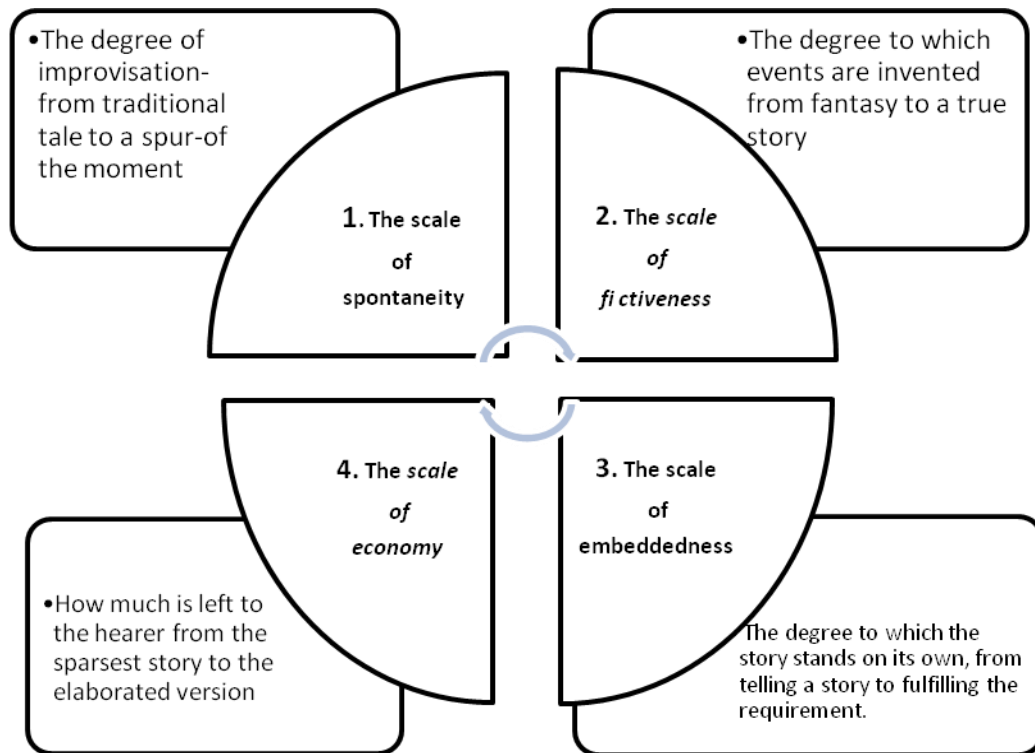
...one version of a tale is bound to differ from another version, depending not only on the narrator's personal skill and experience but also on the context (e.g., type of audience) within which the tale is told.

The assertion above indicates that for health workers to become storytellers, as emphasised in Zeelan (2010:382-398), they must be health workers first before they are storytellers, for their choice of tales largely depends on their knowledge of their real purpose for wanting to use this method. Benefits of storytelling have been explained earlier but the qualities of a good narrator are crucial. Whether narrators have acquired skills formally or informally, Okpekwho (1992:21-25), the storyteller strives to dramatise various actions described in the tale so that even though it is set in a fantastic world, it assumes the proportion of real life. Tales need to portray various emotions and attitudes while giving warmth and life in the entire production of the oral art (Scheub 1975 in Okpekwho 1992:17)

Although folklorists confirm that oral literature is fundamentally by word of mouth, it has to be better organized so that it can create a good relationship between the audience and the narrator. The narrator therefore has further duty to make the narration more vivid and convincing by accompanying the words with innovation and manipulation of the core images and stylistic features of folktales (Scheub 1975; Okpekwho 1992). Gestures and facial expressions are an example of important aspects that create a meaningful relationship between the narrator and her audience.

Woodhouse (2007:65) has suggested that health workers explore a model for storytelling in health care contexts, which the researcher selected to illustrate as below:

Figure 1⁶



“What this model offers us is the chance to explore and use storytelling in healthcare to a greater degree and purpose.”(Woodhouse 2007:65)

To explain the above assertions, I shall use two examples of iintsomi

- Abantwana beNtab'esiduli*, The Children of the Anthill (first narrated to the researcher as a child by her grandmother and her uncle a long time ago but often reformulated to suit specific occasion, audience and situations (Finnegan 2012:4)
- Inkwenkwe neyeza lokumitha*, A Boy who drinks some medicine and falls pregnant, one of Nongenile Zenani’s extracted from the long version in Scheub (2005:230)

Intsomi 1

| | |
|-------------------------------|---------------------------------|
| Kwathi ke kaloku ngantsomi! | Once there was a folktale |
| Kwakukho intombazana | there was a young girl |
| Entle entle, entle | so beautiful |
| Le ntombazana yaqaphela ukuba | the girl noticed that there was |

⁶ Source: Woodhouse (2008:65) Illustration designed by researcher for further clarity on process of narration for beginner storytellers

| | |
|---|---|
| Inento engayiqondiyo eyivayo | something she did not understand |
| apha kuyo emzimbeni, | in her body |
| kodwa yanyamezela kuba ingafuni | but she resisted because |
| kuxelela namnye umntu. | she did not want to tell anybody |
| Yaphatheka kakubi le ntokazi yile nto, | This made her feel very uncomfortable |
| kodwa yaqin'enyaleni. | But she held on to her disgrace |
| Zaqengqeleka iintsuku, | days passed by |
| zahamb'iinyanga, saye sikhula nesisu! | Months passed by, the stomach was growing |
| Zaqengqelek'iintsuku, zaqengqelek'iinyanga, | Days passed by and months passed by |
| aye ekhula amabele! Aye khul'amabele | the breasts grew bigger and bigger |
| Lahamba ke lona ixesha, nayo ke ngoku | Time passed by and now |
| intombazana yazifumana ilikheswa | the girl found herself isolated |
| elingatyeleli nabahlobo. | Not visiting any friends |
| Ibisele iyiqonda ngoku | by now she understood |
| eyona ngxaki! | what the real problem was! |
| Ibingasayi ekuthezeni, | the girl stopped going to fetch wood |
| ingasayi nasemlanjeni, | she stopped going to the river |
| ingasahambi nabo nabahlobo bayo. | she stopped going out with her friends |
| Lahamb'ixesha, zaqengqelek'iinyanga. | Time passed by, months passed by |
| Ngelingeni yaziva intombazana igula. | At some stage the girl felt sick |

| | |
|-----------------------------------|---------------------------------------|
| Yayilunywa sisisu ixakiwe, | with stomach pains and was confused |
| suka yacing'icebo | Suddenly, she thought of a plan! |
| yazimela. | She eloped and |
| Yemka! Yemka! Yemka, | went away, away, away |
| yaya kuuude aph'ingaziwayo! | She went away where nobody know her! |
| Yemka, Yemka, Yemka! | She went away, away, away |
| Yemka! Yemka! Yemka. | She went away, away, away |
| Ngaxesha nye ke nenimba | At the same time the labor pains |
| ibisele isithi ndilapha! | were growing faster |
| Ibisel'ibile ilithontsi | She was now sweating |
| ngelo xesha icinga cebo limbi | while she was still thinking about |
| ngento emayiyenze. | what to do next |
| Ibisel'ixakwe nakukuhamba, | it was also difficult for her to walk |
| idumbe neezo nyawana. | as her small feet were now swelling |
| Kuthe kusenjalo, intombazana | At that moment, the girl |
| yabona intab'esiduli ekufutshane, | saw an anthill close by |
| yagqiba ukuba yembe | she decided to dig |
| umngxuma apha kuyo esizikithini. | a hole in the anthill |
| Yemba, Yemba, Yemba! | She digs and digs and digs |
| Yemba, Yemba, Yemba. | She digs and digs and digs |
| lthe igqiba yaye inimba | By the time she finished digging |
| seyingxam'okwamanz'abilayo! | The pain was like boiling water! |
| Yhoo! Kwangamantsintsintsi | Oh, it was really hard work |

| | |
|--------------------------------------|---|
| ke izama ukubeleka kobo bunzima. | Trying to give birth under such difficulty |
| Kuthe ngeli ngeni, yazal'amawele, | At last, she gave birth to twins! |
| inkwenkwe kunye nentombazana. | A boy and a girl |
| Yakhefuzela, ikhawulezisa ngoku | Fast breathing and in a hurry, she |
| ibasongela ngaloo ngutyana | wrapped the twins in her small blanket |
| yay'iyambethe, | with which she covered herself all along |
| Tshwa! emgxunyeni wentab'esduli, | Inside the hole of the anthill! |
| yabashiya apho ingabheki nangasemva. | She left them without ever looking back |
| Yahamba ke yaphind'ekhaya | She went back home |
| ingathi zange kwenzeke | and acted as if nothing ever happened |
| kwanto kweso sisu sayo. | with her stomach |
| Basala abantwana bentab'esduli, | The children of the anthill were left there |
| bakhulela apho bade babadala. | Grew up there older |
| Baziwa ngokuba ngabantwana | and become known as the children of |
| bentab'esiduli! | the anthill! |

Phela-phela ngantsomi.

Intsomi 2

| | |
|--|---|
| Kwathi ntsom'...indoda nomfaz' | <i>Once there was a folktale</i> |
| Wazal'umfaz'... nkwenkwe | <i>The wife gave birth to a boy</i> |
| Akaz'aphind'amithe lo mfaz'... | <i>and then she never became pregnant again</i> |
| Wahlala ke ngoku engamithi tu | <i>she then sat not falling pregnant</i> |
| Uhleli wahlala wahlala lo mfaz'engamithi | <i>she sat and sat</i> |
| Intliziyo yakhe yabuhlungu yile nto | <i>her heart was very sore about this</i> |

Yokungamithi, kuba ngonje *thing of not falling pregnant again*

Uyakhul'akanamntana *because now the child is growing, no other child*

Wafun'umnt'okwazi ukunyanga *she looked for someone who knows how to cure*

Umntu amithe *someone to fall pregnant*

Ngoku ke wath'abefikile kulo mntu *Now when she arrived to this person*

Wath'uzuzolithath'ieyeza, *the person said you must come back for the medicine*

Andikalikhi. *I have not yet picked it*

Kuthe kwakufik'ixesha...wathum'inkwenkwe *when the time came she sent the boy*

Leya ukuba mayiolithath'ieyeza elo *to go fetch her medicine*

Iyile ke inkwenkwe yayolithath'ieyeza likanina *the boy went to fetch his mother's medicine*

Eli yeza ke kwedini unyok' *This medicine young boy, your mother*

az'alifake eziko *must put on fireplace*

Ath'alifak'ezik'alibasele *And cook it*

Ath'alibasel'alihlafune...aliginye *after cooking it, she must chew and swallow it*

"Ungakhe ulitye wena eli yeza" *"You must not drink this medicine"*

"Hayi, and'utya yeza mna" *"No, I won't drink the medicine"*

Yahamb'inkwenkwe yakufik'ekhaya *The boy went back and arrived home*

Yathi ke yakufik'ekhay'ayamnik'unin'ieyeza *When he reached home he did not*
give the medicine to the mother

Yafik'engekho, yalijong'eliyeza lihle *Because she was not there,*
he looked at this beautiful medicine

Yabon'uba lifanel'ubamandi *and saw it really looking nice*

Yalifak'eziko, lavuthw'iezeza, *The boy boiled the medicine to cook*

Yalihlafun'inkwenkwe *He chewed the medicine*

Yahlal'inkwenkwe...ngonje wafik'unina *The boy waited until his mother arrived*

Yamnik'unin'iezeza...yamnika ke *He gave the medicine to her...he gave it to her*

Eli belishiyekile *what was left*

Kuthen'elenze libe lincinci kangaka? *Why has he given you such so little medicine?*

Hay'ayandazi ke mna ke undinike elo *No I don't know, he only gave me that one*

Walifak'eziko ke unina naye walitya *The mother boiled it and drank it*

Kuthe ke ngoku inkwenkwe *and then now the boy*

Yahamba yahamba yahamba *as time passed by*

Yazibon'iphum'amabele *He saw himself growing breasts*

Yabon'iphum'amabel'inkwenkwe *He saw himself growing breasts*

Yaman'iwacofa amabele *He continuously pressed them*

Tyhini, ndiphum'amabele! *Oh! I am growing breasts!*

Yathi yaphum'isisu inkwenkwe *And the boy's stomach grew*

Tyhini le nkwenkw'imithi ngoku! *Oh the boy is now pregnant!*

Yahlal'imith'injalo, *He remained pregnant like that*

Yasolok'i-i-iyoyika le nto *He was so scared of this thing*

Yathi ngonje ukwambatha oku... *and now when he covered himself like this...*

Yayiqhobosh'ingubo *he fasten the blanket*

Yahlala yahlala yahlala *he sat and sat and sat*

Zahamb'iinyangaaaaaa...lhlala yodwaaaa... *months passed and he lived alone...*

(It is quite a long iintsomi. I will end it here)

Eventually the boy gave birth to a baby which he continued to secretly breastfeed away from his mother. He was a loving 'mother' until the secret was discovered by his mother who took the baby girl. The baby was raised by both 'parents' with love and care until she became a healer who helped the community.

In relation to the model advised in Woodhouse (2007:65), the folktales illustrated above are a readily available resource which are rich in a variety of themes and topics which according to the previously cited maternal health reports deserve priority. These folktale examples have been used spontaneously in the study to address, among other things;

- a) social problems encountered by pregnant women in the community;
- b) laziness to access information and ignorance about own health;
- c) fear of revealing and talking about pregnancy
- d) unfriendly service at local clinics;
- e) poor education of women
- f) traditional taboos and stigmatisation associated with women sexuality

Although Woodhouse (2007) points out that most stories are true, short, spontaneous anecdotes which are rarely planned, there is evidence that isiXhosa folktales can be very long and can be viewed as time consuming by someone who has not used them. The researcher believes that as part of their planning towards becoming skilled storytellers, novice storytellers would require time to select relevant aspects from a variety of iintsomi in line with their topics or themes. On a positive note improvisation does not depend on this knowledge as the health workers already have their stipulated central ideas for maternal health education lessons, hence Woodhouse's assertion about 'the scale of spontaneity'.

Again, as evident from the two examples of iintsomi illustrated above, the scale of fictiveness, also does not require any high level of skills as the narrator would use her background knowledge and understanding of her audience; purpose for narration; the context and the social concerns to transform or reformulate what might be considered as fantasy to the real situations, not by any other means but by exploiting the stylistic features of the iintsomi as described in (Scheub 1975 & Okpewho 1992). It is also important to note that some (*iintsomi*) will use animals like '*udyakalashé, umvolofu, umvundlana, ufudwazwana*, where the angle of narration incorporates more fantasy than in those that use '*inkwenkwe, umfazi, intombazana*'. It is still upon the narrator to use her discretion as Okpewho (1992:36) emphasizes that "all storytellers treat the story in their own way and in accordance with their energies, temperament and overall personality."

The researcher has earlier indicated the age and the era of narrators as also important. In the case of the selected intsoni, the researcher narrated from a different perspective than Nongenile Zenani's perspective. Our cueing and scanning as Scheub indicates is determined by a number of factors, for example in her own era, babies were nurtured and raised collaboratively whereas in today's society babies are likely to be abandoned, illegally aborted or consently terminated. In terms of language use, Nongenile uses words like 'ngonje' which are commonly used by elderly rural women. Although there are similarities in the theme of these two folktales, the choice of words; the voice; the pace; the tone and the rhythm; etc. are tools special to different narrators. To that, Finnegan (2012:6) further points out that "such devices are not mere embellishments, but an integral as well as flexible part of folktale full realization as a work of art."

Regarding the scale of embeddedness Finnegan (2012:13) explains that many oral recitations arise in response to various social obligations which, in turn, are exploited by poet and narrator for his own purposes. The performer of oral pieces could thus be said to be more involved in actual social situations than the writer in more familiar literate traditions. If folktales are selected to be told for the sake of narration, then the embeddedness of oral literature as well as the goals of the immediate context shall not be achieved. The Department of Health (2010, 2011) has raised serious concerns on maternal and child health, thus, any innovative strategies should contribute to the realisation of the revitalised Primary Health Care maternal health education initiatives. To this effect, Olver et al (2011; 25) stipulates that,

Awareness campaigns aimed at mobilising communities to reduce maternal and neonatal deaths are vital to the process. ECDoH is promoting early clinic booking for pregnant women; encouraging regular clinic attendance; counseling and support for pregnancy and childbirth; encouraging planning for transport and childbirth; and encouraging childbirth at a health facility attended by skilled personnel.

It is during these awareness campaigns that storytelling could also be exploited as a way of ensuring that women take responsibility of their own health by being engaged in the discussions rather than only becoming recipients of information from the health educators.

The concerns raised in Pattison (2011:17) as avoidable patient associated factors of maternal and child mortality require multiple strategies which suit rural women. For example, the following issues have been raised in Pattison's report;

- a) Delay in seeking medical attention during labour
- b) Inappropriate response to poor fetal movements
- c) Booked late in pregnancy

- d) Never initiated antenatal care
- e) Infrequent visits to antenatal clinic

The above mentioned examples are without doubt addressed through the 'The Children of the Anthill' folktale. Citing Richter and Koppett (2000), Eck (2006:11) also states that a well told story can bring about a sense of belonging in learning communities, better than most traditional teaching methods. The researcher therefore views the scale of economy as explained in Woodhouse (2007) model, as relating to the current discourse on PHC, which focuses on both health improvement and the struggle for social justice, which is further emphasised in Moodley (2008-2010) as a collaborative approach to maternal health education. When a folktale has been narrated, the channel for women participation employs a different perspective: not that of the tale and not of the health educator as a narrator; but of a combination of experiences which have been put together through a single communicative event. As a result of integrating a folktale in the lesson, the women have opportunity to contribute new information which can assist the health worker to establish trends in social life while a holistic approach in dealing with the pregnant women is employed.

Guardriola & Bertrand (2013:4-5) conclude that the use of storytelling device is a way for the listener to display his/her stance toward the events told by the storyteller. If the listener's stance is congruent with that of the storyteller, this reveals a high degree of affiliation between the participants. The long term desire of health education is to assist in women taking responsibility of their own health. When patient related factors of maternal health risks are also raised through the storytelling method, more women can improve the behaviours and attitude towards health education.

2.6. Other storytelling studies in different contexts

The benefit of using stories in different contexts is fast becoming an impressive evidence of oral tradition art playing a significant role in both the global and local contemporary context. As Steve Denning⁷ puts it:

“People think, plan, decide, and dream in stories, so storytelling comes naturally to human beings. This is how our brains are made. Storytelling is also the oldest form of communication—people have drawn and/or told stories to explain events and make sense of their world. Through the millennia, all great religions were founded on stories. All great political changes have happened because people believed in a new

⁷ Health Care Innovations Exchange Team <http://www.innovations.ahrq.gov/content.aspx?id=2800>

story. If you look closely at any business leader who has successfully initiated change, you will find a capable storyteller.”

Various experiences by different organisations, individuals, conferences and research are an indication of various forms of storytelling being taken serious in transforming organisational practices, employee behaviours and attitudes towards civil society. Although not all specifically refer to (iintsomi) folktales, the study has selected to use a few examples indicating relevance of storytelling in different contexts.

As it always occurs with most development in the global trends, the role of storytelling in countries like the United States of America has long evolved from the fireplace to different government and non-government workplace. Ellis (2007) shared experiences of attending storytelling presentations at a conference organized by the Northern Centre for Storytelling where the significance of storytelling in the arena of healthcare was explored.

2.6.1 Storytelling as patients voices

According to Ellis (2007) experiences from use of storytelling methods for adults in the health context highlighted very important lessons, for example, the following:

- a) Storytelling as interdisciplinary in nature
- b) Storytelling encouraged adults to seek to understand particular stories in a particular context
- c) Adults are provided with opportunity to actively participate
- d) Stories encouraged creativity

There is an indication that storytelling has not only remained as a face-to-face oral activity but has evolved into other media. While the Atlantic Health Systems incorporated video storytelling as a tool in patient safety training, the Patients Voices also uses recorded voice-overs from patients. Nonetheless, the power of oral storytelling in adult healthcare training contexts is confirmed in the project called StoryWorks, where stories are gathered and fed back to healthcare organizations for further use for awareness-raising workshops for healthcare staff, managers and trustees.

Further evidence from Clinical Leaders Network (CLN) states that storytelling is helping clinicians and professionals to understand the experiences of patients. This network also affirms storytelling as a highly effective communication tool which gives human voice to processes and an innovative way of spreading knowledge throughout the healthcare community. Furthermore, midwives are also quoted to have used it to reduce high caesarian

rates while ophthalmologists have used it to develop new techniques to improve eyesight (CLN 2011).

2.6.2 Storytelling in nursing education

Hunter (2008) explored the benefits of storytelling in nursing education focusing on its use as a teaching strategy and means to promote students understanding and integration of art in nursing education. Having experienced a transformative challenge of being a nurse, Hunter thus sought a creative strategy to not only enhance students' aesthetic learning, but also to create a connected environment within the classroom. Introducing a narrative assignment for her undergraduate nursing students, she required them to share a personal "story" that either they or a family member/friend had experienced related to the course topics. The story could also include artwork, music, or poetry if they desired. She therefore pursued this study by engaging in qualitative narrative analysis of collected stories, using Carper's (1978) Fundamental Patterns of Knowing as a guiding framework for her research.

Some valuable comments from this study (2008:5) reveal that storytelling;

- a) Creates a safe space for adults knowledge
- b) Promotes reciprocity that helps to develop authentic relationships
- c) Allows students to creatively integrate their experiences into their future nursing practice
- d) Teaches cultural values

In summary, Hunter (2008) revealed that storytelling enables integration of art and science while it creates more opportunity for students to look beyond and critically reflect on their experiences. The study also found a link between the student storytelling experiences and the course content. The study also revealed that use of storytelling method encourages moral reflection while it provides another valuable tool to move the students beyond their textbooks.

2.6.3 Storytelling for health literacy

Day (2009) conducted a study on the role of storytelling as a method to promote health literacy. The study focused on the importance of patient education in healthcare comparing the linear and experiential ways of learning with a description of storytelling as a way of teaching learners. In encouraging health literacy through storytelling, Day (2009: Manuscript 06) states that one reason that purposeful storytelling works is because it brings across factual information along with a human interest perspective drawing upon emotions. The study further argues that;

Telling the right story at the right time can help the patient understand the importance of adherence to a treatment plan or move from a pre-contemplative state to a contemplative one during the process of making lifestyle changes. Hence storytelling can be beneficial for both teaching and motivating change.

A further important comment from Day (2009) about storytelling and health literacy is that,

‘The real health literacy issue is not the lack of information, but rather the ability of the healthcare consumer to access and process the information.’

Given the accessibility of stories as a vehicle to distribute health information, there is opportunity for women to easily understand the health messages and equally contribute in the discussions during maternal health education lessons.

Day (2009) also revealed that the value of the stories is also important to the performer as she or he remained open to listen to patients. When using the storytelling methods, the performer also augments cultural sensitive care by treating the patients with tolerance and empathy. Singleton et al (2009: manuscript 4) also supported this viewpoint thus:

The culturally bound beliefs, values, and preferences a person holds influence how a person interprets healthcare messages. Knowing about a patient’s language and culture is key for knowing how health literate the person is in a given situation.

2.6.4 Storytelling as a clinical approach for health practitioners

Gersie (1997) outlined how storytelling has been used effectively to bring about healing change in many hospitals and community health visits. Her clinical research continued to explore how therapeutic story making may help people to integrate and surmount the troubling effect of painful life events like overcoming resistance, working with despondancy, mistrust and anger, and coping with pessimism, disappointment and frustration. As Gersie (1997:4) describes, the people who participated in the groups experienced a range of emotional, social and economic dilemmas. While pregnancy needs to be approached with positive attitude, it is equally important that health educators be equipped with more methods to help pregnant women face the negative experiences such as their fear to die while giving birth, stillbirth, vulnerability to disease, gender-based violence, failed relationships, unplanned pregnancy, poor nutrition and lifestyles, and so on. Stories bring forward a therapeutuc environment which encourages personal healing. To this, Crawford et al (2004:19) further suggests that, ‘It is vital that the therapist begin to identify stories for certain purposes of functions, whether it is to exchange people’s attitudes, emotions, behaviour, and self-image and so on.’

Schwartz and Abbott (2006) also explored storytelling as a clinical approach for undergraduate students. The students were given a task to gather information from multiple sources and to put it into a cohesive story in order to provide comprehensive, holistic, and individualized care. Various storytelling techniques were implemented in the classroom and clinical settings as a means for teaching and learning. As Schwartz and Abbott (2006: 182) describe,

'Storytelling benefits patients, nurses and students. The patient is able to express who they are, relieve tensions and resolve conflicts. It also provides the chance to reflect and reminisce, which can be therapeutic in helping patients cope with current conditions and illnesses. As a result patients may develop an increased sense of accomplishment and self awareness.... The nurse benefits from storytelling by deriving information from the story that may not have been collected from basic health history and physical assessment.'

While pregnant women have a responsibility to give birth to healthy babies, health educators have to be accountable for both the woman and the baby's lives while in the PHC service. It all begins with communicating with the pregnant women about clinical implications of pregnancy, particularly to teenage women who require assistance to cope with their first time pregnancy. By introducing storytelling in maternal health education, any possible feelings of being vulnerable and afraid have potential to be eliminated. As Dundes (1965:33) suggests, folklore serves as a psychological escape from many repressions, not only sexual, which society imposes upon the individual. The use of folktales in maternal health education is therefore relevant to clinical settings for a variety of other reasons either than therapy but also as a means to equip educators with teaching and learning methods which result to effective dissemination and access to health messages.

2.6.5 Storytelling for orphaned HIV/AIDS victims

In a local study, Mayaba (2012) explored the use of folktales to enhance the resilience of children orphaned by HIV and AIDS. Although their study refers to the effect of folktales to orphaned children, the researcher finds it important that folktales provide mutual benefit to educators and their audience in any pedagogic context.

According to Mayaba, the recent increase in the number of children orphaned and rendered vulnerable by HIV and AIDS in South Africa has placed an added burden on schools as sites of care and support. Mayaba (2002: ii) further states that education policies mandate schools to develop strategies to support such children, but this is no easy task in contexts where teachers are already struggling to fulfill instructional requirements. In order to ascertain the

important role of storytelling in this context, Mayaba (2002) adopted a reflective action research enquiry to show how folktales could be used to enable teachers to meet both pastoral and academic requirements. In her first study cycle, she used selected isiXhosa folktales which were narrated to isiXhosa speaking children who were orphaned and rendered vulnerable by HIV and AIDS (OVC) between the ages of nine and fourteen years. This was done to explore if merely telling the stories would enhance the resilience of these children. The second cycle observed the same children using these folktales as stimuli to produce drawings, collages, drama which in turn assisted to equip teachers with tools to enhance the resilience of OVC in a way that also promotes the attainment of instructional outcomes.

While those caregivers tasked with looking after and educate the orphaned children were confirmed to be facing challenges to effectively disseminate lessons, this study revealed that stories have potential to contribute to emotional healing on a subconscious level thereby enabling resilience. It was therefore concluded that culturally relevant stories could be used by South African caregivers, service providers and educators as an accessible, inexpensive and ready-made tool to directly empower children who have been orphaned by AIDS. Moreover, folktales were found to embrace both language and content in a way that culturally ignites prompt participation, entertainment and education of adults or children across contexts.

2.6.6. Storytelling for transforming society

Dinslagte (2001) in Kaschula indicates that oral storytelling has in Africa been used as a tool to transform society as they still kept their pedagogic value in the three different ethnic groups in West Africa. The Lyela in Burkina Faso; the Balsa in Northern Ghana and the Junkun in Northern Nigeria still use folktales as a pedagogic instrument for sex education (Kaschula 2001:46-47).

The remote rural district of Pallisa in Eastern Uganda as cited in the study by Silver (1997:2) is another example of the power of storytelling for a better health for the community. Methods used ranged from use of songs within stories which encourage citizens to utilise primary and secondary healthcare:

If their eyes are pale, and they're feeling very weak,

to the hospital, to the hospital;

If their hips are small, and they're looking pretty thin,

to the hospital, to the hospital;

If their fever's high, and they're having lots of chills,

to the hospital, to the hospital.... (Translation from Iteso)

If important health messages can be carried through the medium of songs and poems, there is nothing difficult in integrating folktales in maternal health education as they would equally function as a powerful means to allow pregnant women to reflect in their own lives and prepare to take responsibility for their own health. Traditional storytelling therefore has place in health care. As, Finnegan in Sienaert, Bell and Lewis (1991:21) puts it,

‘There is nothing strange or inappropriate about mixing drinks or making new blends or indeed of selling old-established tastes in new packaging to new customers for new kinds of profits.’

As society evolves, old ways of teaching should find place in new contexts through innovativeness by educators in different contemporary contexts. IsiXhosa folktales therefore have potential to survive in new environments, a fire-place at the clinic, in the maternal waiting homes and in community circles where health educators are obliged to create access to health messages for all.

2.7. Summary

This chapter reviewed literature related to the study and its pre-set objectives. With reference to the nature and the model for PHC and the priority values underpinning maternal health education, this first part discussed issues pertaining to revitalization of antenatal care through education. Literature discussing the benefits of storytelling and its significance in the health context has been explored with reference to relevant maternal health reports.

Further discussions on the actual context in which maternal health education takes place; for example the environment, maternal health educator skills, ways of communication and the nature of the audience; their socio-cultural circumstances; were conducted with reference to theoretical basis and a further reference to related studies. Suggested models for creating awareness and implementation (Moodley 2008-2010:309; Woodhouse 2007: 65) were also graphically illustrated as a way of linking the selected folktales with the relevant health literacy themes and objectives for rendering quality maternal health education for rural PHC context.

The chapter therefore reviewed all selected literature with the aim to broaden understanding of isiXhosa folktales while it also created awareness on their relevance for maternal health education in PHC context.

CHAPTER 3 METHODOLOGY

3.1 Introduction

This chapter describes the methodology, the research design, ethnographic action research approach, the study stages, the study area; sampling and selection, data collection, management and handling procedures which all were undertaken during the study process. The study explored IsiXhosa storytelling (*iintsomi*) as an alternative medium for maternal health education in Primary Healthcare in the Eastern Cape. The researcher sought to explore the understanding of folktales in the health context without disrupting the readily taking place maternal health education lessons. As a result, the study became part of the natural setting while those selected to participate were also made to collaborate, participate and explain the significance of isiXhosa storytelling in their own context and in their own language (Ely et al 1991: 4-5; Patton 2002: 40-41; Meyers & Sylvester 2006:1). In order to achieve this purpose the study adopted a qualitative research design.

3.2. A qualitative research design

Meyers and Sylvester (2006:1) define qualitative research as an umbrella concept covering several forms of inquiry that help us understand and explain the meaning of social phenomena with as little disruption of the natural setting as possible. Citing Kirk and Miller (1986), Pope and Mays (2006:4) also describe qualitative research as a particular tradition in social science that fundamentally depends on watching people in their own territory and interacting with them in their own language, on their own terms, hence it is also termed naturalistic research.

As the researcher had previously embarked on a single preliminary observation of a lesson by one maternal educator, there was a need to further apply an adequate understanding of the relevant usage of *iintsomi* in maternal health education with more health educators; in their context and under their natural environment. Target participants in this study were therefore approached in their familiar setting and in their own languages, namely isiXhosa and Sesotho, so as to exploit a more natural way of inquiry which provided meaning to the research objectives.

The use of a qualitative design also presented the researcher with an opportunity to engage face-to-face with all participants while they explore a familiar phenomenon of isiXhosa storytelling and share their maternal health education experience and insights on what improvements could be implemented (Patton 2002: 40-41).

As Ely et al (1991:4-5) also describes, “qualitative implies a direct concern with experience as it is ‘lived’ or ‘felt’ or ‘undergone’.... Qualitative research, then, has the aim of understanding experience as nearly as possible as its participants feel it or live it”. The target participants had to speak for themselves by experience, words and actions, thus the researcher engaged them in the research process as ‘participants-as-practitioners-as-researchers’ (Cohen et al 2007: 310). As also highlighted in Tacchi (2003:5),

“There is never a simple division between us (researchers) and them (research subjects). Rather research involves many different roles and different kinds of conversations. Hence, you can involve participants both as informants and as fellow researchers. Action research should be a way of listening carefully to what people know from their experience, helping to structure this more clearly, and bringing it into the processes of planning and acting.”

In conclusion, choosing qualitative research therefore assisted the researcher and the participants to ‘understand a given research problem or topic from the perspectives of the local population it involves as it is also known as the method which is especially effective in obtaining culturally specific information about the values, opinions, behaviors, and social contexts of particular populations (Mack et al 2005:1). Thus, the researcher’s passion and understanding of storytelling would not have justified her perceptions on its role in teaching without seeking from people faced with health education; its relevance in their own cultural experiences and immediate health care context; their knowledge and understanding of its use; and how they perceived it. The chosen design was better employed through an ethnographic action research approach which followed three stages as explained in the following section:-

3.2.1 An ethnographic action research approach

In explaining the relevance of ethnographic approach, Hancock (1998:5) states that in health care settings, researchers may choose it because the cultural parameter is suspected of affecting the population’s response to care or treatment. The study was undertaken to introduce storytelling in the target area, but not without an interest to also obtain more culturally specific information about the values, opinions, behaviors, and goals for health education by all stakeholders (Mack et al 2005:1). This was possible only through being part of their environment, which fortunately as described in chapter 1, was not a totally strange environment to the researcher. Though this was an initial introduction of storytelling and not a long term study, an ethnographic action research approach was identified as suitable for achieving the study purpose.

Tacchi et al (2003:1) describes ethnography as, “A research approach that has traditionally been used to understand different cultures. Schutt (2012:334) also states that ethnographic research can also be called *naturalistic*, because it seeks to describe and understand the natural social world as it really is, in all its richness and detail.

Action research, on the other hand, “is used to bring about new activities through new understandings of situations” (Tacchi 2003:1). The study sought to also introduce an innovative idea which, to her understanding, had not been formally explored by many maternal health educators in the target area. Choosing action research therefore, allowed for a professional reflection on the traditional methods of teaching while an opportunity for introduction of isiXhosa iintsomi in maternal health lessons as another way of interacting with rural women was explored. Koshy et al (2010:1) further describes action research as, “also known as Participatory Action Research (PAR), community based study, co-operative enquiry and action learning- is an approach commonly used for improving conditions and practices in a range of healthcare environments. It involves healthcare practitioners conducting systematic enquiries in order to help them improve their own practices, which in turn can enhance their working environment and the working environments of those who are part of it-clients, patients, and users. The researcher therefore found it relevant for the study design to follow the stages of action research as outlined in the cycle of action research illustrated below:-



Illustration 1: Kemmis and McTaggart (2000) Action Research Cycle

3.2.2 The study stages

The study followed three stages, namely:-

3.2.2.1 The pre-storytelling stage

A pre-storytelling stage was conducted with selected participants engaged in maternal health education; namely the management, the maternal health educators and the pregnant women. In order to explore the relevance of storytelling in the health context, views from (4) managers, (10) maternal health educators and (6) pregnant women were collected. Unstructured questionnaire and an interview, a focus group discussion and unstructured conversational interviews were used as a way of collecting baseline information from the selected participants.

The main aim was to further map the field for the purposes of gaining access, to know the people, the organizational structure and resources, the clinics, and health education activities taking place, including prior knowledge of stories in maternal health education lessons (Schumacher & Macmillan 1993: 412-413). This was conducted within one (1) week through brief site meetings in different management offices located at district and sub-district level.

3.2.2.2 The storytelling stage

Tacchi et al (2003:2) further states that by observing our actions we can generate knowledge and learn from our experiences, as a result, the researcher visited seven (7) clinics and one (1) maternal waiting home to observe lessons which were presented to either a group of pregnant women or mixed audiences with pregnant women attending antenatal care check up. Each PPR presented a 30-35 minute maternal health education lesson while the researcher observed their teaching practices. The easiest way for immediate experimentation with storytelling was to use a 'before-after' experiment simultaneously so as to avoid establishing two equated groups. PPRs presented their normal lessons on their selected themes before the researcher introduced a selected folktale in the same audience with PPRs acting as observer-participants in the same lesson.

The team teaching approach allowed for both the PPRs and the researcher to teach the same group in each visited site. This arrangement was easy to control as there were time limitations and other structural arrangements of the antenatal clinic in some areas (Jahoda 1951: 65). Some PPRs, for example, had to make a special arrangement for the availability of pregnant women in the clinic as there was no special antenatal care clinic day. In some cases, the number of women coming was too small to be divided into two separate groups, moreover, some venues were not suitable for teaching. Lastly, aim of the study was to

explore the storytelling approach as an alternative medium to maternal health education and not just to experiment how it works, so it was important that all selected health educators be simultaneously engaged in the process of understanding the significance of folktale use in their lessons. All seven (7) sites were visited within a period of two (2) weeks.

3.2.2.3 The post-storytelling stage

The reflection and evaluation stage was conducted in two ways, namely through recorded unstructured interviews and an open ended questionnaire where individual maternal health educators reflected on their actions and experiences while also identifying opportunities, advantages and challenges in their maternal health education methods. This was done within the two (2) weeks after each lesson observed. Naturally occurring evidence from other people who were indirectly involved in the study, like community members who were present during the maternal health education lessons, was also taken into consideration for analysis where opportunity allowed.

In addition to the questioning method, a five (5) hour focus group discussion workshop was conducted with a group of the maternal educators whose lessons were observed. The researcher also collected perceptions about storytelling from one (1) manager who participated as an observer in the focus group discussions. This was the final one (1) day activity, which was conducted with the purpose to do a collaborative informed reflection on the introduction of isiXhosa storytelling in the maternal health education lessons.

3.2.3 The study area

The study was undertaken at Elundini Sub-District comprising five (5) demarcation areas namely Maclear; Ugie; Tsolo; Qumbu; and Mt Fletcher under Joe Gqabi previously known as Ukhahlamba District. Eight (8) clinics namely Sonwabile; Empilisweni; Hlankomo; Katkop; Queen Noti; Taylor Bequest PHC; Mangoloaneng and Seqhobong and one (1) Maternal Waiting Home (MWH) also known as the Obstetric Waiting Home (OWH) at Taylor Bequest Hospital were identified to be part of the study. A total of 10 female maternal health educators, comprising Nursing Assistants and Community Health Workers were purposively selected for study. Their ages ranged from 39-52 with at least work experience of 7-15 years in the health care sector.

Pregnant women receiving maternal health education lessons were conveniently met in their respective clinics and the waiting home where they attended their antenatal care sessions. At least 8/23 clinics were selected which only (7) could be visited because of unavailability of suitable antenatal schedule for the study in (1) clinic. All educators selected for study fully

participated until the end of approximately two-months of the study period, including contact and non-contact time for closing study gaps.

3.2.4 Sampling and selection

Hancock (1998:2) describes qualitative sampling techniques as those concerned with seeking information from specific groups and subgroups in the population. As the study was a collaborative initiative by the researcher; a meaningful and purposeful exercise by the district and sub-district management team, a non-probability purposive sampling method was therefore utilised. To describe the nature of non-probability purposeful sampling, Cohen et al (2007) expands thus,

'The selectivity which is built into a non-probability sample derives from the researcher targeting a particular group, in the full knowledge that it does not represent the wider population: it simply represents itself. This is frequently the case in small scale research...this is frequently the case with...action research... As its name suggests, purposeful sampling has been chosen for a specific purpose... (Cohen et al 2007:113-115)

The sampling of participants was further guided by management's understanding of the expected role of selected CHWs and nurses in the Primary Health Care outreach program but with no intention to generalise any findings to the entire community health workforce in the district. As Mack et al (2005:5) also suggested, "Purposive sampling, one of the most common sampling strategies, groups participants according to preselected criteria relevant to a particular research question. The management interest in the study and their choice of participant was also based on their sub-district specific problem of teenage pregnancy rates. The sub-district had further identified teenage pregnancy and family planning as their priority health themes which required strengthening of the maternal health educator capacity to address these issues. One of the managers consulted for sampling and selection of study participants, also commented that there was high teenage pregnancy in their area which was further described as mostly affecting very young girls. In order to strengthen maternal health education, the manager further stated an interest to train their CHWs on presentation skills so that they become approachable to the women. The selection and sampling of the study participants was therefore influenced by the management purpose to develop CHW capabilities in MHE. Hysamen (1994: 44) also regarded purposeful sampling as most important kind of non-probability sampling where researchers rely on their experience, ingenuity and or/previous research findings to deliberately obtain participants in such a manner that the sample obtained may be regarded as representative of the relevant population. The supervisory and health promotion team therefore had criteria on who they

ideally wished could be involved in a storytelling study. To the researcher's advantage, the targeted participants were willing to be part of the study though they were initially not sure what it entailed.

3.2.5 Data collection

The study employed qualitative data collection techniques, which Schumacher & Macmillan (1993:42-43) describe as those techniques that collect data in the form of words rather than numbers; are focused on in-depth verbal description of phenomena with a goal to capture the richness and complexity of behaviour that occurs in natural settings from the participants perspective. Hancock (1998:9) further claimed that qualitative studies derive data from face-to-face interviews, focus group, or observation and tend to be time consuming to collect. The following qualitative data collection techniques were used

3.2.5.1 Semi-structured and Unstructured interviews

Since the study was conducted in an environment that required an open and informal approach, the researcher had to ensure selection of suitable data collection. Hancock (1998:10) stated that qualitative interviews should be informal. In order to find and to encourage the management to share their values on maternal health education; the researcher had intended to use semi-structured interviews. In describing semi-structured interviews Zhang & Wildemuth (2009:1) states that,

'an interview guide, usually including both close-ended and open-ended questions, is prepared; but in the course of the interview, the interviewer has a certain amount of room to adjust the sequence of the questions to be asked and to add questions based on the context of the participants responses.'

On initial meeting with the sub-district officials, it proved to be very difficult for all of them to be available for such interviews as the timing of the study coincided with their busy schedule and nearing public holidays. As a result, three (03) answered the questions as a written questionnaire. The researcher also learnt that she had to be flexible and adopt a conversational approach for one manager who agreed to an oral interview. As a result, the nature of the interview was found to be moving from structured to unstructured interview which she found to be useful for all participants during the study. According to Hancock (1998:10) the unstructured interviews are exactly what they sound like ...have no structure of a preconceived plan or expectation as to how to deal with the topic. Because of its conversational nature and flexibility to allow for elaboration, this method also helped the researcher to be highly responsive to individual differences and situational changes (Zhang

& Wildermuth 2009:3; Hancock 1998:9). The researcher further found this method as very useful for interviewing pregnant women and the PPRs before and after lesson observation sessions at the clinics and the maternal waiting home. (Pope 2002 in Zhang & Wildermuth 2009:1)

3.2.5.2 Focus group discussions

The Fisk Focus Group Research (2004) describes a focus group as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. Wilkinson (2004) in Onwuegbuzie (2009:2) further describes a focus group as a way of collecting qualitative data which-essentially-involves engaging a small number of people in an informal group discussion (or discussions), 'focused around a particular topic or a set of issues'. Although Ebrahim & Sullivan (1995:203) suggested a focus group as usually composed of 6-8 individuals who are not known to each other, but who have been selected because they share characteristics that are relevant to the research, Onwuegbuzie (2009:2) further suggested it can consist of 6 to 12 members. Through this method the researcher facilitated the first participant preparatory meeting and the final evaluation meeting with PPRs.

Although she was also not familiar with the subject at hand, the outreach manager volunteered to function as "a moderator" (Onwuegbuzie 2009:4) for the entry and exit focus group sessions as also agreed with the sub-district management and PPRs. This was done to ensure credibility of the study while it created an environment that was conducive for group discussions, for example, assisting with arranging logistics, attending to registration and welcoming of participants, note taking and data verification at the end of each session (Onwuegbuzie 2009:2). The maternal health educators were from separate clinics of different demarcation areas of the sub-district and there was a possibility that they never met or do not know each other, hence the use of 5 hour focus group discussion sessions pre and post storytelling.

3.2.5.3 Participant observation

According to Mack et al (2005:13), participant observation is a qualitative method with roots in traditional ethnographic research... The method is distinctive because the researcher approaches participants in their own environment rather than having the participants come to the researcher. Wolcott (1988) in Ely (1991: 44) commented thus:

'We ethnographic observers when we are attending to the cultural context of the behaviour we are engaging in or observing, and when we are looking for those

mutually understood sets of expectations and explanations that enable us to interpret what is occurring and what meanings are probably being attributed by others present.'

Although the researcher had earlier obtained information from the PPRs during the first focus group discussion meeting, it was necessary to undertake a more reliable way of also verifying this information by observing their teaching practices in their respective clinics (Hancock 1998: 12). The researcher was mainly interested to find out what happens in the class before and after storytelling, thus the focus was on the manner of presentation; methods used by the participant practitioner researcher and their immediate observable effect to the audience. As a participant observer, researcher observed the first lessons by PPRs who in turn observed her *intsomi* narration in the same lesson. After narration, the educators were allowed to continue with their lessons; to identify areas needing improvement and to comment on the role of *intsomi* in their lessons. Using participant observation method led to an informed integration, reflection and evaluation of the role played by isiXhosa *iintsomi* by the PPRs, the researcher and the audience where they were able to do so (Cohen 2007: 304-305).

It is also worth reporting that for most educators, particularly the CHWs, it was their first time to be observed while teaching. As a result, the observation of lessons was taken with mixed feelings of great pride, enthusiasm and anxiety by all those observed. Although all these feelings had potential to expose the researcher to an amount of subjectivity, the methodologies used were able to accommodate all participants without compromising the study objectives.

3.2.6 Data management and handling

Data collected through the above mentioned methods was stocked in three different techniques:-

3.2.6.1 Audio-video recorded data

Since the nature of the study was not controversial or presenting anxieties to the PPRs, they had agreed to the request by the researcher to record their lessons. The researcher used a two-in-one Sony cyber-shot 16.1 camera which digitised and recorded lessons and some interviews. Permission to record, digitise and take pictures of the lessons and the sites visited was initially requested from the district, the sub-district and the clinic management. Before each lesson started the researcher and the PPRs approached the audience to

explain the purpose of visit and request by researcher to record, video and take photos. It is important to note that the focus of the study was the lesson, thus not all sites visited enabled use of the device as different circumstances (for lesson environment, business at the clinic, noise levels etc) rendered it impracticable to utilise such methods. The researcher mainly also relied on her field notes which she captured during lesson observation and while also conducting some interviews.

Using the video element assisted the researcher to record 'not only the voice, but also the non-verbal expressions and the environments in which the recording is made. Audio-video recorded data is known for its being tedious and time-consuming to transcribe, but the researcher listened to all recorded data, transcribed it and stored it in picture, audio-video recorded, and field notes files according to each site and PPR visited, e.g. Clinic A, B, C, D, E, F, G and one (1) maternal waiting home.

3.2.6.2 Field notes

During each observation and encounter with the PPRs, their managers and the pregnant women, the researcher made notes of any relevant information observed. It is also important to note that writing everything was difficult, so the researcher used a simple open thinking units approach, which Lofland & Lofland (1984) in Ely (1991: 143-144) considered as helpful to manage while it creates a guide towards meaningful triangulation of data from the overall methods to be utilised in the entire study. The researcher found this approach to be very useful for feedback with her team as their novice background to research required much clarity and credibility of all what the researcher was doing 'with and about them' and their audience. The researcher was also mindful of the fact that this stage of the study had potential to tempt her to become the 'subject' because of her teaching background which the target participant did not have. The researcher therefore used the observation matrix⁸ as a strategy to control herself and to try focus on data organisation which would at least control subjectivity. The audio-video recorded lesson observation data also helped to foster objectivity while adding more information which the researcher might have missed or not understood due to language. For instance, two PPRs (2) presented their lessons in Sesotho. Although the researcher understood some basics, it was not easy to capture everything without collaborating with the interpreters who were other co-workers purposefully invited to the lessons.

⁸ Researcher used a field log observation matrix template adopting the Open Thinking Units approach by (Lofland & Lofland (1984) in Ely 1991: 143-144)

3.2.6.3 Photographs

In Hancock's words, 'photographs are a good way of collecting observable data of phenomena which can be captured in single shot or series of shots.'(1998:13). Where the situation allowed, the researcher, with the help of a trusted assistant, took pictures of the sites visited and the lessons observed with the aim to easily remember and triangulate all data for further record management and analysis.

3.2.7 Handling qualitative data

3.2.7.1 Data transcription and translation

Transcription means producing a written version of the audio-video recorded data. The researcher, as unfortunately a very eloquent person, had collected so much recorded data which, was at first very difficult to handle. It took almost two full months to complete the transcribing process. As Hancock also commented, 'transcribing is a time consuming process (1998:14)

Using the tape analysis technique (Hancock 1998:14), the researcher listened to all recorded data; transcribed it; and translated it from isiXhosa into English for reporting purposes. Sesotho data was also transcribed and translated with the help of a proficient qualified Sesotho-IsiXhosa translator.

The Oxford dictionary defines translation as a process of translating words or text from one language into another. The main language used for the study data collection was isiXhosa. All data was transcribed from its original language and translated by the researcher into English. Though not a highly skilled translator, the researcher relied on her proficiency in the source and target language as well as her basic translation studies. The study has therefore strived for translations that are easy to read; culturally appropriate and which would not cause any misunderstanding of the information provided (Nida 2001:3). Services for Sesotho into English translations were outsourced to a professional translator. All relevant data was then arranged in tables⁹ for ease of analysis and appending to the study.

3.2.7.2 Data control and management

The purpose of the study was to explore, integrate and evaluate use of isiXhosa iintsomi in the maternal health education lessons in selected clinics and a waiting home. Data was therefore collected, controlled, managed in relation to the preset study objectives. Working with only one private student assistant whose role was to assist with the video and audio

⁹ See list of Tables provided on table of contents.

recording, the researcher ensured use of data management control systems which were easily understood by all parties involved.

As the principal investigator, the researcher explained the data control processes to the PPRs and the private assistant prior each intervention session. Although this was an open participatory session, all parties involved were made aware of the three objectives set for the study, for example, for each interview with the PPRs, the researcher explained its intended purpose. The pre-lesson discussions and observations were recorded in field notes while the PPRs were reminded to write their notes in their log booklets which the researcher collected after each session so as to control data. (Tacchi et al 2003)

All recorded data and was transcribed, translated and typed by using MS Word. To keep an organised record of the data collected through the three stages of the study, it was necessary to clearly code the data types according to each PPRs 01-10 and site name. Grbich (2007) in Saldana (2008:8) states thus:

To codify is to arrange things in a systematic order, to make something part of a system or classification, to categorize. When codes are applied and reapplied to qualitative data, you are codifying – a process that permits data to be “segregated, grouped, regrouped and re-linked in order to consolidate meaning and explanation.

Study data was further stored in three category files namely:

- a) Preparatory
- b) Intervention
- c) Evaluation

Only the acquired study names were used to code log books from participants, for example PPR1-10, not their real names. For the focus group moderator notes, the researcher used Moderator Focus Group 1 & 2 (MFG1-2) instead of the manager’s name. Although all site names were mentioned in the study as per target area management specifications, during the data collection stage, the researcher preferred using alphabetical reference for confidentiality reasons, hence Clinic A-G.

Audio-recorded data was kept in recordable compact disks (CDs) which were clearly labelled according to each data type. Digital video disks (DVDs) labelled Clinic A-G and one (1) maternal waiting home were also used to keep all originally digitised clips which were further used with Lightworks V11 software to create a twenty-five (25) minutes summary of the study which was intended to provide a meaningful synopsis of the motivation for study, its objectives, the experience and the perceptions by participants. All audio-recorded data was analysed for reporting and further kept safely for submission to Rhodes University, which shall release to the study area as deemed applicable to their procedure and study area requirements.

3.2.8 Data analysis

According to Schutt (2012:321-322) qualitative data analysts seek to describe their textual data in ways that capture the setting or people who produced this text on their own terms rather than in terms of predefined measures and hypotheses. What this means is that qualitative data analysis tends to be inductive—the analyst identifies important categories in the data, as well as patterns and relationships, through a process of discovery. In preparation for a meaningful interpretation of the findings, data was ordered in relation to the objectives of the research by using the appropriate stages of data collection (Ebrahim & Sullivan 1995:208) A presentation of data from each stage and accompanying summaries assisted the researcher to identify variables requiring analysis, reporting and reaching common conclusions as illustrated in Chapter 4 of the study. Where appropriate, a limited amount of quantitative analysis method was used but the study mainly used content analysis as verbal and behavioural data from participants had to be interpreted (Hancock 1998:17)

3.3 Summary

Chapter 3 provided methodology used in the study; a detailed account of the methods; the study approach and design processes. A picture of the study area and details on targeted population; sampling and selection has been provided. Furthermore, information of data collection instruments with valid description and purpose for use of each method was provided. Types of data collection instruments were open-ended unstructured group and individual interviews; focus groups; conversational interviews; video and audio recordings while field notes were collected in PPR log books and researcher observation matrix. Additional sources of evidence were in the form of feedback notes and post-storytelling interviews with the participants and the observer-manager as a final way of validating the study findings. Lastly, this chapter provided details of data control, management and an insight to data analysis as discussed in the next chapter, (Chapter 4: Data analysis and interpretation)

CHAPTER 4

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This chapter provides data presentation and analysis. The study is trying to answer the main research question as follows:-

“Can the introduction of isiXhosa storytelling (*iintsomi*) as an alternative medium of education assist in the effective delivery of maternal health education lessons in rural Primary Health Care in the Eastern Cape?” The data presented further seeks to answer the following sub-questions:-

- e) To what extent are *iintsomi* relevant for maternal health education in the PHC context?
- f) What teaching practices and methods are currently used by maternal educators?
- g) What happens when *iintsomi* is integrated in the lesson by the health educator?
- h) How is the introduction of *iintsomi* perceived by the health educators and their audience?

The study is mainly qualitative in nature, although it partly used the quantitative data approach for the purposes of analysing a few data components. Data were therefore collected by using qualitative methods namely; participant observation; semi-structured and unstructured questionnaires, audio and video recorded interviews, informal conversation and focus group discussions as described in chapter 3. Since the study also assumed an action research design, data in this chapter is further presented according to three stages, namely:-

4.2 Preparatory stage 4.3 Intervention stage and 4.4 Evaluation stage

Since the study seeks to explore, introduce and evaluate effectiveness of use of folktales as an alternative method in the maternal health education context, data for preparatory stage was collected from a variety of respondents so as to gather sufficient evidence on maternal health education values, priority topics and responded prior knowledge and understanding of folktale within the teaching context of pregnant women. Qualitative data was therefore obtained from (4) maternal health education managers identified responsible for the target area as identified by the district officials. One of these managers was further tasked to assume the role of moderator-observer for both focus group discussions undertaken during the study.

Stage one data was also solicited from (10) maternal health educators (Community Health Workers and Nursing Assistants) as purposefully selected to become Participant Practitioner Researchers (PPRs) in the study (Cohen 2007:310). Because it was also important for the researcher to have background information on the nature of teaching, (6) teenage pregnant women who were conveniently available at the maternal waiting home during the initiation of the study, were also interviewed though an informal conversational approach using a semi-structured guided questionnaire.

The researcher has therefore identified the respondents as follows:-

| | |
|-------------|--------------------------------------|
| MHEM =1-4: | Maternal Health Educator Managers |
| MO= 1: | Moderator-Observer |
| PW=1-6: | Pregnant Women |
| PPRs=01-10: | Participant Practitioner Researchers |
| CFs= | Co-facilitator/s |
| VHW= | Voluntary Health Worker |
| VYW= | Voluntary Youth Worker |
| VP= | Visiting Parent |

Other included respondents in intervention and evaluation stage were some co-workers who were delegated by the clinic supervisor to assist some PPRs in teaching. VHW, VYW, and other CHW as CFs were therefore part of lessons and their views on introduction of folktales have been captured. In one site, one elderly VP was involved in the lesson, thus the researcher included her views as a respondent. Some CFs who understood both isiXhosa and Sesotho also provided interpreting services where the PPRs language was mainly Sesotho.

For the intervention stage, data was mainly obtained from the following sources:-

- a) Researcher's observation notes which were organised into a lesson observation matrix;
- b) The lesson examples delivered by the educators before and during introduction of the folktales (Lesson A, B, C);
- c) The folktales selected by the researcher for narration in the visited sites. (Folktales 1-3).

Data for the Evaluation stage was collected from the participants through:-

- a) Semi-structured and unstructured questionnaires;

- b) Audio-video recorded unstructured interviews which gathered the views and perceptions of participants on their lessons before and during folktale narration; and
- c) A focus group discussion which gathered the overall post-storytelling views and perceptions of participants and the moderator-observer.

All data collected in isiXhosa was translated by researcher into English. Sesotho-English translation was outsourced to a qualified private provider. Lastly all information emanating from these various data pieces were put into Tables 1- 12 which are included in the study as appendices.

This chapter first presents data collected during the preparatory stage for the purposes of exploring the relevance of folktales in maternal health education. As the researcher was venturing into a non-clinical subject, it was necessary to obtain sufficient background on maternal health education before proceeding with intervention. The intervention stage presents data on lesson observation and integration of folktales in the observed lessons. Further data from the lesson types; thus pre-storytelling and during storytelling lessons is presented. Lastly, post-storytelling data collected through semi-structured questionnaires; unstructured recorded audio-video interviews; and a focus group discussion is presented as a third and last section for this chapter.

4.2 The Preparatory Stage: Pre-storytelling

As stated in Pattison (2010-2011:iv) the model favoured by Saving Mothers Saving Babies is '*action orientated*' as it gives the level (community/individual, health care manager and health care provider) that should be targeted when developing strategies for improving the health system. Furthermore, the symbiotic relationship between health promotion and health education has to be understood in line with trends that drive the real purposes for improving education, thus, those responsible for maternal health education are regarded as having the necessary background to whether any education intervention will fulfil the function of agenda raising; professional education; lobbying, advocacy and mediation. (Tones et al 1990:4-6)

4.2.1 Management values on maternal health education in Primary Health Care

To avoid making any unfounded assumptions and generalisations on the intentions for maternal health education, it was therefore necessary for the researcher to approach the identified key personnel as advised by the district and the sub-district management. This was done to ensure thorough preparation and to find out their views on the relevance of

folktales in their teaching and learning context. As the researcher was in an effort to immerse into the lives of the people who were to be indirectly and directly involved in the study, it was important to observe any values which she perceived as impacting on the success of the study. To this effect other naturally occurring evidence from meetings¹⁰ and from letters was considered as credible data for analysis as follows:

Extract A:

From minutes of meeting 1 with the first two maternal health education managers (MHEMs)

Both managers received the presentation and the project positively but shall report to the senior management for further confirmation of the ethical stance of the project and give feedback to researcher by 02/12/2013. (Meeting on 29/11/13)

Extract B: From the letter replying to grant permission for study

This office is wishing you the best of luck in your study and thank you for bringing the project to our Sub-district. We trust that it will add value to our systems strengthening and the skills enhancement of the targeted health workers. You are further allowed to request any further information required to validate your study from our offices. Lastly, as this sub-district, we are interested in the findings and recommendations of the study and therefore shall request your institution to consider feedback/access to the entire final products for our records and a possible use of any relevant outcomes/products, which are a result of this project. (Appendix A4 29/11/13)¹¹

4.2.1.1 Professionalism, respect and commitment to Primary Health Care goals

Data from the above extracts revealed the professional and respectful manner in which the study was handled by the management. This was revealed by positive attitude and their demonstration of complying with the requirements of their department on handling research issues. As further indicated in extract B, there was promptness in terms of feedback which the researcher attributed to the values of customer care principles which on her observation during the meetings, were boldly displayed on the walls of the office and the waiting room. Data from the extract B also revealed commitment to promoting the goals of the PHC system by trusting that the study will add value to their systems strengthening, and skills

¹⁰ For the purposes of respecting confidentiality of some discussion items and people's names, the researcher only presented data relevant to the study objectives

¹¹ Only the names of the top management who agreed for the study permission letters to be appear in the study.

enhancement of the CHWs. The researcher regarded this as synonymous to their valuing the focus of the study; maternal health education.

Data further revealed the management knowledge and understanding of empirical research, although the researcher later learnt that they were not fully conversant with some components of the action research approach. As a mutual process in which the researcher was also immersed for learning and sharing of skills, the study welcomed a volunteer MHEM to become moderator-observer during the focus group discussion sessions.

Further data seeking to establish more information about values underlying the maternal health education was collected through a semi-structured open-ended questionnaire for three managers and a semi-structured interview for one manager who could not fill in a written questionnaire. Data collected from the all four managers has been collated and presented together so as to represent the management views. The researcher has chosen to present only the data considered as relevant to the study objectives. The following table presents some of their responses to the open ended-questions asked by the researcher:-

Table 4.2-1: Maternal health educators and location of lessons

| Research Question 1: Who teaches pregnant women in your area? | |
|--|---|
| Respondent 1 | Health promoters, nurses, and the community health workers |
| Respondent 2 | CHW, nurses in clinics and maternity ward |
| Respondent 3 | CHWs, maternal health, health promotion unit |
| Respondent 4 | Luxanduva lomntu wonke sisi ukufundisa abafazi abakhuleweyo, by Clinic Supervisors, nurses, community health workers, and volunteers. <i>(It is everyone's responsibility to teach pregnant women...)</i> |
| CHW = 4 100% | Nurses = 3 75% |
| Health Promoters = 2 50% | All= 1 25% |
| Maternity staff = 1 25% | |
| Research question 2: Bafundiselwa phi abafazi abakhulelweyo? Where does maternal health education take place? | |
| Respondent 1 | Community, clinics, hospital |
| Respondent 2 | Hospital, clinics, community |
| Respondent 3 | Hospital, clinics, community |
| Respondent 4 | Most of the time eklinikhi okanye kwicomunity nasesibhedlele if umntu uyile ewaiting home, uyazi mors sinewaiting home eMt Fletcher? |

| | | | | |
|------------------|---|--------------------|---------------------------------|--|
| | <i>Most of the time at the clinic or in the community and hospital if one goes to the waiting home, you know we have a waiting home in Mt Fletcher?</i> | | | |
| Clinic =4 | Community =4 | Hospital =4 | Maternal waiting home =1 | |
| 100% | 100% | 100% | 25% | |

4.2.1. 2. Responsibility and location of maternal health education lessons

Data from Table 4.2-1 indicates that although maternal health education is everyone's responsibility, all four respondents (100%) identified the Community Health Workers (CHWs); as mainly responsible for maternal health education. All 4 respondents (100%) also confirmed maternal health education to be taking place at the clinics, hospitals and in the community. 25% of the respondents also mentioned some lessons taking place at a maternal waiting home where some women were admitted to await delivery.

The purpose of the study was to explore folktales but the researcher had to obtain enough background about the nature and priority goals for teaching so as to learn about relevance of the study before taking action. Data presented in the table below has combined (2) research questions:-

Table 4.2-2: Priority objectives and themes for maternal health education.

| | |
|---|--|
| Research Question 3: Ziziphi ezona njongo ziphambili ekufundisweni kwabo? <i>What are priority objectives for maternal health education?</i> | |
| Respondent 1 | Avoid maternal deaths |
| Respondent 2 | Ukhukhusela bangosuleleki zizifo / <i>To prevent being infected by diseases</i> |
| Respondent 3 | Zingasweleki iintsana/ <i>infants not to die</i> |
| Respondent 4 | Zininzi kakhulu, andifuni nokuxoka. Sinexhala xa umntwana emithi kuba asifuni kuswelekelwa ngumfaz'omithiyo apha. Sifuna ukuphungula inani labantwana abakhulelwayo kuba irisk ababakuyo iphezulu kunabafazi abatshatileyo. Asifuni kusweleke nezo ntsana zabo. <i>There are many, I do not even want to tell lies. We get worried when a teenager is pregnant because we do not want a</i> |

| | |
|--|--|
| | <i>maternal death here; we want to lessen the number of teenage pregnancies. They are high risk than married women. We also do not want their babies to die.</i> |
| Research Question 4: Ziziphi izihloko ekugxininiswa kuzo xa kufundiswa abafazi abakhulelweyo? Bhala nje zibe (4) <i>Which topics do maternal health education emphasise? Just write (4)</i> | |
| Respondent 1 | TB, HIV/AIDS, Child health, Malnutrition, Breastfeeding |
| Respondent 2 | Nutrition, HIV/AIDS, Family Planning, Child health |
| Respondent 3 | Maternal Risks, Pregnancy (Teenage), Family Planning, Nutrition |
| Respondent 4 | Antenatal Care (ANC), High Blood Pressure, Diet, Exercise |
| Prevent maternal and child mortality= 3 prevent disease = 1 Eliminate teenage pregnancy= 1 | |
| 75% | 25% 25% |
| TB = 1 | HIV/AIDS=2 CH=2 Family Planning = 2 Teenage pregnancy= 1 |
| 25% | 50% 50% 50% 25% |

4. 2.1. 3 Priority objectives and maternal health education themes

(75%) of the respondents cited prevention of maternal and child mortality as priority objectives for maternal health education. Although teenage pregnancy has been identified as a concern for high pregnancy risks and prevalence to disease by some managers only (25 %) of the respondents identified it as a maternal health priority topic. It is assumed that the (50%) for family planning also accounts for pregnancy related education which largely focuses mainly on child health, HIV/AIDS, nutrition, high blood pressure, breastfeeding and TB.

4.2.1.4 Level of satisfaction and maternal health education challenges

Regarding their satisfaction with maternal health education taking place in their area 50% of the respondents indicated to be trying to do better while the other 50% indicated that the level of maternal health education is unsatisfactory, more especially with more teenagers becoming pregnant every day.

Among other reasons cited for their dissatisfaction was lack of staff and other undisclosed challenges inhibiting teamwork towards effective maternal health education. As data also indicated, 25% of the respondents identified teenage girls as high risk as they were mainly

affected by premarital sex problems and pregnancy risks which they had to collaboratively address through awareness and education campaigns, like *Campaign on Accelerated Reduction of Maternal and Child Mortality* (Carmma). Lastly data further indicated the respondents' views on the training needs of the Community Health Workers as quoted below:

“We must be sure about teaching girls about pregnancy risks. The teenage pregnancy rate is very high in our area. You must see our daily intake at the maternal waiting home! It is mostly very young girls. So we want to train our community health workers to be open, talkative, and approachable. Our rural youth are faced with many things like ‘amakrexe’ (married partners engaged in extramarital affairs) so they need to be educated now and again, we need help. If we have to properly implement Campaign on Accelerated Reduction of Maternal and Child Mortality (CARMMA)¹² in our clinics, waiting home and hospitals, we have to strengthen education on teenage pregnancy.”

The researcher was mindful of the purpose for the study and therefore diverted inquiry to find out the extent to which folktales are known and utilised in the health context. As the previously asked questions assisted the researcher towards cueing and scanning of relevant core images for the health context (Scheub 1975:93), this question assisted to inform the study about the extent to which storytelling has been used or not used in the teaching of pregnant women at clinics, community or the maternal waiting home. Data was collected from the three types of respondents engaged in teaching and learning activities in their respective areas, namely MHEM, PPR's and PW's as recipients of lessons.

Table 4.2-3: Prior knowledge and understanding of folktales in MHE

| Maternal Health Education Managers (MHEM) (4) <i>Data Source: Semi-structured questionnaire & interview</i> | Participant Practitioner Researchers (PPRs) (10) <i>Data source: Focus group discussion</i> | Pregnant Women (PW) (6) <i>Data source: Informal conversational interview</i> |
|---|--|---|
| Research Question Has a folktale been narrated during maternal health education lessons in your area? Yes/No Explain | Research Question Do you sometimes use folktales or stories when you teach pregnant women? Yes/No Explain | Research Question 5: Have you heard a story/folktale being narrated during health education lessons at the clinic? |
| Respondent 1 No | Respondent 1 no answer | Respondent 1 no answer |
| Respondent 2 I am not sure | Respondent 2 no answer | Respondent 2 (hesitant to answer) |

¹² While talking to her, I had no idea what is Carmma until I got a brochure about it from the list of brochures on the table in one of the clinics I visited. See Appendix E.

| | | |
|--|---|---|
| | | then..) No |
| Respondent 3 <i>No I do not know</i> | Respondent 3 <i>We do have stories but I do not know about intsoni</i> | Respondent 3 <i>I only heard it from a lesson here at the rondavel (maternal waiting home) when the sister came to teach us about the importance of breastfeeding.</i> |
| Respondent 4 <i>You mean folktales? (laughing) No I don't know how it fits at the clinic; I do not want to tell lies. I do remember it being used to entertain at home but I don't want to say I know it or we sometimes use it here.</i> | Respondent 4 <i>Yes sometimes you want to make an example about something or you heard something and make it a story when you teach.</i> | Respondent 4 <i>Smiling and shaking her head) I cannot remember</i> |
| | Respondent 5 <i>no answer</i> | Respondent 5 <i>I do not remember well</i> |
| | Respondent 6 <i>no answer, smiles and looks at her colleague</i> | Respondent 6 <i>No, I do not know.</i> |
| | Respondent 7 <i>I don't remember, I am not sure because narrating is something that just happens</i> | |
| | Respondent 8 <i>We were told about storytelling at the waiting home, but we want to see how that works.</i> | |
| | Respondent 9: <i>no answer</i> | |
| | Respondent 10: <i>We make examples, as for me when I teach something, but I cannot really claim I use them. I do not have a picture of a folktale at the clinic.</i> | |
| No=1 = (25%) Not sure=1= (25%) Do not know=2= (75%) | No answer=5 (50%) Told about it=1 (10%) Do not know how it fits=1 (10%) Do not remember=2 (50%) Yes sometimes=1 (10%) | No answer=2 (33%) Do not remember=2 (33%) Do not know=1 (17%) Heard it at MWH=1 (17%) |

4.2.1.5 Prior knowledge and use of folktale in maternal health lessons

Data indicates that 75% of the MHEMs had no knowledge of use of folktales in maternal health education. While 50% of PPRs confirmed using story examples but not folktales, 33% of the PW interviewed also did not remember any folktales or stories being used in their lessons. Similarly to their educators, half of the PW also did not respond to this question.

A slight understanding of folktales only as relevant for entertaining children has been recorded from at least 25% respondents who also clearly voiced their doubt on the relevance of folktale use in maternal health education. It was commendable that at least 17% of the PW and 20% of the PPRs had experienced some stories at clinic or maternal waiting home level, though it was not clear if those were folktales or not. It is also worth noting that the PW also had some memory of the lesson theme, breastfeeding.

Besides all the uncertainty; forgetting; no knowledge and limited exposure to some storytelling, all respondents expressed willingness for folktales to be integrated in the maternal health education lessons, as long as it would be useful; helpful and encouraging effective teaching; particularly for the Community Health Workers (CHWs) identified to be study participants (PPRs). The discussion with the PPRs also indicated interest to see folktales introduced in their maternal health education lessons as quoted below:-

“Ee ke ka thaba haholo ha keka bona tshomo e sebediswa dithutong tsaka nakong e etlang.” (*Yes I'll be very happy if I can observe use of folktales in the future lessons.*)

There were other issues pertaining to teaching methodologies; resources; and skills of educators which the researcher considered as important to effectively answer the question of relevance and a need for folktale integration in maternal health education. After the first week of consulting with the management, the researcher arranged a one day meeting with the selected PPRs for their orientation to the study. Data collection was possible through a focus group discussion method with the selected PPRs.

4.2.2 Maternal health educator views on maternal health education in Primary Health Care

Onwugbuzie (2009:2) suggested different role players in a focus group discussion, for example, the moderators, assistants and one moderator-observer. Due to the timing of the study which coincided with a number of relevant managers' end of the year holidays it was not possible for the researcher to get all these role players. The researcher was satisfied with the availability of one manager who was identified by the sub-district to be moderator-observer. To the researcher's advantage, the field of research was her direct responsibility in the sub-district. Although she was not very familiar with the approach adopted by the study, she willingly consented to the assigned role in the study. The following were some of the questions discussed and the responses obtained from the selected PPRs:

Table 4.2-4 Methods, resources and maternal health educator lesson preparation skills

| | |
|---|--|
| <p>Research Question 5. How do you teach and what do you use to prepare for your maternal health education lessons? (they keep quiet for a few minutes before they respond to the question)</p> | |
| <p>A1: <i>No, each and everyone knows what the sisters (nursing) teach us, moreover we cannot be confused on what to teach about. We have been in this job for a long time)</i></p> | <p>A2: Those posters (<i>pointing at the ones on the wall</i>) and some more books are helpful where we have such</p> |
| <p>Researcher: There is a brochure in your file, let us look at it and see if it does have any themes you think are relevant for your lesson preparation for the week I will be observing your lessons. (we read the brochure for at least 10 minutes and explained some words where one does not understand because it was in English, some are just perusing it, I am not sure they are reading or viewing)</p> | <p>A3: We sometimes get them from the workshops and also add our work experience and that of being women.</p> |
| <p>A4: <i>It cannot be that difficult to teach them because we also stay with them in the community, but I can be glad to get something to help me prepare for my lesson because I do not have it.</i></p> | |

4.2.2.1 Factors affecting selection of teaching strategies

Although not all the ten (10) PPRs gave answers to the discussed issue, it is evident from 40% of respondents that the teaching strategies also depended on a number of aspects, for example:-

- a) Individual experiences as women and as employees of the department;
- b) The availability of support materials like brochures, posters and books
- c) The advantage of working closely and staying in the same community; as well as
- d) The amount of exposure to training from the clinic sisters and the workshops they attend.

4.2.2.2 Other available teaching resources for lesson preparation

The researcher noted that brochures used for lesson preparation were mostly written in English. This resulted to the researcher's uncertainty on whether these brochures were read with understanding or were just perused to conform to the researcher instructions at that moment. As a result in order to prepare for their lessons some educators indicated that they still needed more resources to help them with lesson preparation and presentation.

4.2.2.3. Challenges facing maternal health educators

Generally, data from the focus group discussion indicated that all (100%) of the respondents fully understood their role as maternal health educators. Similarly to their management, some PPRs indicated challenges related to satisfactory delivery of maternal health education, for example:

- a) Lack of time for maternal health education at their clinics;
- b) Unsuitable antenatal clinic style for maternal health education as indicated in the dialogue illustrated below:-

PPR05: *Mna ke...kweyam indawo asibikho ispecial day seANC, oko kwathiwa masisebenze ngesupermarket style, so beza one-by-one. Sisafuna lubuyiselwe usuku lwabafazi abakhulelweyo*

(In my case, there is no special day for antenatal care clinic since we were changed to the supermarket style)

Researcher: *Yintoni leyo isupermaket style? (What is the supermarket style?)*

PPR05: *Yile yokuba beze nanini na ngoku xa befuna ukuza. Ayikho laa nto yokuba siyazi ukuba lusuku lwabo apho singababona beliqela. (It is the one that makes them come to the clinic anyday they feel like. It is not like when we used to know they have a special day where we can meet them as a group)*

4.2.2.4 Priority topics and available opportunities for maternal health education

Further data on priority topics revealed similarities to the findings from the management. Examples of identified topics were TB, Diabetes, HIV/AIDS, Sexually Transmitted Diseases, Family Planning, Contraceptives and Traditional medicines. Data indicates that maternal health educators conducted lessons to individuals or groups of women at the clinic; the community and a maternal waiting home when opportunity arises. In some cases, it was confirmed that the clinic sisters and the lay counsellors had a fair opportunity to talk to pregnant women during examination and counselling than the CHWs.

4.2.2.5. Maternal health educator skills and capabilities

Cohen's view (2007:310) points out the importance of engaging participants as researchers. The researcher provided the CHW's the opportunity to demonstrate their skill and capabilities to interact with the PW, reason being the researcher wanted to observe their inter-cultural communication skills in the rural health care setting. During the initial meeting with the PPRs, the researcher had also observed their differing levels in terms of personalities and presentation skills. Some were still shy and uneasy to participate freely, therefore, the researcher hoped that engaging them would help her gain their trust and allow them to take responsibility of the work to be undertaken. Furthermore, the management had stressed a need to train CHWs on presentation skills to improve approachability by pregnant women.

The researcher therefore engaged the PPRs in interviewing of the pregnant women. They were given a guided unstructured informal conversation questionnaire to practice interviewing the pregnant women, who to our advantage were at the maternal waiting home where the first focus group meeting occurred. To ensure the validity and reliability of the data gathered by the PPRs, the researcher observed all (6) 10-15 minute conversations within an hour and a half. Permission to talk to the women was requested in writing from the hospital manager and nurse in charge of the waiting homes. The approached pregnant women also agreed to a formal verbal request by the researcher to answer questions about maternal health education from the PPRs. As pointed out by James Nathan Miller, 1965 in Zhang & Wildemuth (1995:1):

“There is no such thing as a worthless conversation, provided you know what to listen for. And questions are the breath of life for a conversation.”

Since time could not allow all ten (10) PPRs to do the informal interviews, the researcher requested the moderator-observer to supervise the other four (4) PPRs while they prepared a maternal health lesson on a topic of their choice with the aid of the selected brochure (attached to the study report as Appendix E).

4.2.3 Pregnant women experience of previous maternal health education lessons

The PHC system encourages a collaborative approach in health promotion, thus the views of the pregnant women regarding the awareness and education they receive from the health educators are important. The following table presents some of the questions and responses gathered from the six (6) PW who voluntarily participated in initial preparatory inquiry during the pre-storytelling stage.

Table 4.2-5 Pregnant women experience on maternal health education

| | |
|---|---|
| Research Question 1: <i>Have you received any maternal health education lessons at your clinic? Yes/No Explain</i> | |
| PW1 (21 years, unmarried): Ewe/Yes | Yes clinic |
| PW2: (28 years married, studied at Maluti JSS) Ewe. Yes | Yes clinic |
| PW3: (19 years unmarried) <i>I never heard from the clinic about being pregnant, I heard from the teachers at school about pregnancy. I did not feel well and visited clinic at 4 month.</i> | Yes school |
| PW4: (19 years unmarried, Grade 11) <i>Taught at the clinic.</i> | Yes clinic |
| PW5: (unmarried, 17 years, grade 10 drop out). <i>Taught at the clinic.</i> | Yes clinic |
| PW6: (not want to reveal her age and marital status but from my observation looks young). <i>Here at the clinic from the clinic sister and other people</i> | Yes clinic 06 05 01 100% 83% 17% |
| Research Question 4: <i>What would you like to learn? You must also explain how you would like learning about maternal health to take place?</i> | |
| PW1: <i>I wish to be educated about pregnancy. When someone finishes teaching us, I wish she/he could ask whether we understand or not so that we are clear by the time we go to hospital/clinic.</i> | |
| PW2: <i>I wish we get education at schools where pregnancy has increased and also get education at the clinic.</i> | |
| PW3: <i>My problem is discharge but I went to the clinic and I am still getting treatment here (referring to the hospital) other can also be educated about that.</i> | |
| PW4: <i>After prayer¹³, there is supposed to be teaching.</i> | |
| PW5: <i>We want to be taught how to meet those who are not yet pregnant and to also be taught in community meetings.</i> | |
| PW6: <i>I noticed that in our area health education and about family planning is scarce because the clinic is far. I got married very young and my husband does not want me to use contraceptives.</i> | |

¹³ In some of the clinics I visited, I observed that there is a morning prayer, which starts at 7:30 and 8:00, with all patients visiting the clinic involved and in some cases just a staff prayer.

4.2.3.1 Access to maternal health education

Regarding the access to maternal health education, data indicates that at least 100% of the PW had access to lessons via clinics. Only 17% confirmed to have received lessons on pregnancy issues from school teachers. As also indicated by data from the above table, the age range of the pregnant women interviewed is between 17-28 years old. Data also indicates 68% of the PW between the ages of 17-21 as unmarried women who are either drop out or still at school. Only 17% of the respondents account for adult married pregnant women. From the data collected through an informal conversation with PW, it is important to note that although one respondent initially did not expose her age and marital status, the nature of interaction between her and the maternal health educator made her to later indirectly give a clue to her age and marital status without being asked.

4.2.3.2 Maternal health education challenges facing pregnant women

Similarly to educators experiencing challenges with maternal health education, data collected from PW also indicated some systemic and personal (social and clinical) challenges experienced by PW in accessing maternal health education, for example,

Systemic challenges:-

- a) Being far from the clinic;
- b) Transport problems;

Personal challenges (social and clinical)

- a) Lack of family planning information;
- b) Problems of discharge (sexually transmitted diseases);
- c) Husbands refusing them to use contraceptives and
- d) Getting married at a young age;

4.2.3.3 Pregnant women suggestions on how to improve access to maternal health education

As indicated in table 4.2-5, PW had several suggestions on what and how they would like to be educated about maternal health issues:-

- a) PW would like to be asked if they understand after each lesson taught so that they are clear.

- b) PW would like to get more maternal health education in community and in schools where teenage pregnancy rate is escalating.
- c) PW would like be taught how to also educate those who are not yet pregnant.
- d) PW suggested that maternal health education lessons start immediately after the morning prayer at the clinic.

4.2.3.4 Mostly remembered themes and effectiveness of previous maternal health education lessons

Data collected from the PW further also indicated that a majority of the maternal health lesson taught could still be remembered. The topics mainly remembered were:-

- a) Family planning
- b) Types of contraceptives
- c) Breastfeeding
- d) Teenage Pregnancy risks and hardship facing pregnant teenagers
- e) Importance of starting early antenatal care visits and encouraging others
- f) The importance of exercise and not always sleeping (particularly at the waiting home)

Although data also indicated that some pregnant women (17%) had not received proper lessons due to the challenges mentioned earlier, most of the pregnant women (83%) interviewed by PPRs felt that education at the clinic has helped them to understand issues ranging from information regarding being first-time expectants to understanding of condom use. Consequently, as earlier indicated in Table 4.2-3, the same number of women (83%) had no knowledge or experience of either stories or folktales in use during their maternal health education lessons.

4.3. The Intervention stage: Storytelling

There are several aspects of teaching and learning which the researcher observed as a result of visiting the PPRs in their respective maternal health education sites. Through the field notes gathered from each clinic, the researcher tried to capture all data which she considered would describe the teaching practices of the selected participants while they work with PWs.

The following aspects describe the overall researcher experiences of lessons before integration of folktales. This data is important to provide a valid comparison of lessons with no folktales with those integrating folktales.

4.3.1. Teaching and learning methods in maternal health education

There were seven (7) sites visited. From these sites the researcher noted different teaching methods that were used. Five lessons observed presented the talk or lecture method, two (2) employed mixed methods of talk-song and talk/story and dramatization. Only one PPR employed a group conversational method. In cases where the Community Health Worker has requested presence of the Lay Counsellor, the Nursing Sister; other VHWs and CF's; lessons were co-facilitated.

4.3.2 Language of teaching and lesson facilitation

Two sites were Sesotho while five (5) were isiXhosa. The purposes for co-facilitation were in two instances due to language differences where an isiXhosa speaking facilitator needed interpreting by a colleague who speaks both isiXhosa and Sesotho. Other lessons were co-facilitated due to the CHW maternal educator not familiar with the clinic audience more than the Lay Counsellor and the Nurse or as normal procedure adopted by that particular site in dealing with health education. The only exception for a lesson where researcher arranged for a co-facilitated lesson was where one of the PPRs was refused to teach at her clinic by her PW's of mostly teenagers in one of the township clinics. Only three lessons were single-facilitated.

4.3.3 Maternal health educator attitudes, behaviour and the environment for teaching and learning

Data further reveals that generally all educators observed displayed a positive attitude and behaved professionally with remarkable interest and respect during the entire lesson observation exercise. Where there were signs of panic, tensions and discomfort, those were attributed to the environment under which these lessons took place. In some instances; the clinics had no proper space for maternal health education, for instance, in some clinics, the waiting room with a mixed audience made it difficult for the educator to focus the lesson to the targeted PWs. Although the mixed audience showed interest in the lesson, the overcrowding and the noise posed a barrier to effective teaching and learning, hence the panic from the educators.

Much as it was added advantage to enable a storytelling lesson to be marketed to larger audiences, the lessons in such environments were difficult to handle for both the observer and the PPRs involved, moreover, the PW had advantage to hide and not participate in the lesson as intended by the PPR. Similarly, too small spaces like the consulting rooms were not conducive to teaching as they posed a panic to both the PPR and her PWs. The level of

PW involvement by the PPR and of meaningful participation by the audience was frustrated by the venues.

Data also reveals that this had effect on PPR movement during teaching. For example, PPR movements, more especially in the single method lessons, were limited to one corner from where the PPRs and/or CFs stand and took turns to talk to the audience. Data shows that in such instances PPR-PW interaction was limited. As a result the PW's only had brief responses such as yes/no/mhh/ehh/. In fact, the arrangement of the lesson room had in most cases not been done to suit an interactive approach¹⁴.

4.3.4 Audience participation and interaction

From the data collected, there is evidence that the maternal PPR-PW interaction was likely to be affected by space and type of teaching method used. Where lessons were presented through the talk/lecture method under uncondusive teaching and learning environment (big mixed audience/small consulting rooms), data revealed some of the following aspects:-

- a) The audience response and interaction to the lesson was limited to question and answer.
- b) There was limited or no further attempt or creativity by some educators to involve their audience.
- c) The voice of the educator dominated the lesson, for example, occasionally, not more than four (4) members of the audience asked or answered questions across all lessons observed. Where there was commendable participation, it was usually triggered by one active member of the group who was keen to answer or ask questions more than once during the same lesson.

4.3.5 Pregnant women attitudes and behaviour

Although they generally displayed a positive attitude, a good behaviour and an assumed interest in the lessons, data reveals that the youth or teenage pregnant women were generally shy, uneasy and took longer to be fully engaged in the lesson. In some cases , more especially where they panic about time and transport or suspicious of being summoned into small rooms for a special lesson, which in other cases happened for the first time; these women looked bored, blank-faced, uninvolved, folding arms and less interested. It took a skilled educator to turn around the situation. Surprisingly, some of the clinics, the elderly women, were attentive and engaged in the lessons on behalf of their teenagers in absentia. They also asked questions after the educator finished the lesson.

¹⁴ See diagrams and pictures of different teaching space (Appendix H)

4.3.6 Available resources and teaching strategies

Although the researcher noted availability of other resources like television, information booklets and pamphlets from different sites, data shows no evidence of extensive use or reference to these during the lesson presentation 100% of the sites visited. The lessons were basically oral and minimally used prepared speeches or just a talk from the educator's experience. In lessons where there were songs, role-play and dramatization, data revealed a difference. There was less tension, more laughter and more sounds of audience voices whether they responded in chorus or talk to each other. The educator also enjoyed some reasonable amount of active participation from most of the pregnant women than when there was only a talk-based presentation.

Data also reveals additional benefits where a story was narrated, (no folktales at this stage). Where the educator lead the group by narrating a story, data shows that some audience members were more likely to share their own stories in relation to maternal health issues. For example in two sites, the story of the broomstick and the condom triggered narration of new stories from the audience as indicated in the examples¹⁵ below:

Story 1 from a pregnant woman: One of them shared a story about how their boyfriends discourage them about using female condoms and contraceptives, saying 'ziyabamanzisa' (*they make them wet*) during sexual intercourse.

Story 2 from a voluntary youth worker The husband told the wife to give him his jacket from the hanger before having sex with her because the nurse had told him to wear the jacket of the son-in-law each time he has to sleep with her.

With such laughter and action during the lesson data indicates more movement and improved non-verbal communication from the part of the educator. Data also revealed improvement in standing up, using hands, smiling, nodding, and shaking heads by the audience.

Table 4.3-6 Lesson A: Maternal health educator lesson presentation skills (1)

| |
|---|
| Educators: PPR02 and two (2) Co-facilitators Lesson Duration: 25-30 minutes Venue: Waiting Room Audience type: Mix (+-10 Pregnant women, +-15 elderly people, +- 3 Children (one of them a girl who was involved during storytelling lesson), 1 Lay Counselor and 1 Nursing Assistant): Method: Teacher talking to audience, also referring to a prepared paper presentation, |
|---|

¹⁵ These stories are appended in the study as some of the myths examples affecting maternal health education in rural PHC level. See Appendix

though she used it for a few minutes: **Position:** Front corner near entrance (see diagram...)

(Lesson opened with normal short greetings and a request for attention for a few minutes)

PPR02: *Ndicinga ukuba ayivumelekanga into yokuba umntu akhulelwe esemncinci, amaphupha ayacima angade abe yiyo into afuna ukuba yiyo. Nina, niya ecantsini nibancinci, lo mntwana useluxanduva kuwe kwaye wenza ungaqhubeleki nasesikolweni. Sithi singoCHW noonurse zikhona izithinteli eklinikhi azithengwa nangecent; sinepilisi, izitofu niyazi mors ukuba kuya abstainwa noabstainwa. Umntu xa ekhulelwa emncinci kungenxa yokudinga ulwazi. Masixelelane emakhaya, nomzali amxelele umntwana oze kakuhle ebuntombini ukuba, 'mntanam xa uqale ukuthandana namakhwenkwe, yiya eklinikhi mntanam uye kucwangcisa.' Loo nto uyenza kuba kaloku uneenjongo, usancwase ukubaancedise ukufundisa nabanye. So ke xa ukhulelwe umncinci unje, uza kuluthanda kanjani usana lwakho? Luza kulufumana phi uthando? Khanindixelele uza kuluthanda kanjani?*

I think teenage pregnancy is not acceptable because dreams get shattered, you do not become what you want to be. You, you have sex while you are still young The baby becomes a responsibility which makes you drop out of school. As Community Health Workers and nurses we say contraceptives are available at clinic, you do not pay a cent. We have pills, injection and you also know you can also abstain. When someone becomes pregnant at a younger age that shows lack of knowledge so let us talk to each other at homes. Parents must educate their girl children when they reach puberty that when they start to have boyfriends, they must go to the clinic for prevention and family planning more especially when a parent still looks up to you to help her with education of your siblings. If you are a pregnant teenager, how are you going to give love to your baby, is the baby going to get love? Tell me how are you going to love your baby?

A1: ... *(akukho mpendulo ithe ngqo, bayandumzela nje)* There is no straight reply to this question, they are just mumbling) The educator continues with lesson.

Luza kulufumana na uthando kuba akazi nto ngosana? Ndiza kuthenga ke mna ndingumzali ndithengele wena iimpahla zosana nezakho, ndikutyisa.

So masincedisani, sibaxelele, sibacebise beze eklinikhi baze kufumana iimfundiso. Siyafundisa thina ukuba umntwana makaqhubeleke nesikolo, siyafundisa nangeengozi zokuya ecantsini ungatshatanga. Nina niya ecantsini nibancinci, ukuya ecantsini akulunganga. Okokuqala uza kufumana isifo sangaphantsi, ude ufumane nentsholongwane kagawulayo. Nokuba usebenzisa isitofu, ikhondom siyayikhuthaza kuba soze ube nazo izifo zangaphantsi. Obunye ubungozi bokukhulelwa umncinci kukuba isibeleko sakho sise ethe-ethe. Kwakhona usengafumana neoperation ugule ngexa bekusajongwe umntwana oya esikolweni kuwe. Ukukhulelwa oku kokokugqibela, iyingozi ke le nto yokukhulelwa

usemncinci.

Is the baby going to get love whereas you do not know anything about the baby? As your parent I have to buy clothes for you and your baby and also feed you. So please let us assist each other by advising the youth to come to the clinic for education. We educate about pre-marital sex risks. You engage in sex while you are still very young, having sex is not good. Firstly you will get sexually transmitted diseases, HIV/AIDS. Even if you use injection, we encourage condom use to protect you from STIs. The other risk of teenage pregnancy is that your uterus is still fragile. You can also be operated and maybe get ill while you are still attending school. Pregnancy should be the last thing as teenage pregnancy is dangerous.

PPR02:... *ithini into....ucinga usaza kuqhubeleka nesikolo?* What do you think? Do you think you will continue with school?

A3: *Hayi No (chorus from the audience)*

PPR02: *Khanindixelele ukuba uza kulufumana na uthando.* Tell me if the baby will get love?

A2:.....*Hayi No(chorus from the audience)*

PPR02:*hayi ke ndicinga ke niyeva...ikhona indawo endiyishiyileyo.* Alright. I think you hear what I say...is there anything else I have left out? (*inviting the Nursing Assistant to add more information*)

4.3.7 Style and tone of presentation

From the researcher viewpoint, the tone of Lesson A as illustrated above, sounded confrontational from the beginning. Although its intention was mainly to educate about risks and dangers of teenage pregnancy, the manner of presentation had potential to send feelings of guilt from the present pregnant teenagers and thus decreased opportunity for their active participation. The selection of words which were rather blaming, for example:-

“Nina, niya ecantsini nibancinci” (You, you have sex while you are still young.)

Such statements as above revealed to have potential to limit causes of teenage pregnancy to the pregnant women's choice without any opportunity created to get their viewpoints on what are the other reasons they became pregnant. For instance, if a pregnancy was as a result of other causes, for example, rape; incest; forced marriage, it was for the educator to select an appropriate teaching method to promote sharing of any experiences or comments from the audience. In most cases observed, this also had potential to increase the power

barriers between the educators and their audience, hence the observation of signs like shyness, boredom and lack of interest from some of the pregnant women.

Although the educator tried to involve her audience by asking questions as quoted below:

“If you are a pregnant teenager, how are you going to give love to your baby, is the baby going to get love? Tell me, how are you going to love your baby?”

“What do you think? Do you think you will continue with school?”

There was limited response from the audience, more especially teenage pregnant women. For example, there were only three vocal answers from the audience (A1-A3) and yet this audience was due to listen to the additional information from two more CFs who assisted the PPR during this lesson.

Table 4.3.7: Lesson B: Maternal Health presentation skills (2)

| |
|---|
| <p>Educator: PPR 01 Type: A Conversational Discussion mixed with a story</p> <p>Duration: 25-35 minutes Topic: Teenage pregnancy and associated risks Venue: Waiting room with a special seating arrangement in a circle. Audience type: 1 elderly woman from the community, 2 teenage pregnant women, 1 Volunteer Health Worker and Volunteer Youth Counselor</p> |
| <p>PPR01: <i>Mna ke ndisebenzisa ukuncokola nabo abafazi abakhulelweyo, ndibandakanye nabanye abantu endisebenza nabo ekuhlaleni njengaba ndibamemileyo apha. Siyaxolisa ke nenani lethu leANC visits lincinci kule nyanga.</i></p> <p>(As for me I use a conversational method with pregnant women and also involve people I work with from the village like the members I have invited here today. We also apologise about our numbers who came for antenatal care, we have small numbers for this month)</p> <p>Researcher: <i>Akukho ngxaki, ndiza kuphulaphula incoko leyo ndibe yinxalenye yayo, sincokole, kodwa ke ndibuze imibuzo esisikhokhelo njengoko ndiphanda ngendlela enifundisa ngayo abafazi abakhulelweyo. (No problem, I will just listen to your conversation and be part of where I can but stick to my role as a researcher for I have to ask you questions after you finish your lesson)</i></p> <p>PPR01: <i>Namhlanje ke incoko yethu inge teenage pregnancy neengxaki eziqondene nayo. Andazi ke nokuba singaqala kuba ufika sesincokola okanye ndenze njani? (Our conversation today is about teenager pregnancy and related problems. I don't know if you want us to start from the beginning or what I must do?)</i></p> |

Researcher: *Hayi masiqhubeni ngokwesicwangciso sakho.* (No, let us continue according to your plan)

PPR01: *Ngumsebenzi wethu, umsebenzi wethu kukuba masishumayele. Ndithi njengokuba ndiphaya elalini, bayandazi aba baphaya elalini ndiye ndithi kubo ukuba bangandijongeli ukuba ndingumama owoyikekayo. Ukuba umntu uyamoyika umama wakhe makeze kum umntu afike abuze.* (It is our job to preach; as I am in the community I always tell them not to be afraid of me. If one is afraid to ask things from her mother they must come and ask)

“Mam’u.... (name omitted for confidentiality), ndirhalela ukuya phaya eclinic, qha ndoyika aba mama baphaya.” Mam’u.... I want to go to the clinic but I am afraid of the women there” (not sure whether ‘abamama are nurses/who)

Researcher: (ebhekisa kuNurse) *Nini aba boyikwayo? Imele nobanoyika ntoni?* Is it you they are afraid of (I am referring to a nurse who came in briefly. She just shrugs her shoulders, no chance to answer that question. I am also not keen to disturb this conversation by following up that point)

PPR01: *Mna ke ndiza kumcacisela mos ukuba hayi yenza kanje kanje. Umzekelo indlela endiza kuthetha ngayo asiyondlela imbi.*

Ndiza kuthi, “Hayi uze uye phaya eclinic akuzokubakho ngxaki, uza kufika ndikuxelele ukuba hlala phi, ungene kowuphi umnyango ulungise le nto uze kuyilungisa.

(I am going to try and talk gently and explain to the youth and say, “No you must come to the clinic, there won’t be any problems, I will guide you where you must sit and which door you will get help from.”)

Ndizama ukuthi ke ukufunekanga boyike ukuza eclinic, njengokuba silapha sisebenza ngabo thina.

(All I am trying to say is that they must not be afraid of us, we are here for them, we work with them)

Ithi into ke njengokuba kukhulelwa ulutsha, abantwana abangatshatanga iyababambezela ezikolweni la nto athi ngoku esenza ustandard 8 ... kufumaniseke ukhulelwe angaqhubekiki, yaqonda, (pause) nesikolo sakhe.

And then what do we do now that it is youth who gets pregnant..., unmarried who get delayed from school as early as standard 8... then you drop out of school.

Ude wathi omnye obelapha ekuseni yena ebefunda u-8 kulo nyaka, wathi akabhalanga itest kuba engenayo i-uniform, itshile. Utshilo ke xa eyicacisa, senditsho kodwa ke iyambambezela umntwana laa nto, kuba kaloku ngela xesha aye kubeleka kuyabhalwa esikolweni, nasebomini bakhe akahambeli phambili.

(Another one who was here earlier told me she did not write standard 8 exams because her uniform was burnt and she did not go to school so she became pregnant and now has a baby and cannot continue with her dreams.)

Kodwa ke xa sele the wakhulelwa umntwana, okona sikukhuthazayo kukuba umntwana makeze eclinic, mininzi iminyango aza kuyingena apha eclinic. Kufuneka xa ezayo eze eziphathele busikhafutinana ngoba kaloku kufuneka eyile kwaVCT aye kutest igazi ukwenzela ukuba ngoku aqhubekayo nenyanga zakhe abe esazi into yakhe ithini kwaye uza kuqhuba njani nomntwana wakhe.

(But when one is already pregnant we encourage them to come to the clinic, there are many doors and many things to do from VCT to test blood so that while the pregnancy is progressing one is also sure of her status and what will happen to the baby.)

Ibikade ikhona la nto kuthiwa umntwana akancanciswa xa upositive. Uyancanciswa umntwana ngoku ngalaa six months. Kufuneka umncancise lasix months, umntwana ungamxubeli, ancance bele kuphela.

(That you do not breastfeed your baby when you are positive does not apply now, you breastfeed your baby for six full months without mixing with other feeds.)

Itreatment, iipilisi ezi azinikwayo makangazonqeni ukuzitya kuba zinento eziyenzayo phaya kusana lwakhe lukhule right, umzekelo ifolic acid (the treatment, don't be lazy to use it because they help your baby to grow well.. for example folic acid...)

(I was already worried this is not a conversation if she talks alone for more than 12 minutes while others listen, luckily a new speaker joined the conversation)

VHW: *Asikho phandle thina singabazali, abantwana bakhumshile, bathetha yonke into, so ndiyamxelela owam ukuba usexabisweni lokuba azikhusele acwangcise, ndicacise umahluko phakathi kokhuseleko nokucwangcisa.*

(Parents are not transparent with their children, these children are enlightened and talk about everything, so I talk to my child because she is now the right age to take contraceptives, and I explain the difference between protection and prevention)

(I was already afraid the dialogue has taken long now with one person talking and tried to facilitate a discussion.)

Researcher: *Mama (referring to the parent), yeyiphi indlela omxelela ngayo omntwana wakho ngento yokukhulelwa, umqala kanjani? (kuthe cwaka imizuzwana ndade ndawujika umbuzo) Yeyiphi indlela onokumngena ngayo umntwana xa ufuna ukuncokola nomntwana wakho?*

Mama, how do you tell your child about pregnancy, where do you start? (quiet for a few seconds until I tried to ask differently) How do you start a conversation with your child about pregnancy?

Parent: *....yho..Thixo wam... (Ebuthandabuza ukuphendula)....mna andonqeni ukubaxelela abam, nalo uyinkwenkwe ndiyamxelela ...*

Oh My God, (hesitant to answer, I could see she was not a talkative kind).. I am not afraid to tell my own children about it, even the boy, I tell him.

Researcher: *Akhona amabali okhe uwabalise xa usenza isifundo sakho? Do you have any stories you tell at times when you do your lessons?*

PPR01: *Ndibe kwenza buntsomarha, ithe le ntsomi yam,*

(I did a folktale-like, this folktale goes as follows;

“Kukho iinkolelo esiye sizive ukuba xa uxhwithe umsila wehashe xa uza kuya ecantsini uwubophelele esinqeni soze umithe! (Bekhuza abaphulaphuleyo.) kodwa ekuyeni sikhula soze ungamithi kuba umsila wehashe ungaphezulu, phezu kwenyama mos esinqeni, so ke ndenze iintsomi kanjalo, nyhani yaba ziinkolelo esaba nazo ezo sisakhula, umsila wehashe awuyokhondom mos.

(There is a belief we heard that if you take a horse’s tail and put it around your waist when you have sex you will not become pregnant! (Group exclaims on hearing this.)but as we grew we understood that the horse’s tail is not a condom, it cannot protect you,, so that is how I narrated a ntsomi (so this is her understanding of what is a ntsomi, I thought and noted that)

VYW: *(Engenelela ebalisa naye elinye ibali alaziyo) Nam ndinalo elinye ibali ebekhe ndaliva. I also have a story I heard, so a story triggers a story, I noted this as well)*

“Kufuneka xa uza kusebenzisa isondo nenkosikazi yakho funeka uthathe idyasi kamkhwenyana, ungalali ngaphandle kwayo.”

“When you want to have sex with your wife you must take a jacket, do not sleep without a jacket”

Yena lo tata ucinga yena ucinga kuthethwa ngale yakhe inxitywa xa kubanda. Then this man thought the nurse refers to the jacket you use when it is cold.

“Nyhaani maan! Uthe unurse, uthe mandinxibe idyasi xa ndizakulala nawe.

“It is true maan! the nurse said I must wear my jacket when I sleep with you”

“Thula pha kujingi idyasi yam.” Wayethula pha kujingi umfazi wanika indoda.

Give me my jacket from the swinging rope.” The wife gave him his jacket.

Yathi indoda, “ Masiqhubekeke”

The man said, “ Let’s continue”

Akukho khuseleko kuqhutyekwa ngalaa ndlela, akakhange amnike idyasi eyeyona dyasi. Kulo mhlonipho wethu uyeka ukuthi, ‘ thatha, faka umpipi wakho apha phakathi kwicondom’

There is no protection, they continue as normal, she did not give him the real jacket because of ukhlonipha she did not tell him that, ‘take, put your penis inside the condom.’

4.3.8 Comparing audience involvement: Lesson A and Lesson B

Although this lesson was different from Lesson A, it was similar in terms of the delay in involving other members of the conversation. The educator talked alone for a long time although she had announced her approach as conversational.

Nonetheless, the tone of the lesson was indeed different from Lesson A: it was less confrontational. The PPR was trying to emphasise her role as a CHW while also attempting to convince her audience about accessibility and approachability of the CHWs.

Given that, the size of her audience was also favourable (only five women); the approach used was suitable although it could have been exploited better where there was no temptation to dominate the conversation. A further observation from this lesson was that there was no participation from the only two (2) teenage pregnant women in the discussion. In fact, the researcher also tried to involve them without success. Much as the researcher noted them as very shy, especially the younger one, (*her hand on her face, looking tired and sleepy*) the lesson was not calling for their comment or anything but for their listening.

Further observation made by the researcher regarded the role of other people (not pregnant women) in the lesson. In this case, the researcher observed that it was beneficial to have the Volunteer Health Worker (VHW) and the Volunteer Youth Worker (VYW) in the lesson, for they added value to maternal health discussions. Asking for their direct comment and experience on specific maternal health issues helped the PPR to continue with her lesson without any anxiety.

On knowledge and understanding of folktales, the researcher noted that the educator knew a folktale as that story “which bears no truth” (into ebuntsomirha). From the narration of what she claimed was an intsomi, the researcher noted her understanding as only narrowed to the belief that folktales are lies.

“Ndibe kwenza buntsomarha, ithe le ntsomi yam, (I did a folktale-like, this folktale goes as follows:-

“Kukho iinkolelo esiye sizive ukuba xa uxhwithe umsila wehashe xa uza kuya ecantsini uwubophelele esinqeni soze umithe! (Bekhuza abaphulaphuleyo...) Kodwa ekuyeni sikhula soze ungamithi kuba umsila wehashe ungaphezulu, phezu kwenyama mos esinqeni, so ke ndenze iintsomi kanjalo, nyhani yaba ziinkolelo esaba nazo ezo sisakhula, umsila wehashe awuyokhondom mors.

(There is a belief we heard that if you take a horse’s tail and put it around your waist when you have sex you will not become pregnant! (Group exclaims on hearing this...) but as we grew we understood that the horse’s tail is not a condom, it cannot protect you, so that is how I narrated a ntsomi

In isiXhosa when someone is telling something that will never happen, there is a saying that ‘wenza iintsomi emini’ (telling a folktale during the day). So, the researcher also understood what PPR01 meant by calling her story an intsomi as referring to some views that deceive people without any positive significance in their lives.

It is also important to note that no matter this was a folktale or not, it had potential to help the group interact freely, the euphemistic approach to sex terminology was broken for a moment while a new story was also narrated:-

‘There is no protection, they continue as normal, she did not give him the real jacket because of ukuhlonipha she did not tell him that, ‘take, put your penis inside the condom.’

The researcher viewed this as a benefit to both the audience and the educators, since the story stimulated a safe and trusting environment where women could express themselves, unlike when only a talk method is used.

Table 4.3-8: Lesson B Continued: Integrating folktales

(I narrated the folktale of the Jackal and the Wolf¹⁶ first) and thereafter invited the team to continue with their discussion for a further 15- 20 minutes by asking questions as follows:

Researcher: *Nibona ingena phi le ntsomi kule ncoko besinayo? (kuthe cwaka ke umzuzwana , ndibe nexhala ndiwulungise umbuzo,*

How does this folktale relate to your conversation? (There's silence for a few minutes, then I panic and rephrase the question) Nibona ukuba ingayiphi indima yale ntsomi? What do you perceive to be the role of this folktale?

Researcher: *(referring to the elderly woman as there is no hope to get any response from the two teenage pregnant women) Mama, into endiyivayo kwincoko ebeninayo apha ngabafana abaqhatha abantwana benu abangamantombazana. Ma, what I heard from the conversation you just heard are boyfriends who deceive your daughters. (ayikho impendulo) no answer, she just smiles and puts her hand on her mouth.*

Researcher: *Babaqhatha ngantoni aba bafana? (ebhekisa komnye okhulelweyo)*

(the researcher continues with the comment and changes it to a question again and directly looks at one of the two pregnant teenagers adding a humorous and a pleading gesture) With what do they deceive the girls?

(to my relief, she speaks at last!)

TPW1: *Basiqhatha ngoba bangafuni kusebenzisa icondom besith' andiz' umitha. They deceive us by not wanting to use condoms saying we are not going to get pregnant.*

Researcher: *...athi awuzukumitha okanye avuyele ukuba ikhondom ihlale pha entongeni yomtshayelo?....(bahleke) (I add more humour by relating her answer to the previously narrated story of the broomstick and the condom, they all laugh) This opens a chance for the educator to add*

PPR01: *Omnye uthi ebeqhathekile xa aphinde ebuya umfana aphinde aqhatheke. Others get deceived again and again by their boyfriends.*

(there's reference to the folktale I narrated for the first time, when the next speaker joins the

¹⁶ See Appendix G intsomi kaDyakalashe noMvulofu

conversation)

VYW: *Ubethe utat'u udyakalashi umvolofu makasebenzise ingqondo, ifune ukuba noba umntu sele ekuqhatha baleka uze eklinikhi uze kusebenzisa ingqondo uhlabe inaliti.* The jackal had reminded the wolf to use his brains, and that means even if someone deceives you, you must come to the clinic to use your brain by getting injection.

PPR01: (ebuza koo**TPW**) (also trying her luck to get a response from the pregnant women) *Ubona ngathi ungamfundisa njani ke umhlobo wakho ongekakhulelwa njengoko uve le ntsomi?...*

How do you think you can also teach your friend who is not yet pregnant after you heard this folktale?

abaphenduli.....bayajongana nje... bencuma. (no reply, they just look at each other and smile)

Researcher: *Nicinga ingabanceda njani oonesi aba xa benokuncedisa ngentsomi kuba kuthwa mabafundise ngeteenage pregnancy ezikolweni?* How do you think this folktale can help the health workers as they are required to teach about teenage pregnancy in schools?

VYW: *Mna ndicinga ingena kwiziqendu ezininzi, ize nobulumko, asebenzise ingqondo uba ooh ndiyithihlile¹⁷ phaya .*

As for me, I think it fits in many avenues, it brings wisdom, for one to use brains when they realise they have made a mistake.

Researcher: *Uyayithanda le ngxowa yamagqabi uMvolofu, le ahleli nayo ngoku?* Does the wolf like the bag with leaves, this one that he is sitting with?

Impendulo (Chorus) Hayi... No

VCW: *....akayifuni...uva kabuhlungu. (Utsho elinganisa nangezandla ezibeka esifubeni)* he does not want it, he feels pain. (she says this imitating with her hands, putting them on her chest)

VYW: *Kunje ngam, xa ndiphethe umntwana, ndikhulelwe andithi ngoku iba luxanduva lwam andivi kamnandi.. ndodwa xa umntwana uyagabha uyahambisa, kwenzeka yonke into mna ndikha amagqab'apha...(bahleke bonke) yena ukh'ama-apile pha! Wonwabile aphinde ayoqhath'abanye...* It is like me, when I carry this baby inside me, I am pregnant and now it is my responsibility, I do not feel happy about it.. I will be alone when the baby vomits, has diarrhea, all this happens while I pick leaves.. (they all laugh) (Feeling that the conversation is gaining its momentum, I take a chance to introduce a second folktale) I narrated the folktale

¹⁷ uthe ke xa sele ndimbuza bucala ukuba lithetha ntoni eli gama - ndiyithihlile -wathi lithetha ukuthi "ndibhatyazile" I asked her what this word mean an she laughs and tells me it means "I have made a big mistake

of the boy and the pregnancy medicine (Inkwenkwe neyeza lokumitha *and re-open a chance for the conversation although I am aware of the time the lesson has taken, luckily everyone is still interested*)

Researcher: *Niva ntoni ke kule iintsomi? What do you learn from this folktale?*

PPR01: *Ndingathi le ntsomi mhlawumbi ukhulelwe kuba engacinganga, kodwa mna ndiyayithanda le ndawo yokuba akayibhudi tu le yokuya kumncancisa nokuba imeko ithini! (bayahleka bonke)*

What I can say about this folktale is that maybe you are pregnant without having planned it, but what I like about it is that he does not miss out on breastfeeding no matter what! (they all laugh)

Researcher: *(ndizame kwakhona ukubandakanya abafazi ababini abakhulelweyo) Nina, nithini ke njengokuba beza kufika abantwana benu? Niza kubancancisa nje ngale nkwenkwe?*

I try to engage the pregnant women again by asking a direct question) As you expect your babies soon are you going to breastfeed them like this boy in the folktale?

TPW2: *....(bencuma nje) smiling and....omnye kubo ((lowa ebefile zintloni) ...Eewe (one of them, the one who was very shy answers with a friendly smile and looks up an answer with an emphatic)... Ye-e-s*

(voluntary youth worker keen to continue with the conversation again)

VYW: *Ubeyiba yonke ke le nto yakhe, kodwa kuza kuba sathiwani? Mhlawumbi akanalo nolwazi lokuba uthiwani lo mntwana!! (behleka bonke) Yho nantso ke ingxaki!*

(He was aware about all what has happened to him, but what else can be done. Maybe he does not even have knowledge about taking care of the baby! (they all laugh) That's a problem!

(The voluntary health worker adds by trying to involve the pregnant women again although they were already tired, it has been a long conversation)

VHW: *Ndingathi mna, izindidi ezininzi le ntsomi iyalimaza! Usele iyeza angalaziyo, phinde futhi ayenze yedwa le nto, Nicinga ngekwenzeke ntoni kuye? (naye ke ebesele encedisa nje ukubuza abafazi abakhulelweyo, nangona bebediniwe)*

(As for me I can say there are many angles to this folktale, it is painful! He drinks a medicine he does not know and again he does this alone, what do you think could have happened to him?

(*Akukho mpendulo, sebesozela abafazi abakhulelweyo ababini ngoku sherm*) There is no reply now as they are tired; it is in the late afternoon.)

VYW: *Mna ndiyabulela kakhulu, mna ndinayo nento endiyifundileyo, umzekelo nasenkonzweni ndingayisebenzisa intsomi ukufundisa abantwana. Ukufunda ayikokuya esikolweni qha, nokuba besimbalwa sifundile kule nto ibithethwa apha.*

As for me, I am grateful for this conversation as I have gained something, for example even in church I can use it to educate children, to learn is not only going to a school. Even if there we were few, we learnt a lot from what was said here.

Parent: *Siyabulela, Nam ndifundile noko naba bantwana ke ndiyathemba bafundile.*

(We are grateful, I have also learnt a lot and I hope my children here, referring to the two girls, have also learnt something)

(End of lesson)

Data from continuation of Lesson B indicates similarities with the first part of the lesson where the educator had difficulty getting direct responses from the pregnant women. Although the non-verbal communication improved, for example, eye contact and facial expressions of PW, they were still quiet and less involved. It took an effort from the storyteller to engage teenage pregnant women in the lesson, for example, she had to employ multiple strategies to engage them. From rephrasing questions to paraphrasing the lesson themes as well as giving clues to certain tendencies of the animals in the folktales, the researcher had managed to assist the educator to exploit the folktales as a means to improve attitudes of the PW towards the lesson.

Because this study was also an opportunity to learn, the researcher also learnt that it was normal for an educator to panic when the audience seems less likely to be involved in the lesson. The researcher noted how she grew to be so desperate to get responses from the audience (*remembering my purpose for being in this class*), but, the method of teaching adopted by this lesson, a conversational discussion, offered a very good opportunity to overcome feelings of anxiety, unlike if it was a lecture or talk-based approach.

Data from this lesson also indicates improved participation from the pregnant women as they at least answered a few questions, unlike during the first part of the lesson. Although they were generally shy and tired, they laughed and smiled from time to time. The researcher employed repetition in the folktale narration, which is known to ignite movement from the

audience, but the PWs did not respond to the PPRs invitation to stand up and exercise, for example:

Bahamba, Bahamba, Bahamba (uDyakalashé noMvolofu)

Yahamba Yahamba, ihamb'ibheka-bheka le nkwenkwe (Inkwenkwe neyeza lokumitha)

Nonetheless, the researcher also considered respecting their physical condition as she assumed they were already too heavy to be obliged with the actions like everyone was doing. What was better than during the first part of this lesson was their facial expressions: they looked free and happy; they were laughing and looked entertained and relieved.

When the second folktale was narrated, the researcher noted more excitement from their faces. There were a lot of other sounds like “mhmhmh”, yhoo! Tyhini!. The quietness in the room was of engagement rather than of being distanced from the lesson. The women listened attentively. The educator found more examples related to her lesson topic, which the researcher thought was because the folktale was talking about a pregnant boy instead of a girl. To the audience, this was an indirect reference to their own experiences and not confrontational, as a result, they were entertained and prompted to align themselves with the lesson.

4.3.9 Maternal health educator ability to use folktales in teaching and learning

The researcher further observed that the relevance of the folktales to the theme of the conversation was understood. Data indicates that the types of questions asked by the educator were improved by reference to both folktales. The analysis of the folktales also triggered additional maternal health education topics as follows:-

- a) Condom use: community stories indicating the importance of intercultural communication between patients and health educators.
- b) Male domination in sexual reproductive relations which is tantamount to gender-based violence (issues of being forced or misled about family planning and contraceptives by spouses or boyfriends)
- c) Ignorance of women: taking backstage in matters of sexuality
- d) Relevance of maternal health education in schools, churches and in communities
- e) Pains or traumatic experiences of women as a result of child-bearing and rearing: More responsibility facing women during and after delivery.
- f) Child Health: vomiting, nutrition, diarrhoea, breastfeeding
- g) Family planning: unplanned pregnancies, role of men in family planning

- h) Risks posed by lack of information, hiding pregnancy
- i) Drinking traditional medicine during pregnancy
- j) Poor communication about sexual reproductive health issues (in families, between partners, and in healthcare facilities.
- k) Fears of approaching nurses were raised more often during the second folktale , for example when they discussed the significance of the pregnant boy in the folktale, who is afraid to tell his mistake to his mother and decides to hide the pregnancy until he gives birth alone without help from anybody.

Lastly, data from the lesson indicated more benefits for the educator, for example:-

- a) There was fun and entertainment for all.
- b) There is evidence that the educator was assisted to relate better to her audience.
- c) Questioning skills improved.
- d) The folktales gave her an opportunity to teach beyond the planned lesson as she covered more topics than what she initially planned.
- e) There was imagination and reflection to real life experience through use of fable characters (*dyakal Ashe, mvolofu*) and strange characters like *a pregnant boy, a woman with no name* (Lo mfazi):

“*Yemka le nkwenkwe imfihlela lo mfazi*” the boy went away hiding himself from this woman

Even if the educator referred directly to the pregnant teenager at a later stage, the mood of the lesson was already transformed by the stories and folktales narrated. The attitudes and behaviour of the pregnant women showed no signs of boredom, unlike how the initial choice of words as illustrated in Lesson A and other lessons observed by the researcher where phrases like the following were used:

| | |
|---|-----------------------------------|
| “ <i>Nimitha nibancinci</i> ” | you become pregnant very young |
| “ <i>Nitya amayeza esintu</i> ” | you drink traditional medicines |
| “ <i>Nifihl’izisu</i> ” | you hide pregnancy |
| “ <i>Nithand’ana namadod’ atshatileyo</i> ” | you fall in love with married men |

4.3.10 Maternal health educator ability to engage their audience

One of the most important observations made by the researcher is that the more the educator employed examples from the folktale in the lesson, the higher the PW level of participation and the greater the chances of story sharing by the audience. This also depended on a number of other variables, for example, the level of educator exposure to

maternal health education; the nature of the audience; and the environment under which the lesson took place.

After listening to the first part of the lesson by PPR 06 & PPR10, the researcher narrated two folktales, thereafter the educators opened a discussion for all PW to participate. It is important to note that the educators (PPRs) in this site were Nursing Assistants, whereas in the other site the PPRs were all Community Health Workers. It is also important to note that the audience was a combination of mostly teenage pregnant women from various clinics who were due to deliver their babies but were kept busy with health education for at a least a period of two-three weeks before they gave birth. The lesson was presented in the evening from 17h00-19h00 as Lesson C below:-

Table 4.3-9 Lesson C: After-folktale discussions (1): Intsomi kadyakalashe nomvolofu

| |
|---|
| <p>Venue: Lesson presentation at the maternal waiting home Audience: PW only (from various clinics)</p> <p>Time of lesson: 17h00-19h00 Facilitators: PPR06& PPR 10</p> |
| <p>PPR06: <i>Nive ntoni kwesi sifundo sinentsomi?</i></p> <p>What have you learnt from this lesson with a folktale?</p> <p>A1: <i>Uthi umngane uyeyelisela</i>, (she says a friend is misleading)</p> <p>A2: <i>Umngane akalunganga</i>(a friend is not good)</p> <p>A3: <i>Nguye omeyeliselayo, uthi makakhe amagqabi kodwa ukha ama-apile</i> (it is the friend who misleads saying he must pick apples while he picks apples)</p> <p>A4: <i>Eyakhe ingqondo akayisebenzisi</i> (<i>He does not use his brains</i>)</p> <p>A5: <i>Kodwa nawe kufuneka usebenzise eyakho ingqondo nokuba unomngane omthembayo.</i></p> <p>But you must also use your brains even if you have a trusted friend.</p> <p>PPR 10: <i>Niyabona ziphuma kwakuni ezi zinto?</i> You see these things come from you?</p> <p>Researcher: <i>Amagqabi. Niyawabona la magqabi.Uyawathanda umvolofu la magqabi?</i></p> <p>The leaves. Can you see the leaves? (<i>demonstrating how the wolf carried the bag full of leaves</i>) Does the wolf like the leaves?</p> <p>PPR10: <i>Akawatha-andi!</i> He does not like them!(<i>she says that very emphatically and using hands and raising her eyebrows looking at everyone around the house. The researcher observes that this is her other way of calling for further comments on this from her audience.</i>)</p> <p>A5: (<i>Repeats with another sad voice tone, showing her imagination of the wolf's experiences</i>) <i>Akawatha-a-andi!</i>(<i>that tone triggered amusement and the group members also agree and laugh ...haayi tyhini akawathandi.</i>) <i>He does not like them whatsoever, Group: ...not at all, he does not like them</i>)</p> |

PPR 10: *Ngoba akanakudla*. Because they have no food

R: *Kusenokwenzeka ukuba le nto ikula magqabi akuzukuzuza nto ngayo, niyabona?*

It is possible that he will not get anything from what is in the leaves, do you see? (researcher invitation for more input and opportunity for PPRs to further interact with their audience)

A7: *Ehh Ehee. Ye-es. Oh Yes. (from this response she sounds like saying “exactly” or “of course or “indeed”)*

PPR06: *Yabona le nto xa sele uyizisa apha ngoku kule nto yoba unetshomi ikulahlekisa niye emakhwenkweni, uye edisko, utshomi uyenza ethe popup, wena uye kweyela yona itshomi mane isiya eklinikhi, izibe iye kucwangcisa ifaka ikhondom, wena awuboni.*

You see when you bring this here- now (*using her hands to point at the women but not to one woman, using both hands in a rounding way*), to the fact that you have a friend who misleads you to go to the boyfriends, to the disco. The friend is wise and you, you are mislead while she *goes to the clinic for family planning and contraceptives without you knowing, you cannot see.*)

(Laughter)

R: (*again probing further opportunity for discussions by referring to the folktale*) *Nangu umthi uyayokozela, ngubani lo ungumthi, uyadilika ubhuti, ume kakuhle uvela eRhawutini, u-Elvis unequantum (kuyahlekwa) iza kum yonke ekaElvis imali.*

Here is the tree, with plenty of fruit, rich and well-off like Brother Elvis with his quantum from Johannesburg, all his money for me. (They laugh)

A6: *Ayinguwanga wedwa nakulo Elvis*. It is not only you in Elvis's life.

R: *Nibanintshi kuElvis?* Many of you in Elvis's life?

A7: *Andimazi kuba ukhwelisa bani kuXaxazana akhwelise bani eMangoloaneng akhwelise bani (kuhleleke)*

I do not even know who he gives a ride to at Xaxazana and who at Mangoloaneng (laughter)

R: *Zeziphi ke iingozi enokubela xa ekhwelisa kuXaxazana nase Mangoloaneng?*

Which risks are possible when he gives a ride at Xaxazana and Mangoloaneng?

A8: *Ukugula*. Sickness

PPR 10: *Ugule yintoni?* Sickness from what?

A9: *Izifo*. Diseases

R: (*trying to go towards summarising the lesson and also checking if the folktale is still remembered with any significance to the lesson theme*) *Asifuni ke bantwana basemakhaya nikhe ntoni?* We really do not wish that you you pick what?

A11: *Amagqabi*. Leaves

R: *Sifuna nikhe ntoni?* What do we want you to pick?

A10: *Ama-apile.* Apples

R: *Makungaphindi kube lula abuye akuqhathe “ Incinci maan le mali yegrant xa eyi-one sweety- umntwana, masiphinde.... (bahleke), nababhuti bayafola pha epeyini beye kufuna imali yokukhupha ijean zabo (kuyahlekwa)* It must not be easy for you to be deceived...(using a further well-known subject) the grant money is not enough if we have one child sweety, let us have another one the boyfriends also queue for the grant money for their laybies!(this triggered more laughter and further opportunity for educators to teach)

PPR06: *Iyimalini na khona loo mali, ingekho ke, so nifanele niye kufundisa nabanye pha emakhaya. Sinqwenela ukuba nathi kuni bancinci ningaphindi nenze same mistake, la mabali afuna nisebenzise ntoni?* How much is that grant, too small. So you must go home and educate others. We wish that as teenagers you do not repeat the same mistake, these stories want you to use what?

A12: *Inggondo.* Brains

Data from a Lesson C shows that the health educators had potential to use the folktales as stimuli to disseminate the health messages through a conversational discussion method. This is indicated by the fact it was not the researcher herself who initiated the discussion by asking the audience what they learn from the folktale:

“Nive ntoni kwesi sifundo sinentsomi. (What have you learnt from this folktale lesson?)

On the other hand, there is further evidence that the audience had, without any guidance from the narrator or the educators, picked the relevance of the folktale into their real life experiences. Their immediate response to the question indicates that there was no difficulty to engage them in the lesson and furthermore, there was no need to guide them or rephrase the question like Lesson B. As a result of the maternal educators first question, “What do you learn from this folktale?” there were five (5) audience responses (A1-A5) without any educator or researcher maybe asking, “*Omnye/Uthin’omnye/Ucinga ntoni omnye njalo njalo*” (What do other participants think? etc).

The educator further used her skill to encourage them to take responsibility of the lesson by complementing their perceptiveness, for example, “*Yabona ziphuma kwakuni ezi zinto?* (You see these things come from you?)” The researcher viewed this as her other way of saying, “Good girls” like in the normal school classroom. The researcher further interpreted this as the educator’s way of encouraging PW to take ownership of the lesson with more confidence.

4.3.11 Maternal health educator ability to create fun in learning through storytelling

Data further indicates immediate feelings of involvement; more humorous moments and a pleasing response to the educator's non-verbal communication; which showed respect and sensitivity to their different learning styles:

PPR10: *Akawatha-andi! He does not like them! (She says that pleadingly and emphatically; using hands and raising her eyebrows looking at everyone around the house. The researcher observes that this is her other way of calling for further comments on this from her audience.)*

A5: *(Repeats with another sad voice and tone, showing her imagination of the wolf's experiences) Akawatha-a-andi! (That tone triggered amusement and the group members also agree and laugh ...haayi tyhini akawathandi.) He does not like them whatsoever, Group: ...not at all, he does not like them)*

The use of hands, and facial expressions and a suitable voice tone presented a less confrontational approach than the previously observed lessons. There was evidence of reduced shyness and quietness; improved eye contact; and less tension unlike in other lessons observed; where teenage pregnant women had been perceived as cheeky, bored and otherwise less involved. Above all, the women were observed to be very happy and relaxed throughout the lesson.

4.3.12 Maternal health educator ability to empathise with all pregnant women during lessons

Data also shows that a group of pregnant women from different clinics or villages had more interest in the lesson than a homogenous smaller group of women in one clinic. The researcher viewed this as advantageous as she thought it facilitated free interaction with no fears or anxieties that the nurse or the educator or other colleagues know them personally. This was a different environment than when the lesson was conducted for a mixed audience. The researcher also noted how the educators involved demonstrated feelings of empathy towards teenage pregnant women while they discussed the lessons from the folktales.

The researcher thought that it was more likely that when there were other people in the maternal health education lesson, teenage pregnant women may not want to talk because of a variety of reasons, for example;

- a) It might occur that the relatives/families of the men who impregnated them or consented to forced marriages; and any other unacceptable behaviour contributing to teenage pregnancy; are in the same audience visiting the clinic.
- b) Immediately the tone of the educator is confrontational; "*Nina niya ecantsini nibancinci*" there is likelihood of feelings of guilt if the culprit is in the same audience.

Data from the maternal waiting home lesson also showed how the educators used the storytelling background as a way of probing into other possible reasons for teenage pregnancy. As a result of using the *Jackal and the Wolf* folktale, a number of sensitive issues were raised without sounding confrontational:-

- a) Multiple sexual relations
- b) Being wowed by material things (money, cars, parties)
- c) Abuse in relationships (partners keeping secrets, abusing source of income for family (see response to *Elvis and the quantum story* where he gives a lift to different girls and potentially giving them money which the wife or girlfriend needs to look after the children)

Data also reveals that educators obtained a way to summarise all messages by going back and forth from one folktale to another as the discussion continued towards the end. The first folktale was summarized by both educators to also show that maternal health education also focuses not only on teenage unmarried girls but also to married women:-

PPR06: *Nawe mntu otshatileyo akunyanzelekanga ukuba ubenabantwana abaninzi, uba awunankwenkwe xa kuthwa uvale kuba unabantwana abayi10, uye athini?*

To you also (pointing to three elderly women amongst the teenage pregnant women) married women, it is not compulsory for you to have so many children. If she gives birth only to boys and is advised to undergo sterilization because she already has 10 children, what does she say?

PPR 10: *Kulungile ukuba sibashiyanise abantwana ukuze bafumane uthando olwaneleyo, kufuneka befundile, kule mihla kufuneka ukufunda. Abanye xa sincokola nabo bathi bebeye kukhangela uthando kuJohn basuka bafumana amagqabi abangakwazi ukuwakhulisa.*

(It is indeed good that we space our children well so that we give them enough love and education. Nowadays education is needed. Some of you claim to be looking for love from John instead; they get leaves they cannot raise.)

Table 4.3-10 After-folktale discussions (2): Abantwana beNtab'esduli

PPR06: *Mamelani ke, into ekufanele bayazi oosisi aba; umntu okhulelweyo akazifihli okokuqala unayo inkwenkwe. Njengokuba sifundisa nje sithintela ukuba abantu abakhulelweyo bangabhubhi, kuba umntu okhulelweyo uyakwazi ukubhubha. Niyayazi loo nto? Ubhujiswa yintoni umntu okhulelweyo? Cingani ngala ntsomi yeNtabe'sduli. Niyabona laa ntombazana khange iye eklinikhi, khange ithini? Ukuba ibiye yopha pha, yazala yaphelelwa ngamandla, yabhubhela pha, ngeyiyimaternal death igama lalo nto. Okwesibini ibingu-unbooked, khange itsalwe magazi. Kutsalwa amagazi anengxaki, xa kuvela iHIV abonwe kwangoko. Ibinokubhujiswa zizinto ezininzi yona la ntombazana yeNtab'esduli.*

(You must listen, what you must know is that when one is pregnant they must not hide, the fact is she has a boyfriend. The reason we teach you is that we want to avoid maternal deaths because a pregnant woman can die, do you know that? What kills a pregnant woman? Think about that folktale of the Anthill. Do you see that girl; did not go to the clinic, what did she not do? Now if she was bleeding and lost energy and died there: that could have been called a maternal death. Secondly, she was unbooked, no blood tests, maybe she has not tested for early detection of HIV. That girl from the Anthill could have died from a lot of things.)

Yile nto unurse enifundisa, nithathe le miphako nixele nasemakhaya nikhuthaze nabanye beze eklinikhi, bangahlali ekhaya bekhulelwe, umntu angahambi ekha amagqabi, angatyi izinto ezingatyiwayo. Ukukha amagqabi kuchaza ukuba sukuhamba nomntu weyeliselwe, umzekelo, una-12 uhamba nosisi omdala ona-18 uyakuqhatha, uyajola wena awukajoli, uqale umlinganise, andithi?

(That is why the nurses teach you, take these lessons as provision to tell and encourage others in the community to come to the clinic and not to sit at home when they get pregnant, going around picking leaves, eating things they are not supposed to eat. Picking leaves explains that do not go with someone who deceives you, for example, if you are 12years old and your friend who is 18 years old deceives you, you imitate what she does, is that not so?)

A13: Ewe Yes

Uphethe amagqabi! Anantoni amagqabi, niyabona awananto? You carry leaves. What do the leaves have, can you see they have nothing?

A14: Eewe (*also nodding her head and looking very attentive*)

PPR06: *Ufundile yena umntu okuqhathayo ukha ama-apile, wena awufundanga ukha amagqabi. Nifundise nabantwana benu aba ke kuba badala, hlala nabo phantsi. Nifundise oosister benu nibaxelele bangayihambi le Indlela niyihambileyo, irate yeteenage pregnancy*

iza kwehliswa nanini. Xa uziqonda ukuba uxakile okanye ufuna ukulala nomntu sebenzisa into zokucwangcisa. Nina anizisebenzisi izinto zokucwangcisa. Nathi siyazama ukuba mayehle irate bethunana sincedisane. Ikhondoms zikhona. Masisebenziseni izinto zokucwangcisa

(The person who deceives you is educated-picked apples, and you are not educated, you pick leaves. You must teach your children, educate your sisters, and tell them not to travel the same journey as you did. The teenage pregnancy rate will be lowered by you. If you realize that you are uncontrollable (handful) or you want to have sex you must use contraceptives. You do not use contraceptives, we are also trying, the teenage pregnancy rate must be lowered, and we must help each other. Condoms are also available. Let us use contraceptives.)

PPR06: *Nawe mntu otshatileyo akunyanzelekanga ukuba ube nabantwana abaninzi, ukuba awunankwenkwe xa kuthiwa uvale kuba unabantwana abayi-10, uye athini?*

To you also (pointing to three elderly women amongst the teenage pregnant women) married women, it is not compulsory for you to have so many children. If she gives birth only to boys and is advised to undergo sterilization because she now has 10 children. What does this woman say?

A15: *Athi usaya kuxelela umyeni wakhe (bahleke, bayathetha bengqinelana nonesi)*

She says she still has to discuss with her husband (they laugh, and talk amongst each other and to the nurse)

PPR10: *Yho akakho ngoku umyeni uxakwe ngabantwana yedwa, ngubani ovayo, ngubani obeleka abantwana, xa usiya kuye umane ucela itoti yokutya komntwana mhlawumbi ungaphangeli uyadikwa naye, mhlawumbi awuphangeli nophangela, uzophangela nini nawe xa ulibele ngabantwana? (The husband is not home, she struggles with the children alone, and who feels the pain, who carries the babies on her back; goes around to ask for baby food; maybe you are unemployed and the husband gets bored. When are you going to work if you have so many children to mind?)*

PPR 06: *Mabashiyaniswe kakuhle abantwana ngumntu otshatileyo. As married women, let us space our children properly.*

R: *Ibali le khondom nomtshayelo nilivile, kha ulibalise kwakhona nesi ela bali lokuxoxiswa ngokungasebenzi kwecondom! (bahleke) The story of the condom and the broom, have you heard it. Please narrate it again nurse, this story of being deceived about using condoms¹⁸ (they all laugh)*

PPR10: *“Ubutha ndiyifake emtshayelweni icondom, itha xa yithi, ndaya emtshayelweni,*

¹⁸ I had a sense that this condom and the broom story is universal in this area. Almost all women I met knew it.

jonga ayisebenzi” (bayahleka)

“ You said I must put the condom on the broomstick, when it did this (*nurse demonstrating with her hands from in between her legs, supposedly imitating a sexual act*) I went straight to the broom, look it doesn’t work (*demonstrating by pointing at one woman’s stomach*) (*All laughing*)

PPR 10: *Kulungile ukuba sibashiyanise abantwana ukuze bafumane uthando olwaneleyo, kufuneka befundile, kule mihla kufuneka ukufunda. Abanye xa sincokola nabo bathi bebeye kukhangela uthando kuJohn suka bafumane amagqabi abangakwazi ukuwakhulisa.*

(It is indeed good that we space our children well so that we give them enough love and education. Nowadays education is needed. Some of you claim to be looking for love from John instead; they get leaves they cannot raise.)

4.3.13 Maternal health educator ability to raise more clinical and social issues

Data from this lesson indicates that integrating folktales in the lesson helped the educators to facilitate a discussion and raise awareness to a variety of maternal health issues, namely:-

- a) Delayed presentation for antenatal care
- b) Bleeding (haemorrhage)
- c) Loss of energy
- d) Unbooked as a result no blood tests and no early detection of HIV/AIDS and other maternal health problems.
- e) Lifestyles
- f) Nutrition
- g) Peer Pressure
- h) Dating or making friends with older educated females/males
- i) Family planning, condom use, contraceptives,sterilisation
- j) Sexually Transmitted Infections
- k) Testing
- l) Giving love to children
- m) Importance of education

Lastly, data also reveals how the use of the two folktales offered opportunity to the maternal health educators to work as a team and to openly raise awareness about the burden that comes along with motherhood in adolescence for example; gender-based responsibilities, poverty and unemployment in rural settings, as quoted below:

“PPR10: *Yho, akakho ngoku umyeni uxakwe ngabantwana yedwa, ngubani ovayo? Ngubani obeleka abantwana, xa usiya kuye umane ucela itoti yokutya komntana mhlawumbi ungaphangeli uyadikwa naye, mhlawumbi awuphangeli nophangela, uzophangela nini nawe xa ulibele ngabantwana?* (The husband is not there now, she struggles with the children alone, and who suffers? Who carries the babies on her back; goes around asking for baby food; maybe you are unemployed and your husband also gets bored. When are you going to work if you have so many children to mind?)”

4.4 The Evaluation stage: Post Storytelling

This section presents experiences and perceptions of the maternal health educators:

- a) On their lessons without folktales: Data collected through a semistructured questionnaire.
- b) On the lessons with folktales: Data collected through a semistructured questionnaire and unstructured oral interviews.
- c) On the overall storytelling intervention: Data collected through a focus group discussion.

It is important to note that though the researcher observed 8 PPRs, not all managed to answer the written questionnaires because of time limitations, as a result their views integrating their pre and post storytelling experiences were captured through recorded unstructured interviews. Some of the factors which contributed to no consistency for the written questionnaires were:

- a) Circumstances at the clinic (for busy clinics it was not easy to keep the health educator beyond the allowed time for the observation session, so feedback was faster through oral interview)
- b) The lesson completion time (distances travelled from one clinic to another, the roads and the weather conditions required the researcher to be flexible to use any method suitable for each situation as long as data quality and validity was not compromised)
- c) All questionnaires were written in isiXhosa as a result, there are evident gaps from PPR 07 (not answered some questions) who could not read the questionnaire; hence the researcher opted for an oral interview after she finished the lesson.

There are PPRs from whom data was collected through all types of methods. The researcher viewed this as opportunity to establish consistency, reliability and validity of data obtained as a result no PPR views have been left out except in cases where the researcher has acknowledged intentional exclusions. Lastly there are only three (3) PPRs who could not

attend the last focus group meeting due to unforeseen circumstances as reported to the MO. The last part of this section also presents data from the participants (PPR) and the MO as a collective so as to get an overall perception and suggestions regarding the integration of folktales in maternal health education.

4.4.1 Perceptions on lessons without folktales

Data from the semi-structured questionnaires shows lessons observed in order of priority themes, as follows:

- a) Teenage pregnancy risks
- b) Importance of early antenatal presentation
- c) Family Planning
- d) Taking care of one's maternal health
- e) Exercise

The following aspects were viewed as reflective of how educators perceived their teaching of the above-mentioned themes:-

4.4.1.1 Maternal health educator perceptions about lesson observation

All maternal health self-evaluation comments confirmed being happy, free, feeling good and interested in what they were doing. As also noted by the researcher, there was willingness to be observed although some confirmed that it was the first time they teach with colleagues or with an external observer. The fact that they were part of such an activity was generally exciting. This is further indicated by their level of satisfaction with themselves as they all confirmed to be satisfied with the lessons they taught under observation.

4.4.1.2 Educator views on pregnant women attitudes towards lessons

Although data indicates high levels of educator satisfaction with their audience participation, the researcher, through her prior lesson observation, had noted that this was limited to questioning, to which there were limited responses, more especially in talk or lecture based lessons as revealed earlier in Lesson A and Lesson B. Furthermore, evidence collected through researcher observation and recorded unstructured interviews indicated unpleasing participation and involvement of teenage pregnant women. When it comes to the signs indicating whether their audiences were interested or not, data indicates that almost all educators felt good about the attitude and appearance displayed by their audiences towards their lessons. Signs observed from their audiences range from looking and listening attentively when the educator speaks,

“Bane ba ntshebile ha ke bua” (Some were looking at me when I talk).

Data indicates that some educators experienced less talkative or completely quiet teenage pregnant women. They also viewed them as being difficult to involve; more especially when the educator speaks of condom use or attire and calling them to exercise.

4.4.1.3 Areas perceived as requiring improvement

Data shows that not all educators had a sense of what they would like to improve in their lessons, until the researcher gave them feedback on areas perceived as needing improvement. In most cases, improvement was related to things not relating to their teaching abilities but to more content and resources they required for their lessons, for example use of traditional medicine, more pamphlets and getting recognition for their role as CHWs. However, 20% of the educators at least commented that adult learners might get bored doing one thing, thus a variety of activities were required to assist in increased participation and interest in the lessons.

4.4.1.4 Prior knowledge and understanding of folktales

Data also indicated that 80% of maternal health educators observed by the researcher have no prior knowledge and use of folktales in their lessons. From the 10% of educators who had indicated to know and use folktale-like stories, the researcher discovered this knowledge was limited to those stories perceived as deceptive to women as earlier illustrated in data from Lesson B. Another 10% had confirmed prior knowledge and interest in storytelling as it was familiar practice from their clinic. Also looking at 83% of PW who had no knowledge of stories or folktales, it was not surprising that 100% of the maternal health educators observed express interest and willingness to observe integration of selected folktales into their maternal health lessons.

4.4.2 Maternal health educator perceptions of folktales in maternal health education

The researcher, as participant observer assumed the role of a storyteller after the maternal health educator has taught her lesson. This meant that all the PPRs obtained opportunity to observe the storyteller and thereafter continued to teach their lessons. The researcher was interested to find out to what extent PPRs display the ability to exploit a folktale to disseminate their health messages to the pregnant women and what were their perceptions of folktales in their lessons. The evaluation process was also conducted after all the PPRs had observed storytelling. Thus individual and group perceptions were gathered through a written questionnaire, unstructured interviews and a final focus group discussion.

Management perceptions were also sourced through an unstructured interview and focus group discussion observation feedback report from the observer-manager.

Data presented is derived from the semi-structured questionnaire and the unstructured interviews, which were used by the researcher to gather data from the PPRs. It is important to note that some preferred using one method due to time or questionnaire language limitations, while some have responded to both methods. The following table provides some of the questions and responses from the PPRs who filled the questionnaire:

Table 4.4-11: PPR perceptions on integration of folktales in maternal health education

| |
|---|
| Research Question 1: How do you feel when you observe a folktale in your lesson today? |
| PPR03 : <i>I feel interested to teach and add more on areas she did not cover</i> |
| PPR05: <i>I feel very good when I hear my colleague teaching, it is also good to listen because I also learnt a lot</i> |
| PPR06: <i>I feel happy because the pregnant woman realized her mistakes and received health information.</i> |
| PPR08: <i>I feel interested and learning methods make it easy to teach</i> |
| PPR09: <i>I felt interested and very happy. This motivated me, I learnt something</i> |
| PPR 10: <i>I feel interested to continue teaching.</i> |

On being asked about their feelings about folktales in their lessons, all maternal health educators interviewed expressed feelings of happiness. They also felt motivated to teach as data also reveals that they perceived folktales as an easy way of teaching pregnant women. Furthermore, they considered listening to someone else teaching as an opportunity to learn more.

When asked if they were satisfied with the folktale way as another method, educators confirmed to be satisfied with the folktale lesson, more especially when they also observed how their audience involvement improved, for example, data confirms their observations as follows:-

- a) The audience was more interested to answer questions
- b) More interested to engage without being invited to do so
- c) Listening attentively
- d) Smiling

- e) Laughing
- f) Facial expressions indicating acceptance/receptiveness
- g) Participating through exercise
- h) Disciplined

Because of their perceptions on folktales, educators further expressed their hopes that pregnant women had gained a clear understanding of the health messages, particularly awareness about teenage pregnancy risks, premarital sex, antenatal care visits, breastfeeding, and infectious diseases. Although the teenage pregnant women were generally perceived as neutral and less interested, there was an indication of hope from some PPRs that a folktale has to a certain extent tried to assist:

PPR09: I did not notice any lack of interest, joy only although some still looked down when answering questions. At the beginning they were responding slowly but as the lesson continued, they became free.

As data also indicates, in some instances women were quiet and less participative even during storytelling. This behaviour was, in two cases attributed to the language issue. Those who speak Sesotho were confirmed as not understanding isiXhosa folktales. Some teenagers were observed to be afraid to talk although they looked happy.

Some of the educators also voiced their prior doubts about folktales. PPR03 and PPR10 comments are quoted as follows:

"I have never narrated a folktale and never thought it was important, I was also afraid that it might disturb their minds from what they are taught. I did not even know which folktale examples I could use"

"I liked folktales; I never thought they could help in teaching and giving interest to pregnant women."

Regarding how they thought folktales could benefit their future maternal health education lessons, data further reveals that some maternal health educators perceived folktales as another way to get insight to more causes of teenage pregnancy for example,

- a) Lack of health education in some clinics
- b) Some teenagers without parents
- c) Some teenagers deceived by adults or boyfriends

The researcher further investigated their thoughts on how else the lessons could be improved. Data reveals several suggestions as follows:-

- a) Frequency of maternal health education lessons on mainly family planning, abstaining; premarital and extramarital sexual relationships at least monthly.
- b) Increase participation and action by all women also through singing and exercises.
- c) Encouraging testing and Prevention of Mother to Child Transmission (PMTCT)
- d) Improving ways of teaching pregnant women
- e) Train educators to do better
- f) Assist with HIV/AIDS
- g) A special place to educate pregnant women

Further data was collected through recorded unstructured interviews from clinic A-D where PPRs felt they did not provide sufficient answers or have enough time to complete a written questionnaire at the clinic. Their views and perceptions are presented as follows:

Clinic A: PPR02 and PPR03

The interview recorded some positive comments from the educators as follows:

- a) Folktales were perceived as good, educational and helpful.
- b) They were viewed as a reminder to pregnant women to be wiser and not engage in unacceptable behaviours, for example, not revealing their pregnancy so as to get early clinical care.
- c) Folktales were perceived as a clear method that facilitate information sharing and open discussions with pregnant women.

Although both educators expressed their lack of knowledge of folktales, they were positive about the benefits of using folktales. Data further reveals that they were willing to use folktales in their future lessons, more especially if they could get written folktales and further training on how to integrate them in their lessons as they are mostly not skilled narrators.

Data also indicated that as a result of observing introduction of folktales in their lessons, both educators were also able to identify areas needing improvement in their own lesson presentation skills, for example:-

- a) Talking for a long time without engaging the women in the lesson.
- b) Lack of time to prepare lessons properly and write them down.
- c) Not practicing to pause during the lesson, to allow for contribution by pregnant women, for example, finding out if they understand or have any views.

Clinic B: PPR04

Although the maternal health educator confirmed her lack of knowledge and understanding of isiXhosa folktales, data indicates how she received it with enthusiasm and excitement as she perceived it as awesome, beautiful, interesting and very educational. She further considered the narrated folktales as a very good example in relation to her maternal health lesson topics and themes as she confirmed its integratedness to, for example:-

- a) Teenage pregnancy risks
- b) Nutrition for pregnant women

Similarly to lessons observed in other facilities, data also reveals that PPR04 perceived teenage pregnant women as not responding easily to the lessons as they looked bored and less involved even if the educator tries. To this, the educator assumed that being mixed with the general audience could be one of the reasons teenage pregnant women shy away from showing interest in the lessons.

Although the maternal health educator also indicated her lack of exposure to folktales, one pregnant woman, interviewed by the researcher after the folktale lesson, confirmed to have more folktales that she could share with the educator in the future.

Clinic C: PPR07 and her Co-Facilitator

(A combination of English, isiXhosa and Sesotho was used for this interview)

PPR07 mostly answered in Sesotho although she understands English and a little bit of isiXhosa. She invited a male CHW to join her to co-facilitate and interpret in the lesson. He was the only male health worker the researcher met during the study period; as a result his views on use of folktales have also been captured. In this interview, the researcher refers to him as Co-facilitator (**CF**). Data shows that both educators were very happy, as they perceived the narrated folktales as a necessary educational tool, which functioned to sensitise women to make wiser choices.

Data from the transcribed recorded interview reveals further evidence that the educators have grasped the relationship of the narrated folktales to their lesson topics and themes. This was reflected in the manner in which they re-narrated the folktales during the interview. Without being taught, one of the educators beautifully used repetition in re-narration, while he simultaneously demonstrated the interrelationship of the issues raised by the folktale to the maternal health themes, as quoted below:-

“Wathi xa ebona ukuba kubi, wafihla, wafihla, wafihla, engafuni kubonwa. Wathi xa ebona ukuba kubi sakhul’isisu, wabaleka. Wathi xa eduze nesiduli eso wagrumba, wenza elo cebo limlahlekisayo ebelinikwa ziitshomi, Zange achaze kubazali ukuba unje ukuze bamncede ukuba enze ntoni, wazala ke abantwana abo,”

When she saw things were bad, she hides, hides, hides so that no one sees. When she saw things were bad, the stomach is growing, she runs away, when close to an anthill she digs. She takes the plan given by friends, a misleading plan that she must not tell the parents about her pregnancy so that she can get help, then she gives birth to these babies.”

From the data collected, it can further be concluded that the educator demonstrated ability to apply the two folktales narrated into the maternal health themes as follows:-

- a) *Ukukha amagqabi* (picking leaves from the apple tree) has been linked to deceit by friends
- b) The experience of the children of the anthill folktale has been linked to abortion and neglected newly born babies by their mothers.

Like in other sites visited, data from this clinic indicates that teenage pregnant women were perceived as shy, with poor eye contact, bored and looking offended by the maternal health lesson. Data indicates that one of the educators suspected that this behaviour was due to feelings of guilt and embarrassment as the subject touches on their experiences and their pregnancy.

Data also shows how the educators recognized folktale use as another opportunity for exercise by pregnant women. Data further reveals that both educators were willing to use folktales, also from their own language (Sesotho) in their future lessons.

Clinic D: PPR08

Data indicates that the educator, PPR08, enjoyed observing and learning to use folktales in a maternal health lesson. The educator also confirmed that she also perceived the pregnant women as:

- a) Encouraged
- b) Interested
- c) Free to contribute in the lesson

Similarly to Clinic A, the PPR08 also perceived teenage pregnant women as shy and less participative in the lessons. Although she confirmed not to be sure exactly about the cause

of this behaviour and attitude from teenage pregnant women, the educator assumed that it was caused by either laziness or fear.

Because of her experiencing a folktale in her lesson, the educator further suggested strengthening of maternal health education through:

- a) Platforms in community meetings
- b) Behaviour change by health workers, to be approachable and helpful
- c) Creating awareness about maternal health even to non-pregnant girls and women
- d) Emphasis on family planning and teenage pregnancy
- e) Emphasis on causes of maternal and child mortality
- f) Emphasis on reduction of HIV infection.

Clinic E: PPR09

Unlike in the other clinics, data reveals that the maternal health educator perceived most unmarried teenage pregnant women as feeling good about the lessons. She says they liked the folktales as they viewed them as an educational lesson towards wiser decisions and choices. She further described her audience as happy, interested and willing to share their experiences of being engaged in sexual relationships and issues on contraceptives, for example:

“Bathi isitofu nefemale condom ziyamanzisa” They (their partners/boyfriends) say injection and female condoms make you wet during sexual intercourse”

Although the educator revealed that she had not personally used a folktale, she confirmed familiarity with use of stories as the clinic sister also utilises them in her lessons from time to time. She also confirmed willingness to use folktales in her future lessons as she also claims to have more folktale examples, more especially now that she understands their function in maternal health education.

Most importantly, data reveals that the educator has realized certain benefits from the lesson observation and folktale introduction in her clinic, for instance, she felt that:-

- a) Her dignity and the confidence of the pregnant women in her has been restored as the pregnant women sometimes disregard the community health workers in preference of only the examining sister as an educator.
- b) Her own confidence level to stand in front of them and teach increased.

- c) Folktales can strengthen her role as a link between the community, the clinic nurses and doctors as she facilitates relationships towards effective utilization of primary health care.

There is also evidence of the educator ability to interpret and link the narrated folktales to the maternal health lesson themes, as she also re-narrated the folktales while she explained their significance to her lesson as follows:-

Table 4.4-12 Folktale interpretation in relation to maternal health themes

| The folktale | Educator interpretation and link to her maternal health lesson topics |
|--|---|
| <i>uDyakalashe</i> | abantu bebevana |
| <i>becela uhambo, amkhaphe, wamjikela, amagqabi, ama-apile, ubutshomi buphelile</i> | ufihla intloko, umfana amqhathe masenze untwana akaphinde avele if wayevela eKapa nomkhuhlane owawufikile...angaze aphinde ambone |
| <i>Amagqabi</i> | <ol style="list-style-type: none"> 1. <i>ngumzekelo wokwakukhulelwa</i> example of pregnancy 2. <i>uhleli utyhafile</i> dull 3. <i>kungekho nto anakuyizuza...</i>empty 4. <i>uhlukana nesikolo</i>, drop-out from school 5. <i>umntwana uyakhala...</i>baby crying 6. <i>akeva ututshala</i> does not understand the teacher 7. <i>akalali kaloku ngumntwana..</i> does not sleep at night 8. <i>ufunwa kwi klas zalate aphoswe nazi afternu klases</i>, ...misses extra-classes 9. <i>noba uncendiwe ngumzali amgcinele</i>, parent looks after the baby 10. <i>awuphangeli</i> not working 11. <i>awutshatanga</i> not married 12. <i>akho nkxaso</i>, not supported 13. <i>noba akancanci not breastfeeding</i> 14. <i>andizokwazi ukumondla... umhakhulu angamniki ubisi ngendlela eright esonga ubisi angamniki amacephe aright...</i> malnutrition 15. <i>agule yidiarea</i>, diarrhea 16. <i>luxanduva</i> responsibility |
| This is a further illustration that things remembered from the folktale narrated have been juxtaposed to | |

the maternal health education topic and that from just one word from the folktale (*amagqabi*), the maternal educator comes up with (16) possible disadvantages of teenage pregnancy.

The researcher also considered a collective approach to summarise the perceptions of folktales by all educators involved in the study, as a result a last focus group meeting was organised. The following data presents the collective views of all the PPRs involved in the study (except the exclusions reported at the beginning of this chapter)

Data from the focus group discussion (Table 12 (a)) reveals that all educators thought the folktale lessons were generally perceived very positively by pregnant women. They indicated that women liked it; were happy; interested while there was a pleasing understanding of the folktales narrated.

Although the PPRs reported a similar problem of teenagers being less interested in maternal health education, more especially when issues of condom use and family planning were discussed, several observable potential benefits of using folktales in the lessons were identified:-

- a) Increased opportunity for open discussions and sharing of women views and experiences.
- b) Increased approachability of health workers
- c) Easy to use, understand and manage.
- d) Able to assist shy educators and women to a certain extent
- e) Fostering effective listening and participation
- f) Eliminates fear of educators by pregnant teenagers
- g) Promotes exercise
- h) Encourages collaborative team work and teaching
- i) Revitalise interest and love of teaching for maternal health educators
- j) Makes pregnant women happy, attentive and receptive to learning

4.4.3 Management perceptions of storytelling as a teaching strategy

As a result of her role in the focus group discussion, the moderator-observer gathered information summarising participant's views and integrated it with her personal views on the introduction of folktales in maternal health education. Her response to the research question stated in indicates that:-

- a) There were still evident gaps in maternal health education which were caused by euphemisation in respect of culture while education is compromised. To this effect,

there were many stories of misunderstood maternal health messages, particularly regarding condom use, family planning and sexual relationships (the popular broomstick story; the jackets etc)

- b) The talk and talk approach and not listening what educators teach, leaves out a lot of information.
- c) Other maternal health education gaps are caused by assumptions that the health workers are able to teach without proper support, guidance and supervision.
- d) Not interviewing to get more views from pregnant women.
- e) Lack of sufficient ways to distribute knowledge.

Data also reveals further suggestions from the moderator-observer summary of group discussion:-

- a) Community Health Workers must first get thorough training so as to restore their dignity, build trust and respect from the community.
- b) They must be given enough tools to boost their confidence
- c) Maternal health education must explore all avenues and ways of educating women.
- d) Making sure that enough opportunity for pregnant women to ask and share their views is provided.
- e) Ensuring that the pregnant women understand the health messages and it becomes their choice not to utilise it but not the educator's fault of not teaching properly.
- f) It is necessary that we use different ways of teaching, which can also facilitate unity and teamwork among all those involved in maternal health education.

Data collected also revealed moderator-observer personal perceptions on use of folktales in maternal health education as follows:-

- a) Folktales were perceived as a way of reviving interest in teaching.
- b) Folktales were perceived as helping in understanding the messages in the lesson.
- c) Folktales were perceived as another way to help maternal health educators to understand women better.

The researcher has quoted one of her remarks as follows:-

“Yes, it is necessary that we use different ways of teaching, this can help us to be united and work as a team while it builds trust and respect to the Community Health Worker when they teach. They must be given enough tools to boost their confidence.”

4.5 Summary

The main purpose of this study was to explore the introduction of isiXhosa folktales as an alternative medium for maternal health education in Primary Health Care. Firstly, the knowledge and understanding of the role of folktales in the health context seemed to be lacking. From the data gathered through various study methods, it has been revealed that although the management and the maternal health educators have a responsibility to educate adult and young pregnant women by using many methods; there were still doubts; lack of understanding and knowledge about the relevance of folktales (*iintsomi*) in maternal health education.

Although the pregnant women confirmed to be receiving commendable teaching at clinic and maternal waiting home level, they have also attested to not have experienced noticeable use of folktales and stories in their maternal health education lessons. In addition, much as there was evident reference to other local stories in relation to issues of family planning and condom use during teaching, *iintsomi* were not explored and understood to be relevant for promoting effective access to a broader scope of maternal health messages during teaching at the clinics. This had deprived the maternal health educators and their respective audience, mainly the teenage pregnant women, an opportunity to enjoy the benefits of using folktales as a means to make lessons easy, enjoyable, more accessible and participative.

Secondly, data further revealed that educators were very comfortable to integrate folktales in their lessons as they also found it to be helpful and reviving their interest to teach; regardless of the challenges they experience in the maternal health education at their respective clinics. Moreover, the integration of folktales in maternal health education lessons was confirmed to have been perceived positively by pregnant women. Although there were still signs of shyness and poor interaction from particularly the other teenage pregnant women at clinic level, folktales were perceived by maternal health educators as having potential to make the women feel free, relaxed and able to contribute in the discussions, more especially in more conversational than the lecture based lessons. Lastly data gathered has also revealed that the maternal health educators and their management representatives were willing to integrate folktales in their future lessons, more especially if they could access more written folktales and further skills on ways of using them alongside their maternal health themes in Primary Health Care.

CHAPTER 5

DISCUSSION OF FINDINGS

5.1 Introduction

In the previous chapter, results from the data collected regarding the role of isiXhosa folktales in the maternal health education in Primary Health Care were presented. This chapter discusses the results and the findings of the data presented in Chapter 4 in relation to the three study objectives as follows:

- 5.1.1 The relevance of storytelling (iintsomi) in maternal health education in Primary Health Care (Preparatory Stage)
- 5.1.2 The integration of folktales in maternal health education lessons at clinics and maternal waiting homes (Intervention Stage)
- 5.1.3 The perceptions on integration of folktales in maternal health education in Primary Health Care (Evaluation Stage)

5.1.1 The relevance of storytelling for maternal health education in Primary Health Care

Tones (1990: 9) emphasize the importance of values rather than the learning theory, the study therefore explores the relevance of folktales in the maternal education in relation to the values underlying for maternal health education in the PHC system. The pregnant women, as patients receiving health education, are best defined by their socio-cultural experiences as embedded in the primary care, thus the researcher sought to obtain information on what informs maternal health education before an attempt to explore storytelling in the PHC context. The Primary Health Care prioritises on MDG4 and MDG5, namely '*Reduce child mortality and Improve maternal health*'. Pattison et al (2011-2012) identified a need for improving access to health messages by affected women and additional skills for the 'doers' to improve ways of dealing with pregnant women. Through the interviews and discussions, the findings revealed the values described below:-

5.1.1.1 Professionalism, respect and commitment in maternal health education

Buchman et al (2007:9) emphasised that health workers administering care to pregnant women must demonstrate respect and a genuine interest in their clients, and avoid an arrogant, rude or judgmental attitude. Consequently, the researcher sought to understand the extent to which the personnel involved in health promotion, prevention of disease and provision of quality care valued maternal health education. The study revealed that the management and the maternal health educators demonstrated a professional

understanding, respect and commitment to the values driving maternal health education in their clinics, community and hospitals.

5.1.1.2 Collective responsibility towards effective maternal health education

Pattison (2010-2011:iv) announced that the model favored by Saving Mothers Saving Babies is '*action orientated*' as it clarifies involvement and levels of participation by all stakeholders (individuals, communities, health care managers, health care providers;) on developing strategies for improving maternal health. The study revealed that maternal health education was regarded as a collective responsibility, though the Community Health Workers were confirmed to be mainly responsible for health promotion, education and mobilisation at clinic and community level. The study also revealed that some lessons conducted by assigned maternal health nurses took place at a maternal waiting home situated inside a local hospital responsible for deliveries for their sub-district. The study also revealed that the maternal waiting home had high daily intake of young pregnant girls who were due for delivery.

5.1.1.3 A goal-oriented and needs-driven maternal health education

According to the Minister of Health, health education is a priority and a critical social service. Furthermore the Negotiated Service Delivery Agreement signed with the President committed to reducing maternal and child mortality¹⁹. The study revealed that the maternal health management and educators confirmed their primary goal for strengthening maternal health education was to avoid maternal and child mortality and morbidity as stipulated by MDG4&5.

5.1.1.4 Maternal health education awareness campaigns and training of educators

Moodley (2008- 2010:5) highlighted teenage pregnancy as rendering women as high risk when it comes to maternal mortality and morbidity. The study revealed that the teenage pregnancy rate in their area was considered as alarmingly high; moreover unmarried teenage pregnant girls were perceived as high risk than married women. As the study further revealed, teenagers were perceived as victims of married men involved in extramarital affairs, (*amakrexe*), hence drive to intensify continuous maternal health education. The priority topics for maternal health education were teenage pregnancy risks, family planning, HIV/AIDS, nutrition, lifestyles, high blood pressure, breastfeeding and TB.

The study also revealed that the need for strengthening health education was also driven by stipulated special campaigns for maternal health, for example, Campaign on Accelerated Reduction of Maternal Health and Child Mortality (Carmma) and Saving Mothers Saving

¹⁹ . www.doh.gov.za Budget speech 2012 & 2013

Babies (SMSB). To this effect the study revealed that the managers needed training of maternal health educators, mainly the CHWs, to be open, talkative and approachable.

5.1.1.5 Effectiveness of maternal health education in rural Primary Health Care

Tones (1990:6) interpreted effectiveness of health education as one that produces changes in understanding or ways of thinking; bring about some shift or belief or attitude; influence or clarify values; facilitate acquisition of skills; or may even affect behavior or lifestyle.

The study also revealed that although there were attempts to strengthen maternal health education, it was still unsatisfactory due to a number of other reasons, namely lack of staff, and certain issues challenging teamwork towards effective delivery of maternal health education. To this effect the researcher gathered that the management was not satisfied with the level of collaboration displayed to be confident enough about the effectiveness of health education in their area. Moodley (2008-2010:49) cited ineffectiveness of current health messages; minimal community education; lack of diverse ways to empower rural and young women as other challenges facing maternal health education.

5.1.1.6 Empowering rural and young women through diverse ways

Smyke (1991:138-140) suggested action focused ways of reaching women through culturally appropriate channels to behavior change. The United Nations Permanent Forum on indigenous issues also called for 'an integration of indigenous issues into existing training opportunities and also for operational activities and programs at country level (UNDG 2013:3). Consequently, the United Nations Population Fund in the Eastern Cape is a prominent example of partners who continuously supports the 'Saving Mothers Saving Babies' program through capacity building of healthcare workers, rural women and youth on issues of sexual and reproductive health, family planning and safe motherhood in line with the United Nations agenda on strengthening MDG 3, 4, and 5 simultaneously across all countries (UNPFA 2011:14-25).

Although this is the case, the study has revealed that the management, the maternal health educators and the rural pregnant women attending lessons at the clinics, had no knowledge of the significance of isiXhosa storytelling (iintsomi) in their maternal health education lessons. With the study further revealing a majority of the PW between the ages of 17-21 as unmarried women who are either drop out or still at school, there is reason for concern on ways of information dissemination. From the researcher observation of lessons and as also echoed by some PPRs, teenage girls were difficult to engage in sexual reproductive health and family planning discussions. The researcher considers it as very important for the

educators to be mindful of the fact that the educational status of these girls could be another possible reason for their being less participative or responsive to lessons. As it has been stated in Karlsen et al (2011:9),

“Increasing levels of educational attainment are likely to enhance the capacity of women to obtain; process; and understand basic health information about the benefits of good prenatal care and the reproductive health services needed to make appropriate health decisions... Furthermore, more educated women are likely to be more confident about asking questions about their health care needs and are more likely to be listened to by health care professionals.”

Therefore, using teaching methods that will assist in breaking the power barriers and diffuse educational status during the lessons can benefit the pregnant women and the maternal health educators. Labonte et al (2008:58) suggested a comprehensive approach aimed at reducing health inequities that is based on meaningful community participation, multidisciplinary teams and action across sectors. Because the managers and the maternal health educators, as revealed in this study, regarded health education as a continuous process which required strengthening through all available means, they unanimously consented to the study of folktales exploring the integration of storytelling in their lessons.

5.1.1.7 Enabling the Community Health Workers to contribute effectively in Maternal Health Education

Lehman ((2007:4) expressed a concern about CHWs not having professional qualifications enabling them to contribute effectively. Unlike the nursing assistants undertaking some formal curriculum, which the researcher assumes exposes them to formal training on presentation and methodologies, the study found out that the CHWs are educators from a different training background. Although they were expected to deliver effective health messages and work as a team with nurses, as the PHC outreach program suggested, the CHWs confirmed to be teaching pregnant women from their personal experience as women; from the preparations derived from pamphlets they received from workshops and from the information they received from the training they attend for health promotion topics facilitated by senior nurses. Although they confirmed lack of knowledge of the other way of communicating health messages, thus folktales, as it has been found, the study could not rule out the existence of possible gaps in the CHW understanding the theoretical perspectives on adult teaching and learning and the relevant health education models linking health promotion to health education (Tones 1990:1-14).

As data has revealed that most training was on clinical themes and not on mode of delivery and methodologies suitable for a collaborative action-oriented PHC model as described in

Pattison (2010-2011: iv), it was not surprising that the educators had not been exposed to the traditional folktales in healthcare.

In his budget speech the MEC Sicelo Gqobana, Eastern Cape Department of Health (2013) suggested that the bedrock of any functioning healthcare systems rests on a good, efficient and well-oiled Primary Health Care approach where healthcare is brought to the doorstep of the communities. Because they work closely with communities, Olver et al (2011:11) calls the CHWs 'the backbone' to the PHC approach. Although there is no evidence of a clear curriculum suitable to guide the CHWs as maternal health educators, it is imperative that they become exposed to a variety of skills which shall enable them to bring information to communities through culturally appropriate approaches for the benefit of the rural PHC system.

It is on the basis of the above reasons that the study pursued to involve the CHWs in a reflective action research process towards an innovative exercise of teaching with folktales at clinics and the maternal waiting home. The CHW preparedness to be observed while teaching pregnant women and their willingness to introduce folktales in their lessons revealed their eagerness to contribute as envisaged by the PHC approaches.

5.2 Introducing storytelling for maternal health education in rural Primary Health Care
Although Moodley (2008-2010:49) described the current health messages as ineffective and lacking in diverse ways of empowering rural and young women, the study could not rely on the reported research only but instead sought to utilise that as an advantage to observe the existing maternal health education lessons.

The purpose was not to dispute earlier findings but to bring forward more information on other possible contributors to the ineffectiveness of maternal health education so as to enhance clear role playing and meaningful action by the PHC multidisciplinary teams as envisaged in Labonte et al (2008:58).

The aim of an action researcher is to bring about development in his or her practice by analysing existing practice and identifying elements for change. The process is founded on the gathering of evidence on which to make informed rather than intuitive judgements and decisions (McGinty 2006). As a result, the researcher undertook observation of maternal health lessons by the selected maternal health educators in selected PHC clinics. As emphasised in Whitehead (1985:98) the participants were enabled to experience the problems in their educational values, imagine the solutions to those problems, to act in the direction of the solution and to evaluate the outcomes of their actions and the innovative ideas which seek to improve their practice.

A discussion of what was found to be happening during the lessons is presented in the next part of this chapter.

5.2.1 Teaching strategies in maternal health education

Regarding their teaching practices, it has been found that most maternal health educators in primary health care still relied heavily on the talk or lecture method as a dominant means of communicating important health messages. If health education is to be understood in the health care context as meaning 'patient education', it is crucial that maternal health educators should begin to interpret it to be referring to a planned learning experience which uses a combination of methods such as teaching, counselling and behaviour modification techniques which influence patient knowledge and health behaviour (Tones 1990: 118). As Day (2009) also comments, "The real health literacy issue is not the lack of information, but rather the ability of the healthcare consumer to access and process the information.

When maternal health educators do not have knowledge and understanding of folktales, as revealed in the study, there is likelihood that the methods mostly used have potential to compromise the patient's cultural perspective on meaningful learning. The use of only a talk or lecture based method limited the educator choice of words to more confrontational rather than an encouraging mode of accessing health information by their audiences. As a result, as it has been found, in most clinics, teenage pregnant women were viewed as displaying a negative attitude and behaviour towards lesson topics addressing, among other issues, multiple sex partners; unprotected sex; premarital sex; ignorance; late antenatal presentation; peer pressure, and so on. Hence, Smyke (1991:140) suggestion that health information for rural settings should be disseminated through culturally appropriate channels to change behaviour and strengthen family support systems. The study was for example conducted in isiXhosa and lessons observed were presented in both Sesotho and isiXhosa.

5.2.2 The role of language and communication in maternal health education

It is commendable that the maternal health education lessons took place in isiXhosa and Southern Sesotho in some clinics and partly at the maternal waiting home. Although this is the case, the issue of language in teaching has to be understood beyond the language itself. As Saohatse (1998:1) suggests that it is crucial that maternal health educators are made aware of the fact that the effectiveness of health messages also revolves around the quality of verbal communication which takes place between the health worker and the pregnant women.

The findings reveal that pregnant women also become open when the educators choose a culturally conversational language which is contained in stories and folktales. In this case the euphemistic nature of the story and folktale language enhances mutual respect and genuine interest in the issues being communicated while it fosters a good relationship between the educators and the pregnant women (Buchmann *et al* 2007: 9). As Saville -Troike (2003), Churchill *et al* (1982), in Hunter (2008), Mupa *et al* (2013) emphasise, the importance of understanding the meaning of cross-cultural approach in communication, this study has also revealed more maternal health related stories the nature of communication between health practitioners and patients, in this case pregnant women. The constant emergence of Dr X's story of the condom and the broomstick in this study is another important evidence for the relevance of cultural communication aspect in maternal health education.

5.2.3 Maternal health educator attitude and behaviour

Maternal health educators at the clinics, namely the CHWs and the Nursing Assistants involved in the study were capable of organising and conducting lessons for observation. Besides the fact that some were exposed to teaching under observation for the first time during the study, there was evidence of enthusiasm and dedication in their health promotion and health education responsibility. The study has revealed that all the educators who participated in the study were prepared to teach regardless of frustrations which emanated from the following challenges as study revealed :-

5.2.3.1 Space and environment for maternal health education

The study revealed that some lessons take place in overcrowded clinic waiting rooms where it was not possible to separate the pregnant women from the general audience. Although this benefits the educators for community mobilisation, it affected delivery of effective health messages to the targeted recipient, namely the pregnant women, who are required to share their experiences and stories with the educators. In Tones (1990:131) it has been found that, more than anything else, when patients do not get enough time to exchange views with the practitioners, information exchange is affected. Moreover, the health educators might lose patience in overcrowded settings which can compromise their professionalism as they become impatient or even lose passion to achieve their intended outcomes for educating pregnant women. The patients, in this case, the pregnant women might withdraw from participation as they would feel that their informational needs are denied (Tones 1990:131-135). Similarly to overcrowded spaces with mixed audience, the study has revealed that some lessons take place in small consulting rooms which do not provide a conducive

environment to teaching and learning. Thus the Primary Health Care needs to bear in mind the National Development Plan, vision for health 2030 which states that:

Given that the core business of the health sector is clinical services that are both preventative and curative, it is important to provide the necessary environment for this to take place (2011:302).

The delivery of the envisaged clinical services, as it is evident from this study, is also depended on health promotion and prevention which occurs through the vehicle of a collaborative action and community-oriented health education (Patterson et al 2011-2012, Pillay & Baron 2011, Bam et al 2013)

5.2.3.2 Utilising available resources

It has also been found that the maternal health educators have access to educational other resources like television sets, pamphlets and booklets which are mainly in English. Although the focus of the study was on the role of folktales as an alternative methodology for teaching pregnant women, the researcher was mindful of the fact that the health care context could benefit from an integrated approach to utilisation of all available resources so as to add value into the meaningful health education towards the envisaged comprehensive multidisciplinary PHC approach (Labonte 2008). Although the researcher could not really establish the real reasons for ineffective use of these resources, the study revealed that there was limited use of pamphlets (mostly in English) or totally no use of television and videos available in every clinic visited. The researcher viewed this as lack of CHW ability to apply the major elements of the self-empowerment model, that is, an ability to handle social and environmental constraints by providing information; and making sound decisions as also influenced by their immediate choice of teaching methodologies suitable to their different context, (Tones 1990:124). The study also considered that Lehman (2007:4) views on Community Health Workers as not having enabling professional qualifications and appropriate skills as accountable for this shortfall.

5.2.3.3 Use of songs in maternal health education lessons

Spoken words alone do not sufficiently communicate the feelings the artist is attempting to project (Scheub 1975:50). It also emerged from the study that there was use of songs, role plays, dramatisation and stories, although this was generally dominated by talk and lecture method in many clinics. Given the World Health Organisation (WHO) assertion about motherhood as bringing pain, suffering, illness or death due to a list of pregnancy and non-pregnancy related factors, it is crucial for maternal health educators to re-enforce the positive feelings of being a mother by adding fun, laughter, play, songs and dance to their

lessons. This practice, where the study found it implemented, was observed to assist in improving movements of the maternal health educator, who had previously been observed as confined to a corner of a small consulting room or an overcrowded waiting room.

This approach was also perceived as helping the pregnant women to exercise as song involved body movement, for example, in the song, “ *Ndachol’uNodoli ngasemlanjen*”, the educator in one clinic insisted that women must imitate picking up the doll, handling and cuddling; looking at the doll with love and affection and calming the baby to sleep. All the elements of the song, had everything to do with educating young women, who, as confirmed during a few conversational interviews, were in their first pregnancy experience. Even if the teenage pregnant women were generally perceived as not responding positively to maternal health education, the use of a variety of tools to entertain, engage and educate them also revealed improved non-verbal communication and associated behaviours like smiling when pleased, nodding to agree, shaking a head to disagree, shrugging shoulders where they do not understand. Above everything else, laughter, the best medicine, was evidently aroused by use of songs, stories, role-play and dramatisation.

5.2.3.4 Use of role-play, dramatization and storytelling

Through use of role-plays, dramatisation and stories, the study also found there was commendable teamwork between the examining maternal health nursing staff, the CHWs and the pregnant women. During an outdoor under a tree lesson in one of the clinics, items ranging from a mop, broomsticks and packets of condoms were utilised to demonstrate the extent to which communication between the health workers and the rural women affected delivery of health messages in Primary Health Care.

Although the management team had expressed a concern on the teamwork in maternal health education, it was revealed that there was commendable collaboration and teamwork in delivering efficient health education. This was evident from the demonstration of the condom and the broomstick story to the pregnant women by the nursing sister and the CHW though in few clinics. The researcher had also observed how it was impossible for the clinic sisters to support a joint teaching activity at the clinic because of overcrowding and being under staffed. For example where one sister was doing consultation, the researcher even doubted the amount of health education which could be afforded on a one-on-one basis as they had to finish all patients.

To summarise the findings on what's happening in the maternal health lessons at the clinics studied, Tones (1990:1) suggested that it would be difficult to provide an unequivocal definition of what constitutes a success without examining the values upon which different approaches to health education are based.

It is important to note that the variables identified as a barrier to effective teaching of pregnant women were possibly not limited to those identified, but were perceived as an indication that there was still lack of some standard operationalisation of maternal health education which could assist in empowering and promotion of self-esteem of maternal educators.

As also revealed in the study, health educators teach from their different background experiences and not much from an identifiable specific maternal health education program, except the general guidance by the Department of Health specific themes monthly calendar. Under such circumstances as revealed by this study, the educators decide what, how, and when to teach as there was no evidence of a standard guidance on teaching practices, to an extent it would be difficult to measure the effectiveness of the lessons.

Nonetheless, the study at hand was focusing on observing what takes place; create awareness on alternative methodologies and find out perceptions of stakeholders, so that the findings could add value to future research as well as inform the stakeholders of other aspects affecting effectiveness of maternal health education in rural Primary Health Care. For the study time-frame and the processes followed in the initial stage, there was evidence of readiness by all educators involved to explore folktale integration in existing lessons.

5.3 Evaluating perceptions of the role of storytelling in maternal health education in Primary Health Care

From a contemporary perspective, reminding society of its duty to re-awaken; to re-energise and re-image (Bukonya in Kaschula 2001:32, Brown 1999:1) oral tradition can best be achieved by also transporting them to new contexts; as 'form of action, or art and of reflection (Finnegan 2007:1). It is for these reasons that the study pursued for a practical introduction of folktales in the selected clinics and a maternal waiting home. The study further considered that the nature of PHC is action-oriented; hence the PPRs had to get opportunity to act and reflect on their actions so that they could also contribute towards improving their own practices. Below is a summary of the findings on their perceptions as collected from them as individuals, pairs and teams:-

5.3.1 Provision of a non-threatening environment

From a theoretical perspective, Knowles (1980) stated that a key requirement for effective adult learning is the creation of a non-threatening learning environment in which students are made to feel psychologically safe to express themselves openly. It is the sole responsibility of the educator in any given context to create such an environment as it all depends on what strategies she uses to assist the recipients of that particular learning situation to learn. Although it was earlier revealed that some educators had doubts and no knowledge about the significance of folktales in maternal health education, the study revealed that using folktales did not make the content lose the focus on health but functioned as an encouragement for women to discuss, exercise their right to ask questions and to express their beliefs and attitudes about their health (Smyke 1991: 186). The study revealed that the educators perceived the pregnant women as feeling free and relaxed although their level of orality (Bukenya in Kaschula 2001:32) still required improvement. The increased participation in discussions during the folktale lessons is proof that the women gained more focus than when there were no folktale-stimulated discussions in the lesson.

5.3.2 Raising awareness and discussions on a variety of maternal issues

As also acknowledged in Kaschula (2002:4), the didactic nature of oral literature undoubtedly render folktales their recognition and potential to offer a lot when used to interpret the contemporary maternal health issues. For instance, much as the PHC was found to have its own challenges affecting maternal health education, the study revealed that all educators perceived folktales as helpful and useful to raise awareness about a variety of maternal health issues for all pregnant women regardless of their age and marital status.

Besides its didactic nature, oral literature is performance-centred art, which has to be understood for its significance, function and a meaningful relationship with contemporary life (Bauman 1986:3; Scheub 1975:74). As a result the study revealed that folktales were perceived to be relevant and significant for teaching pregnant women. The integration of folktales in maternal health education lessons allowed educators to obtain a way to summarise all messages by going back and forth from one folktale to another through a discussion method. The study also revealed that they also used the storytelling background as a way of probing into other possible reasons for teenage pregnancy unlike when their previously prepared lessons narrowed the information to only what was in their prepared talk.

Most maternal health educators at clinics viewed participation of teenage pregnant women as a worrying factor in their health education lessons. Although some educators attempted to attribute the teenage pregnant behavior to other factors like shyness, being bored, lack of interest, and so on; this study focus was on the ability of the educator to drive the process of communication for effective access to health messages. The study has also found out that most educators still relied on using talks prepared from the pamphlets and previous workshop materials. In this case, Ong (1982:42) strongly suggested that a way of communication derived from a chirographic culture, has potential to distant the oral culture and thus becomes devoid of human action context. The signs of withdrawing from the lessons should therefore, not only be blamed on the teenage pregnant behaviours and attitudes to education. The pleasing level of participation at the maternal waiting home and the other lesson under a tree further indicated that more responsibility to improve lessons was still dependent on the method of delivery and the environment in which the lessons were conducted. From these two sites, the study revealed how the teenage pregnant women and the educators interpreted each folktale in relation to their social life experiences. In this case, the juxtaposition of oral culture derived information to the clinical (mainly derived from written/ chirographic culture) information was found to be advantageous for the primary health care context (Scheub 1975:74; Ong 1982:42)

5.3.3 Promoting a meaningful audience involvement in Maternal Health Education

The study has also revealed an understanding of the metaphorical function of folktales by educators and the pregnant women (Scheub 1975:75). They did not take regard it as offensive or even felt belittled by being exposed to iintsomi as adults, as most people believe them as suitable for children, but instead used them to expand the discussions in their lessons²⁰. Through the use of fable animal characters; (*dyakal Ashe, mvolofu*) and strange no name characters like *a boy who drank medicine; that woman; that girl* and objects like *trees, apples, leaves* presented a fantastic world, educators were able to use the terms from the folktales to interpret and relate to real life situations. This according to Okpewho (1992: 222-223) helps the listeners to tune into the 'capturing' tradition of iintsomi; that of being removed from the real world of men, to participate in or observe the events which they come back to associate with their real life experiences.

5.3.4 Neutralising pregnancy-related anxieties

As Dundes (1965:33) suggested, folklore serves as a psychological escape from many repressions, not only sexual, which society imposes upon the individual. The study revealed

²⁰ See Lesson C at the Maternal Waiting Home

that educators perceived the folktale experience as fun and entertaining. The anxieties about motherhood and such recurring experiences of maternal mortality as described in Moodley (2008-2010) were all for a moment neutralised by the involvement of the educators and the expectant women into that aesthetic experience of storytelling (Okpewho 1992: 71-104). It is therefore obvious that the minds of the pregnant women and the educators were for a moment, during the process of learning, lifted away from the limitations of human life to a world of blissful fulfillment through humour which added drama and meaning to the wording of the folktale. (Okpewho 1992:109; Finnegan 2012:9)

Kehinde (2010:38) further suggested that folktales perform therapeutic functions in easing emotional tensions and expressing, dissolving and resolving repressed anti-social passion of anger, hatred and jealousy which currently bedevil the nation. As this study revealed, folktales also raised other social, economic and political factors which affect rural women, for example, abuse in relationships; different forms of gender-based violence; rape; poverty; unemployment of women; dropping out from school; child-bearing responsibilities like child illnesses; diseases; inadequate support by families; and so on. It was also revealed that the maternal health educators were teaching, not only for educational reasons, but also for fulfilling a very critical obligation of saving mothers saving babies. As one of the educators sadly commented during a discussion of the folktale entitled, *Abantwana beNtab'esiduli* (The Children of the Anthill)

“Siyazama kangangoko sinako, asifuni mfazi uswelekayo nantsana zifayo” Yabona le ntombazana ibingu unbooked, uba ibiswelekile, ngeyiyimaternal death leyo.” (We are trying as much as we can, we do not want women and babies to die. Do you see this girl in this folktale was unbooked, could she have died, and that would be recorded as a maternal death.” (The researcher observed how this was uttered with concern and pain which was noted from the educator’s tone of voice and facial expressions)

Although there was laughter and entertainment, folktales have potential to also raise feelings of sadness in pregnant women and the educators as well. According to Ong (1982:33-35) it is the power of the spoken word, its rhythmic patterns and mnemonic aids derived from the sound of a message passed through oral art performance that makes the listener feel, imagine and participate. The reference to the *iintsomi* by the nurse, long after it has been narrated indicated the sound, the voice and the rhythm of the folktale were still passing a message of wisdom which she could not miss transferring to her audience through a different voice and tone. The feelings of sadness produced by the voices are, like the feelings of happiness, a positive attribute in the lesson. Although used to emphasise a different point by Ong, the researcher found his quote befitting the above explanation:-

“Sorrow is better than laughter, because when the face is sad, the heart is wiser’
(Ecclesiastes 7:3)

When educators express sadness through narration and discussion, the listeners display matching facial expressions and utterances, for example,

“**PPR 10:** *Uyawathand’ amagqab’umvolofu? Akawatha-a-andi.*

PW: (in chorus)... *akawatha-a-andi, hayi akawathandi.*”

As a result of these and other gestures, the study further revealed the maternal educators as hopeful that the lessons would help the teenage pregnant women to remember the knowledge from the folktale lessons; take wiser decisions for future; and also pass the information to other young women in the community and their siblings in their families (Kothari 2007: 4; Goduka 2012:1).

Folktales also enhanced feelings of empathy by some educators. Utterances showing that the educators were through the introduction of a folktale prior the beginning of the lesson, assisted to show care about what the teenage pregnancy were experiencing.

“*Siyanithanda, we want you to get education, ningakhi amagqabi*” (statement from an educator with reference to the jackal and the wolf folktale)

5.3.5 An oral-written-print resource for new health contexts

The study also found that some educators still needed more pamphlets and perhaps written folktales as additional resources to help them continue with storytelling in their clinics and the maternal waiting home. Although Ong (1982:14) warns that the powerful and beautiful verbal performances of high artistic and human worth, were no longer even possible once writing has taken possession of the psyche, Denslaghe in Kaschula (2001:47) suggests that in order to transmit traditional moral codes and patterns of behaviour to younger generation, oral traditions can still be passed off as an educational tool and a pedagogic instrument. As this study revealed, a folktale is for most maternal health educators new knowledge; which is valued enough to be effectively mobilised not only as oral culture but also as chirographic and typographic culture in contemporary health care (Kaschula & Mostert 2011:5). With the availability of television sets and videos in the visited clinics, a meaningful interaction between orality, literacy and technology can promote efficient use, access and integration of the marginalised languages into future technologies within the PHC context. This can further allow for a more collaborative approach where the digitised maternal health lessons in local content could be viewed by the general audience while the health workers continue with their

community outreach education. This would ensure maximised utilisation of all available resources in rural PHC.

5.3.6 Increasing women oracy in rural health care contexts

During the initiation of the study, some educators were confirmed to be shy and less talkative. The management had also expressed a need to develop CHWs ability to be open and approachable. The researcher also observed these tendencies from affected maternal health educators.

Bukenya in Kaschula (2001:33) calls this oracy which he defines as skilful, confident and productive use of spoken word. Because this study regarded folktales also a way of encouraging educator oracy, the findings reveal that the affected educators perceived use of folktales in their teaching of pregnant women as an easy way to help them gain confidence and encouragement to continue teaching and talking.

5.3.7 Providing a holistic communication through folktales

Further evidence has also revealed improved non-verbal communication and gestures from the pregnant women. There was evidence of reduced shyness and quietness; improved eye contact; and less tension unlike in other lessons observed; where teenage pregnant women had been perceived as cheeky, bored and otherwise less involved. The use of hands, and facial expressions and a suitable voice tone presented a less confrontational approach than the previously observed lessons. Bukenya in Kaschula (2001:33) further describes oral literature, “ as holistic communication; as posture; voice; expression; gesture; movement; access, entitlement to contexts, discourses and technologies.” Although this holistic communication was limited by many factors in mixed audience settings, it was found to improve where a group of pregnant women from different clinics or villages were in one venue. For example meeting women at the maternal waiting home was different from the clinic visits. The study also revealed that teenage pregnant girls admitted at the waiting home were more free to express themselves than when they had visited a clinic for antenatal care.

5.3.8 Enhancing listening and understanding of maternal health messages

The study revealed that the maternal health educators involved in the study perceived the pregnant women to be listening attentively during the folktale lessons. This according to some educators was viewed as an indication that pregnant women had gained a clear understanding of the health messages, particularly awareness about teenage pregnancy

risks, premarital sex, antenatal care visits, breastfeeding, and infectious disease which the narrated also emphasised. While Lockett (2011) explored the benefits of storytelling for English learning by foreign students, one of the most important aspects which the students found captivating about use of stories was its ability to keep them listening. This was evident from comments like, “When I listen to your stories, I concentrate on this class. If you don’t tell stories, this class will be boring, and then I might sleep.” Some students spoke of being fatigued and how the use of stories allowed them to concentrate on the teacher’s words and make more of an effort to learn. The maternal health class shares similar benefits from use of stories. The audiences are usually tired, having travelled a distance to the clinic; having to wait in the long queues; thus listening to talk-based lessons only have potential to make them sleep or to get bored. Using a folktale kept them engaged and listening attentively while digesting the story themes in relation to their own circumstances.

5.3.9 Promote storysharing; create awareness about myths and euphemisms affecting rural women

The study has revealed that a limited number of maternal health educators used songs, role plays, dramatisation and stories. As a result of involvement in folktale lessons, all educators expressed willingness to use storytelling, particularly folktales which they observed as advantageous for their clinic, communities (Imbizo’s), schools and maternal waiting homes where most health promotion activities take place.

There is also evidence of pregnant women being encouraged to share a variety of stories. In one clinic, a teenage pregnant woman also narrated a folktale (*The Baboon and the Jackal*). The researcher viewed this as further evidence to the universality of folktales while it was also an indication that folktale narration is indeed a communicative event, and a public activity which is jointly enjoyed and performed to bring wisdom to the members of the group and publicly carry the story forward so others may know it. (Saville-Troike 2003:19; Finnegan 2012: xx)

New stories which bore significance to social issues affecting teenage pregnant women also emerged. Consequently, Ntuli (2011:4) suggested that the recreation of the old brings about the establishment of the new which will in turn produce new offspring. The following stories emerged:-

Story 1: “*U Elvis uneQuantum, ukhwelisa omnye eMangoloaneng akhwelise omnye kuXaxazana*”

This story evoked feelings of sadness on how HIV/AIDS spreads as a result of husbands or boyfriends driving taxis trying to impress many girls from village to village.

Story 2: *“Utata womntwana ufuna ishare yakhe kwimali yegrant azokhulula ilay-bye yakhe yejean”*

This story revealed how girls feel when their boyfriends who did not carry babies demand the grant money which is supposed to help the baby.

Most importantly, the introduction of storytelling in maternal health education evoked other stories which distort the clinical understanding of health education by rural women and men. The researcher believes that where no stories are shared, it is unlikely that participants speak freely to share even the funniest stories from their communities, which the health educators can utilise to get insight to their ways of thinking, their influences and beliefs about sexual reproductive health.

The researcher came across a list of mythical stories and euphemisms which, she thought were very important to be given attention by the rural maternal health educators in rural PHC. Examples of such stories revealed in the study are illustrated below:-

Story 3: Umsila wehashe (myth)

Kukho inkolelelo yokuba xa uxhwithelwe uboya emsileni wehashe uze uphothwe ubhinqelwe esinqeni ngumntu obhinqileyo, uyathinteleka angakhulelwa nokuba ulala nendoda engasebenzisanga ikhondomu okanye acwangcise.

There is a belief that when one takes a horse tail and ties it around her waist during sexual intercourse, they will not fall pregnant, she does not need to use any protection or prevention.

Story 4: Intonga yomtshayelo (euphemism)

Kukho ibali elithi xa amagosa ezempilo elinganisa ngentonga yomtshayelo xa efundisa ngokusetyenziswa kwekhondomu abantu abangootata balala namakhosikazi abo ngaphandle kwekhondom babe beyifake emtshayelweni ikhondomu bengayisebenzisi kubo.

There is a story that when health practitioners use a broomstick as an example when they educate rural people, particularly elderly men, they go back to have sex with their wives without using the condom. They insert it in the broomstick and not in themselves.

Story 5: Isitofu siyamanzisa (myth)

Abafazi abaselula abakhulelweyo babalisa ukuba amadoda wabo, ingakumbi ulutsha alubavumeli bacwangcise ngesitofu okanye basebenzise ikhondom yabafazi kuba

bekholelwa ukuba ibenza babemanzi xa belele nabo. Kukholeleka ke ukuba amantombazana amaninzi athatha ezo zimvo engabuzanga kunesi, akhethe ukucwangcisa ngento ekhethwe nguye neqabane lakhe okanye angaqalisi nokucwangcisa oko.

Teenage pregnant women narrated that their partners, more especially the youth, do not allow them to use injection or female condoms as they believe that it makes them wet during sexual intercourse. It is believed that many girls succumb to advice by their male partner's choice of contraceptive or not use it at all.

Story 6: Idyasi kamkhwenyana emnqiwini (euphemism)

Kukholeleka ukuba xa amagosa ezempilo ebiza ikhondomu njengedyasi kamkhwenyana emayinxitywe ngumntu oyindoda xa ezibandakanya kwezesondo nenkosikazi yakhe, utata ubiza idyasi yakhe exhonywe emnqiwini anyinxibe phambi kokuba alale nenkosikazi yakhe. Loo nto yenza ukuba, ngokungaqondi eyona nto ibithethwa, inxalenye yabantu basezilalini, (ingakumbi abadala nabangafundanga) basahlonipha ukuthetha ngezinto zesondo, nto leyo eyenza namagosa asebenzise kwa ezo ndlela zifikeleleka kubo ngokuthetha, kanti ke bayalahlekisana ngeminye imiyalezo efana nalo, baqhubeke belala bengakhuselekanga kwizifo nokukhulelwa.

It is also believed that when health educators call a condom, 'an in-law's jacket', which the man must wear during sex, the men takes his real jacket as they did not clearly understand the message from the health educator who was simple trying to be euphemistic in her way of talking to them. So they mislead each other and continue to have unprotected sex.

The study therefore also revealed that using the storytelling approach has assisted to openly reveal the risks carried by euphemisms while it also created awareness about other common myths which maternal health educators have to address effectively. Because women were free to express themselves in the medium of folktales, existing euphemisms were in some cases transferred to real terms without fear of being labelled as rude, for example, rural women are known as afraid to call a spade a spade because of their cultural beliefs and respect for tradition.

Although the health system encourages health practitioners to speak openly about sexual organs and behaviours, rural women are perceived as less open and at times euphemistic to their health detriment. The study has revealed that, as a result of this knowledge, the rural health care practitioners fall into trap of not properly communicating the health messages for

fear of sounding rude and disrespecting the local oral culture. The popular story of the broomstick and the condom is evidence to this effect. Folktales, through their euphemistic language and reference to animals, have potential to close the cultural gap between the educators and the pregnant women; to prepare them to trust the educator, the environment and the information.

As women become closely involved in the narration, they recognise the resemblance between the acts of the characters in the folktales with themselves and unconsciously interact freely (Finnegan 1967: 67). In one of the clinics, the narration of a new story made the respondent-narrator angry at the idea of calling a condom 'the son-in-law's jacket' (idyasi kamkhwenyana) as evident from her story below:

There is no protection, they continue that way, she did not give him the real jacket...Because of our euphemistic tendencies, she (referring to the nurse) does not say, 'take, you must put your penis inside the condom.'(See Lesson B: conversational lesson with storytelling)

This was boldly said in isiXhosa, an utterance which could not have been said with such free and trusting spirit should the lesson have been presented under the usual formal circumstances. This further reveals that when educators employ a variety of teaching methods suitable for informal settings, women feel free to share information. As suggested by Churchill et al in Hunter (2008:12), stories can help the doctors and other health workers to prepare the ground for more complex discussions of women problems, hence Scheub (1975: 59) referred to folktale narration as integratedness.

Dederen (2012:86) further asserts that folktales foster some code of elementary morals which dominates both the communicative efforts of the narrators and the didactic purpose of the indigenous narratives. He further emphasises on folklore as part and parcel of what he calls an 'indigenous curriculum' of the wider process of enculturation. The euphemistic nature of the folktale language allows for mutual respect, trust and limits use of confrontational or blaming words while it reassembles a proper tone and an enabling environment for continuous interaction.

5.4 Summary

Chapter 5 presented and discussed findings according to the three study stages and objectives. Findings on the relevance of storytelling for MHE in PHC were presented and discussed in relation to the underlying values, goals and priorities for maternal health

education, namely MDG4&5. Professionalism, respect, commitment, collective responsibility, goal orientedness and the needs driven nature of MHE; were all presented as evidence for the relevance of storytelling as a teaching and learning strategy for PHC maternal health education lessons.

Further discussions on the importance of continuous MHE, awareness campaigns like CARMMA and SMSB, maternal health educator empowerment; priority themes, like teenage pregnancy, HIV/AIDS, breastfeeding, family planning, lifestyles and risks; were all presented and discussed in relation to the folktale integration. As a way of accounting for the introduction of storytelling in MHE, data on the stakeholder and participant perceptions on lessons without folktales and simultaneous use of folktales in lessons was presented and discussed.

Although storytelling in MHE still required further exploration, given the challenges pertaining to suitable environment, knowledge and skills to use folktales; resources and other undescribed barriers possible affecting effective delivery of MHE in the studied area; integration of folktales was perceived as relevant for MHE in rural PHC.

Chapter 5 revealed that folktales were perceived to provide a non-threatening environment which enable maternal health educators to raise awareness on a variety of health issues. While they also probe women to engage in discussions, particularly teenage pregnant women who were generally perceived as difficult to involve; folktales were also perceived as able to provide a meaningful participation which simultaneously assist to neutralise pregnancy-related anxieties. There are also perceived benefits for the health sector as folktales are an additional flexible resource which can be available through oral-written-printed form. Utilised effectively in the context, folktales have potential to increase oracy in women while they also provide holistic communication which enhances listening and understanding of maternal health message by pregnant women.

Lastly use of folktales has been found to be a way of revitalizing the culture of storytelling and sharing which undoubtedly benefits the euphemistic nature of women and health educators in rural PHC context.

CHAPTER 6

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

Chapter 5 discussed the study findings in relation to the data collected, presented and analysed in Chapter 4. The purpose of this chapter is to provide a summary in relation to the study objectives, the questions and the study assumptions. Study conclusions shall be drawn from the summary and recommendations based on the findings shall be presented as the last part of this chapter.

6.2 Summary of key ideas

This section summarises the major findings in relation to the study objectives and research questions. A summary of the findings on exploring relevance of adapting folktales (iintsomi) in maternal health education in the PHC; integrating folktales (iintsomi) in already existing maternal health education lessons; and evaluating perceptions regarding the integration of folktales(iintsomi) in selected maternal health education lessons.

6.2.1 The relevance of integrating folktales in Primary Health Care maternal lessons

The Primary Health Care system promulgates values that seek to ensure quality access to maternal health messages through action- orientated, community -oriented and collaborative approaches (Patterson at el 2011-2012, Pillay & Baron 2011, Bam et al 2013). Moreover the United Nations permanent forum on indigenous issues also called for integration of those issues into existing training opportunities in health care. These are messages emphasising that maternal health education is a collective intersectoral responsibility, hence the idea of oral storytelling in healthcare.

Firstly, Tones (1990:9) emphasised the importance of values rather than the learning theories. The PHC then prioritises on MDG 4 and MDG 5, thus to reduce child mortality and improve maternal health, hence the study revealing the maternal health education team commitment towards these ideals. To this effect, Pattison at el (2011-2012) identified a need for improving access to health messages by affected woman and additional skills for doers to improve ways of dealing with pregnant woman.

Through interviews and discussions, findings revealed a number of values such as; professionalism, respect, commitment, collective responsibility, goal oriented and needs-driven; all as underlying values for strengthening effective maternal health education,

although knowledge and understanding of folktales as a culturally appropriate way to empower women to contribute in their education was found to be lacking (Smyke 1991; Labonte 2007; Buchmann 2007; Moodley 2008-2010; Pattison 2011-2012)

Though maternal health education is understood as a collective responsibility the study revealed that the Community Health Workers were confirmed to be mainly responsible for health promotion, education and mobilisation at clinic and community level (Lehman 2007; Olver 2011). As it was also found that most training obtained by CHWs was on clinical themes and not on methodologies suitable for a PHC model and approaches (Pattison 2010-2011, Pillay & Baron 2011, Bam et al 2013), it was not surprising that the health educators had not been exposed to the use of traditional folktales in healthcare. From a contemporary perspective, the study therefore identified folktales as suitable for enabling the selected CHWs to exploit the universality, affordability, inter-educative, and the aesthetic nature of this oral traditional verbal art in adult teaching and learning context (Brown 1999; Kaschula 2001; Finnegan 2007)

6.2.2 Integrating folktales (*iintsomi*) in already existing maternal health education lessons

Currently health messages are described as ineffective and lacking diverse ways of empowering rural and young woman (Moodley 2008-2010:49). Most maternal health educators still rely heavily on the talk or lecture method as a dominant means of communicating. Day (2009) said “the real health literacy issue is not in the lack of information but rather the ability of the healthcare consumer to access and process the information”. Zarcadoolas (2006:65) also pointed out the nature of the relationship between health and cultural literacy, which the maternal health educators should consider as very important when delivering health messages to their audiences. As she quoted:

Awareness and skill in cultural literacy on the communicator’s part can help frame health information to accommodate powerful cultural understandings of health information, science, and individual collective action (Kreps& Kunimoto 1994)

An observation of the existing maternal health education lessons revealed a likelihood that the methods mostly used for teaching pregnant women have potential to compromise the patient’s cultural perspective, meaningful and understanding of health messages also because of the type of the learners they are. As Syx (2008:50-54) also emphasised the significance of the adult learning theory (Knowles 1980, 1984) in health education:

“With the exception of pediatrics, all patients are adult learners. The nurse must consider this in preparation of an education plan but must also consider the stress hospitalization and change may place on an individual...must also consider the learning environment ...must be keenly aware of how, why and when the patient best learns.”

The study also found that in most clinics, teenage pregnant women were viewed as displaying a negative attitude and behaviour towards lesson topics addressing, among other issues, multiple sex partners; unprotected sex; premarital sex; ignorance; late antenatal presentation; peer pressure, and so on. Saohatse (1998:1) once commented that, it is crucial that maternal health educators are made aware of the fact that the effectiveness of health messages also revolves around the quality of verbal communication which takes place between the health worker and the pregnant women. This means it is appropriate that health information for rural settings should be disseminated through culturally appropriate channels to change behaviour and strengthen family support systems (Smyke 1991:140).

Karlsen et al (2011:9) has also raised an important message to health practitioners, that, more attention should be given to the wider social determinants of health, including education, when devising strategies to reduce maternal mortality and to achieve the increasingly elusive MDG for maternal mortality. The varied levels of educational backgrounds of rural women receiving maternal health education lessons in PHC also count, thus, methods used should strive to accommodate all women. As also emphasised in the recent UNFPA study, Williamson et al (2013: viii) says that it is crucial that the maternal health educators become mindful of the diverse societal factors affecting teenage pregnant girls hence the need for multidimensional approaches to improve attitudes and behaviours towards health information. Therefore it is commendable that the maternal health education lessons took place in isiXhosa and Southern Sesotho in some clinics and the maternal waiting home but necessary to emphasise use of storytelling as a way to enhance strong intercultural relations among all those involved.

Although the study was focusing on observing what takes place in the class; create awareness on alternative methodologies and find out perceptions of stakeholders, the researcher also found it very encouraging that all the educators who participated in the study demonstrated preparedness to teach. As revealed in the study, regardless of their frustrations or challenges of space, inconsistencies for maternal health education delivery; lack of skills to use a variety of methodologies and resources, there was evidence of readiness by all educators involved to explore folktale integration in existing lessons, which

the researcher also considers as probing future research on several aspects affecting effectiveness of maternal health education in rural Primary Health Care.

6.2.3 Evaluating perceptions of folktales as an alternative medium in maternal health education in Primary Health Care

The study pursued a practical introduction of folktales in selected clinics and a maternal waiting home, reason being from a contemporary perspective, reminding society of its duty to re-awaken; re-image (Bukonya in Kaschula 2001:32, Brown 1999:1) oral tradition can be best achieved by also transporting them to new contexts; as a form of action or art reflection (Finnegan 2007:1).

The study considered that the nature of PHC is action oriented; hence the PPRs had to get the opportunity to act and reflect on their actions so that they could also contribute towards improving their own practices. Summary of the findings on their perceptions as collected from them as individuals, pairs and teams are as follows:-

- a) Folktales provide a non-threatening environment for teaching and learning;
- b) Folktales are helpful to raise awareness about maternal health issues;
- c) Folktales provide for meaningful participation;
- d) Folktales neutralise pregnancy-related anxieties;
- e) Folktales as oral-written-print resource for new health contexts;
- f) Folktales increase oracy for women in rural health care context;
- g) Folktales provide holistic communication;
- h) Folktales enhance listening and understanding of health messages;
- i) Folktales encourage storytelling and story sharing;
- j) Folktales build strong cultural relations and break euphemisms

6.3 Conclusions

The main aim of the study was to explore the role of storytelling (iintsomi) as an alternative medium for maternal health education in Primary Health Care. Through a collaborative ethnographic action research approach and use of semi-structured questionnaires, unstructured interviews, observation and focus group discussions, and 10 maternal health educators participated in the study. The management as custodians of maternal health education were also consulted, involved and evaluated on their perceptions of folktales as a teaching strategy for maternal health education. Views of volunteer pregnant women were also taken into consideration so as to inform the teaching and learning practices of the maternal health educators.

Theoretical perspectives on adult learning and teaching strategies and the storytelling as a form of intercultural communication were used as a basis for the study. As the Primary Health Care prioritises on collaborative participatory approaches which seek to enhance a better health for all, the study explored the extent to which folktales are relevant to be integrated in maternal health lessons. Perceptions and views of all participants were further evaluated. Data collection and analysis resulted in emergence of recurring themes throughout the study.

Regarding the relevance of storytelling (iintsomi) for maternal health education, it is imperative to note that the Primary Health Care system is built on the understanding that access to information is one of the crucial factors affecting clinical outcomes, thus, initiatives to assist in dissemination of health messages should be based on the understanding of the intended values, goals and expected effectiveness of service delivery. The information gathered from the management, the maternal health educators and the volunteer pregnant women it became apparent that although there was tremendous effort to educate pregnant women, particularly teenage pregnant women, about the risks of teenage pregnancy, stories, particularly iintsomi (folktales), were not widely explored as another way of encouraging participation during the lessons.

On the observation of maternal health education lessons currently taking place, the study found that the maternal health educators like their respective audiences; value health literacy but were also challenged by various other issues that impact on effective accessibility and delivery of health messages. Nonetheless, the methods of delivering these health messages were also found to be another reason contributing to lack of interest and participation by most teenage pregnant girls. A majority of the lessons observed indicated use of talking or lecturing, with very few lessons which integrate a more conversational approach which facilitates discussions and participation.

On introduction of folktales, the respondents understood the meaning of dealing with pregnant women as adult learners who can bring their cultural experiences and other stories which bear significance to the desired clinical outcomes for maternal health education in rural PHC context. As a result, folktales were generally perceived as another way which benefits both the maternal educators and the pregnant women towards improved delivery and accessibility of maternal health awareness information. The inter-seductiveness of folktales as performance, wisdom and information was juxtaposed to existing health literacy messages. Furthermore, as agents for health promotion in Primary Health Care, the maternal health educators were involved in an exercise of reflecting on their own teaching

capabilities; identifying gaps; and explore an affordable innovative idea of *iintsomi* in their lessons.

Whether continuous use of folktales in maternal health education lessons could reduce teenage pregnancy rates and maternal health risks simultaneously, would require monitoring and evaluation which can be attested by further research. This study has therefore established some ground on the contemporaneity of isiXhosa *iintsomi* and its relevance for maternal health education in rural Primary Health Care.

6.4 Recommendations

Given the action-oriented nature of the rural PHC context and an emphasis for action-oriented approaches to improve maternal health as stipulated in Moodley (2008-2010:309); its values and goals towards maternal and child health, storytelling (*iintsomi*) as an affordable enter-educative oral traditional art form is undoubtedly relevant as an alternative medium for maternal health education. In addition, the revitalisation of the PHC as affirmed by Dr Arom Motsoaledi in 2010, calls for 'pro-active household and community interventions' which seek to strengthen outreach teams also through community-oriented primary care. Recently, Bam et al (2013) also described another primary care model which the researcher considers as valuable opportunity for isiXhosa storytelling to be strengthened in rural Eastern Cape PHC context. In their description of the Community Oriented Primary Care (COPC) approach, which has been implemented as another approach to PHC re-engineering, Bam et al (2023:2) affirm that, "COPC is characterised by local specificity that derives from the behavioural, cultural and social characteristics of people who live in particular places... is grounded in the notion that people's health is determined by their social environment". As maternal health educators are faced with a challenge of ineffectiveness of maternal health messages, and high teenage pregnancy rate which renders mostly teenage girls at high risk; it is crucial that efforts to use diverse ways to approach pregnant women are implemented. For attitude and behavior change as well as a collaborative involvement of educators and women to discuss and share their maternal experiences; a variety of strategies to teach adult and teenage pregnant women must be employed.

As a socio-cultural tool of facilitating intercultural communication between the health workers and their patients, in this case the pregnant women receiving maternal health education lessons at clinics and maternal waiting homes; storytelling (*iintsomi*) is a viable readily available resource which can be exploited by the primary health context.

The study therefore recommends the following:-

1. Maternal health educators at clinic, community and hospital level must be encouraged to use storytelling in their health education lessons.
 - 1.1. The PHC outreach team also comprising of nurses and CHWs must recognise opportunity for storytelling to and by their audiences so as to find opportunity to capture more clinical information for the benefit of the doctors, who might not be fully conversant with the local language or context.
 - 1.2. When information is labeled for a particular gender or age, for example, introducing a topic like, “Teenage Pregnancy” immediately one starts a talk, those who think are not affected by that topic are likely to exclude themselves. Individual and groups of CHWs visiting communities for maternal health education must integrate storytelling, particularly folktales, as a way to approach men, women, boys and girls in a way that will promote accessibility of maternal health information by all, regardless of their gender.
 - 1.3. Maternal health educators must integrate storytelling in the language relevant to their area (isiXhosa or Sesotho) in their lesson preparation, thus to enrich their own lessons themes with some indigenous stimulus which will improve their resourcefulness as well.
2. All maternal health educators and relevant people dealing with health promotion and education in rural PHC context must receive adequate training on how to juxtapose selected folktales to their maternal health education themes.
 - 2.1. Storytelling, though a natural phenomenon, is talent and skill. Some people are good at narration while some require training on how to become a storyteller for the health context. People tell stories in their own way; there is no uniform way to tell stories as audiences and context differ. A database of potential storytellers for health is required.
 - 2.2. A short programme on raising awareness and a skills transfer on use of folktales for maternal health education is required as it can also result to a story resource bank which can be accessed by any educator who wishes to utilise a story as suitable for his or her own circumstances and goals for the priority themes.

3. Given the limitations posed by receiving maternal health education through the antenatal care visits, for example, time, space, standardization and schedule of lessons, decentralization of MHE for wider access), there is a need to:
 - 3.1. Strengthen, monitor and support maternal health educators, particularly the CHWs who mostly do not have any professional qualification background, as a way to co-ordinate some kind of an indigenous curriculum which translates to their social level while it highly responds to the communication needs of rural women, pregnant and not yet pregnant as well as the priority maternal health education goals. (MDG4&5)
 - 3.2. Extend maternal health education through storytelling to schools, community and other social gatherings where CHWs have a platform to educate girls, women, men, boys about maternal health related issues.
 - 3.3. The PHC must create an enabling environment for maternal health education lessons which shall also allow women visiting for antenatal care to have access to lessons integrating stories.

4. The UNFPA report on the Maternity Waiting Homes in the Eastern Cape (2011:18) recommended development of an education program with a variety of topics where Community Health Workers, health motivators and educators can be trained to support the education programme so as to avoid overburdening the midwives. This study further recommends that storytelling should be strengthened as an ongoing health literacy project for Maternal Waiting Homes as a majority of teenage pregnant women are accessible almost every month. Should there be a follow up study, it would be interesting to benchmark the number of teenage pregnancies admitted at the MWH against the implementation of future lessons integrating storytelling (iintsomi) as an alternative medium for maternal health education in the areas of study in rural PHC.

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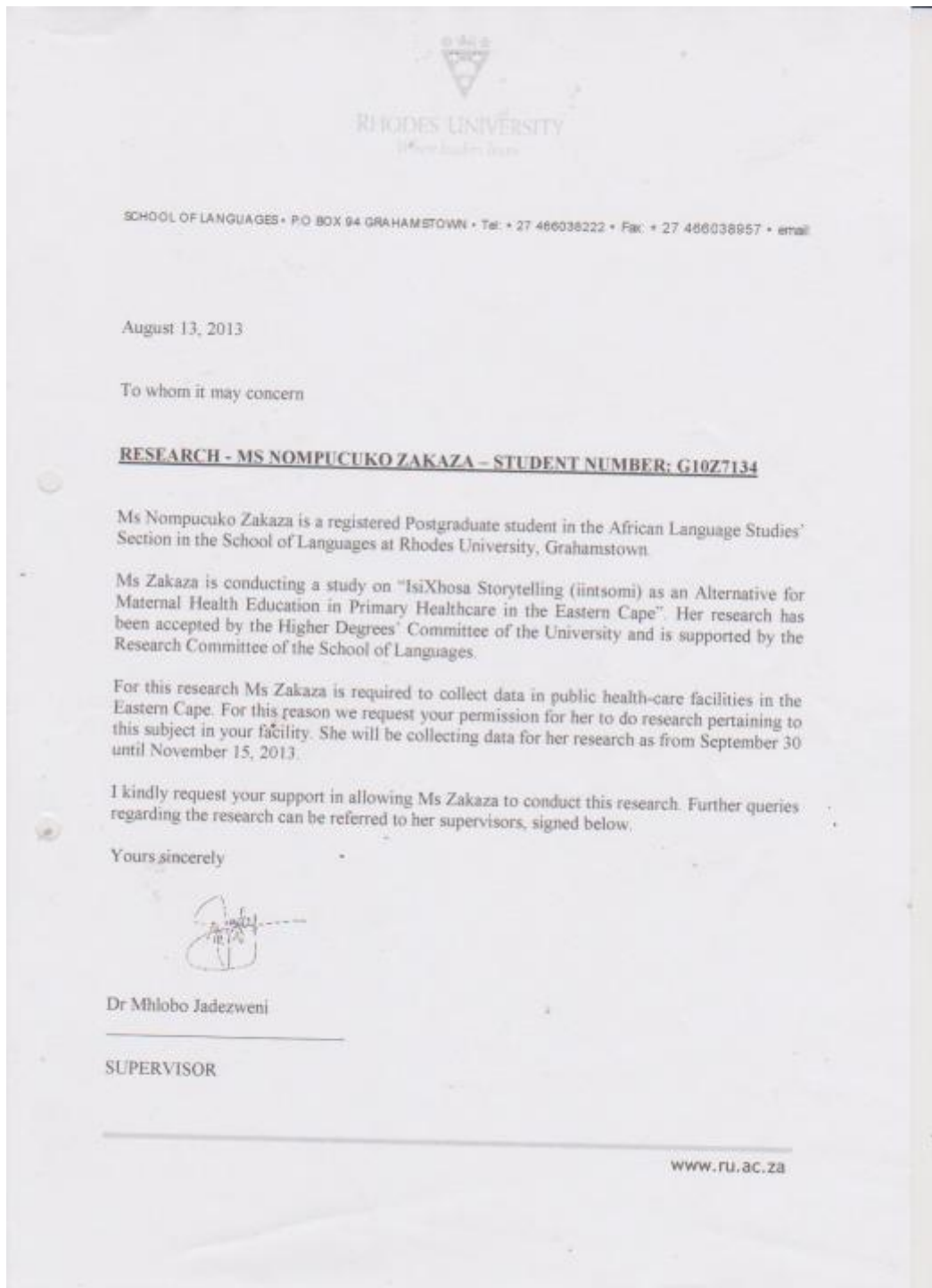
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Appendices

A: STUDY PERMISSION LETTERS

A1: Rhodes Study Permission Letter



A2: Researcher Request to conduct study

Dear Mrs Ndabula

12 September 2013

Cc: Dr Tim Wilson, Mrs Nyangintsimbi, Sub-District Manager, Manager: PHC (Community Services) Sub-District, Hospital Manager (Taylor Bequest), Manager: Maternal Education and CMO (Taylor Bequest).

1. Introduction

During the time I worked for Eastern Cape Rural Doctors Support Program (2011-2012) in your district, I interacted with a Literacy Project at Taylor Bequest Hospital Maternal Waiting Home. I further engaged with Mrs Nyangintsimbi on a storytelling project which was intended to assist Taylor Bequest to strengthen its intended literacy project at the rondavels. Although the ECRD Program came to an end in 2012, my interest in this project never ceased. I therefore carried it forward to my Masters studies through Rhodes University, a proposal which was approved recently. (*See attached letter*)

My proposal seeks to explore how isiXhosa storytelling (iintsomi) can be utilised as an alternative medium for maternal health education in Primary Healthcare in the Eastern Cape.

2. Motivation for study: Since engaging in the initial idea of strengthening a literacy project at Taylor Bequest Hospital, I learnt that my study is relevant to contribute in both systems strengthening and promotion of maternal and child health education which shall:-

1. Promote access to maternal health education by using community-based indigenous means which take into consideration the socio-cultural background of the pregnant teenage and adult women from the rural villages.
2. Promote additional maternal health education resources which can assist the Community Healthcare Worker to broaden their skills and knowledge in disseminating maternal health messages to rural pregnant teenagers and adult women at community, clinic and maternal waiting home level.

3. Objectives: I therefore request your permission to allow me, through this study to:-

1. *Explore* how isiXhosa stories can be adapted to maternal health education.
2. *Integrate* them in the already existing maternal health educator training.
3. *Evaluate* their effectiveness thereof.

4. Methodology: I further request the District to ethically allow me to:-

1. *Engage* with a selected group of Community Healthcare Workers from different clinics feeding the Taylor Bequest Maternal Waiting Home (at least 10 CHWs)
2. *Engage* with pregnant women at the Maternal Waiting Home (at least 15-20) mainly those who will be at the home between weeks 3 October- at least end October/beginning November 2013.
3. I shall through interviewing selected CHWs, conducting focus groups discussions with expectant mothers, observation of maternal health lessons, integrate stories in selected maternal health themes and evaluate the lessons: collect data, analyse it, and report on findings to the University by 2014.

5. Envisaged study benefits

I believe that when my study has been academically endorsed, it will be accessible to the district towards any further strengthening of the envisaged literacy project at hand and any other relevant *Re-engineering of Primary HealthCare* initiatives in your district (e.g. *increasing skills of CHWs in education and training of pregnant women, children and general community members about maternal health risks*). I will further feel that the study has contributed to promote examples of community participation in promotive and preventive health through integration of a still marginalised and underutilised literature (iintsomi) genre in maternal health education.

A request for permission to carry out the study has also been sent to the Provincial Department of Health (22/08/2013) (HoD & SMSB Directorate). Since your District has a background on this study, I will appreciate your assistance in motivating for my study permission request as well.

I trust that my request will meet your favourable consideration.

Nompucuko (known as Hluma) Zakaza Cell: 0839733042 **Email:** hluma.lisahluma@gmail.com

A3: Joe Gqabi District Permission Letter



Province of the
EASTERN CAPE
HEALTH

Joe Gqabi District Office, 32 Dan Pienaar Str. Private Bagingsown Eyodwa/Privaatsak X1005, Alwal North, 9750, SOUTH AFRICA

Tel. No.: 051 633 9603, Fax: 051 633 2665 Email: joegqabi@edc.gov.za

BATHO PELE: PEOPLE FIRST: ABANTU KUQALA

To : Ms N Zakaza

From : Joe Gqabi District Office

Date : 18 September 2013

Subject: APPROVAL FOR PERMISSION TO DO A STUDY RESEARCH

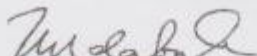
Dear Ms Zakaza

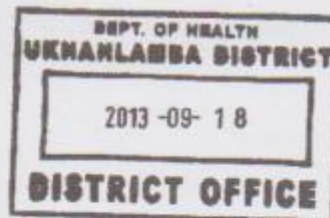
The office of the District Manager is writing this letter in response to your request dated the 12th September 2013.

You are hereby granted a permission to do your research at Taylor Bequest Hospital as requested.

This office is wishing you the best of luck in your study.

Yours sincerely


DISTRICT MANAGER



A4: Elundini Sub-District Permission Letter



Province of the
EASTERN CAPE
DEPARTMENT OF HEALTH

P/BAG X 1129 MOUNT FLETCHER 4770 TEL: 039 272400

TO: Ms N Zakaza/Rhodes University (Dr Jadezweni)
From: Elundini Sub-District
Date: 29 November 2013
Subject: APPROVAL FOR PERMISSION TO DO STUDY RESEARCH

Dear Ms Zakaza

The office of the Sub-District Manager is writing this letter in response to your request received on 25 November 2013. We also acknowledge receipt of the District Manager and Rhodes University permission letters.

You are hereby granted permission to do your research at Elundini Clinics as requested. You are therefore allowed to visit our PHC clinics for the duration of the study. We trust that your study shall abide by our departmental ethical standards as explained.

The following facilities have been identified to represent Elundini LSA for the purposes of your study project:-

Maclear: Sonwabile and Empilisweni; **Tsolo:** ^{Queen Ntzi} Ngxaza; **Qumbu:** Katkop and Hlankomo; **Mt Fletcher:** PHC, Mangolwaneng and Seqhobong

You are allowed to request at least one (1) volunteer **Community Health Worker** to be part of the project for the duration of your study. We apologise that we are understaffed and cannot afford to engage more personnel in the project. Our office shall request targeted PHC facility managers to provide you access to the targeted personnel. As discussed with you, though we have mutual interest in this project as the department, individual maternal health workers cannot be forced by management to be part of your study. We trust that they will find it interesting and willingly offer themselves as participants.

This office is wishing you the best of luck in your study and thank you for bringing the project to our Sub-district. We trust that it will add value to our systems strengthening and the skills enhancement of the targeted health workers. You are further allowed to request any further information required to validate your study from our offices.

Lastly, as this sub-district, we are interested in the findings and recommendations of the study and therefore shall be requesting your institution to consider feedback/access to the entire final products for our records and a possible use of any relevant outcomes/products which are a result of this project.

Yours Sincerely


Mrs G.N. Makalima

Witness: Mrs Bikitsha


G.N. MAKALIMA
LSA MANAGER
ELUNDINI LSA
SUB-DISTRICT MANAGER


SUB-DISTRICT OUTREACH MANAGER

A4: Taylor Bequest study permission letter

 Province of the
EASTERN CAPE
DEPARTMENT OF HEALTH

Taylor Bequest Hospital, P/Bag X 1120 TEL: 039 2570043

TO: Ms N Zakaza/Rhodes University (Dr Jabezweni)

From: TAYLOR BEQUEST HOSPITAL

Date: 04 December 2013

Subject: APPROVAL OF REQUEST TO DO STUDY RESEARCH AT TAYLOR BEQUEST

We acknowledge receipt from our District office (re: Ms Ndabula's letter dated 18 September 2013) of your request to conduct study at our institution. On behalf of the Taylor Bequest Hospital Management, we thank you for your further presentation of the study and wish to welcome you in our hospital, particularly for our on-going maternal health education campaign.

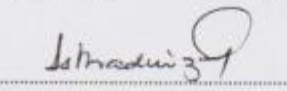
We allow you to work with at least two (2) Nursing Assistants and access to the Maternal Waiting Home for the duration of your study. The maternity management and staff are ready to support the project as discussed. Kindly consult the maternity ward for any further information you shall need to validate your study (i.e. statistics on frequency of teenage pregnant admissions at the waiting home, health education records, and challenges, etc.) We trust that the study shall abide by our departmental ethical standards at all times.

Lastly, we are interested in the findings and recommendations of the study and therefore requesting your institution to consider feedback/access to the entire final products for our records and further improvement to our practices.

We look forward to work with you.

Yours faithfully

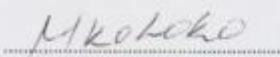
Mrs S. Madikizela



.....

HOSPITAL MANAGER

Witness: Mrs MM Koloko



.....

OPERATIONS MANAGER

TAYLOR BEQUEST
HOSPITAL
Province of the Eastern Cape
M. F. 1120
P. Bag X 1120

Date: 04/12/2013

B: Consent Form

UXWEBHU LWENGCACISO NEFOMU YOKUNIKA IMVUME

ISIHLOKO SOPHANDO

Iintsomi zesiXhosa njengandlela yimbi enokuncedisa ekufundisweni kwabafazi abakhulelweyo

ICANDELO 1: IINKCUKACHA NGOMPHANDI

| | |
|--|--|
| Umphandi oyintloko: | Nompucuko Hluma Zakaza |
| Idilesi afumaneka kuyo: | 435 Street Kei Road 4920 |
| Iinkcukacha zoqhagamshelwano | hluma.lisahluma@gmail.com 0839733042 |
| I-emeyile: | |
| IYunivesithi esingethe isifundo sophando: | Rhodes University, Grahamstown |
| Inombolo yomfundi oyintloko yophando: | G10z7134 |
| Umphononongi wesifundo sophando: | Dr M. Jadezwi |
| Idilesi afumaneka kuyo: | African Language Studies, Rhodes University, Grahamstown 6140 |
| Iinkcukacha zoqhagamshelwano | m.jadezwi@ru.ac.za 046 - 6037591 |

.....

| | |
|----------------------------------|---|
| Isithili esichongiweyo: | Joe Gqabi District, Elundini |
| Abaphathi abanike imvume: | Mrs Nobahle Ndabula (Umphathi- Sithili) |

Mrs Queen Nyangintsimbi (Umphathi wenkqubo yeSaving Mothers Saving Babies) Mrs Makalima (Umphathi kuSinga-Sithili i-Elundini)

| | |
|--------------------------------------|--|
| Iinkcukacha zoqhagamshelwano: | nobahle.ndabula@impilo.ecprov.gov.za |
|--------------------------------------|--|

.....

NdinguNompucuko Zakaza (okwaziwa ngelikaHluma), umfundi weMasters eYunivesithi yaseRhodes eRhini. Ndicela uzibandakanye nesifundo sophando lwam olusihloko sithi:

lintsomi zesiXhosa njengeny indlela enokuncedisa ekufundisweni kwabafazi abakhulelweyo kwiPrimary Health Care eMpuma Koloni.

Usenganemibuzo enjengale ilandelayo ngokuqondene nesi sicelo sam:-

1. Ndikhethwe kanjani?
2. Kulindeleke ntoni kum?
3. Ndinyanzelekile ndithabathe inxaxheba kwesi sifundo?
4. Ingaba kukho bungozi ekuthatheni inxaxheba kwesi sifundo?
5. Ingaba ndingenza ntoni xa kuvele ingxaki?

ICANDELO 2: limpendulo zemibuzo yakho

1. Ndikhethwe kanjani?

Ukhethe ngenjongo ukuba ube ngomnye wabathatha inxaxheba kuba usuka kwenye yeendawo ezinoxanduva lokuSindisa uMama uSindise uMntwana (Saving Mothers Saving Babies Program) Kwakhona kucingeleka ukuba unoxanduva lokufundisa abafazi abakhulelweyo ngezizathu ezahlukeneyo zokukhulelwa kwabo, ngemingcipheko ehambelana nokukhulelwa kwabo kunye nangempilo yabo iphela.

2. Kulindeleke ntoni kum?

Ukuthatha kwakho inxaxheba kwesi sifundo sophando luya kuba ngohlobo lokuphendula imibuzo yophando; uthathe inxaxheba kwisifundo esibukelwe ngumphandilwazi oyintloko; eqokolela namanye amanqaku ngeengxoxo nakwiqela elihlalele isifundo sakho, esebenzisa irhekhoda ethatha amazwi kunye nemifanekiso yenkqubo yokufundiswa kwabafazi abakhulelweyo, kunye nokuvakalisa izimvo zakho ngokusetyenziswa kweentsomi zesiXhosa kwezo zihloko ufundisa ngazo omama abakhulelweyo kwindawo echongelwe ukwenza oko.

Umfundi ongumphandilwazi oyintloko uza kuhlala nawe iiveki ezintathu kusenziwa lo msebenzi. Ingcaciso ezeleyo malunga namaxesha okuphendula imibuzo, ukwenza isifundo esibukelweyo, nokunika izimvo zakho ngesi sifundo sophando iyakufumaneka ngokucacileyo kumphandi oyintloko. Iziphumo zophando ziya kuyakufumaneka ngokupapashwa kwamanqaku ophando ngokwesicwangciso seYunivesithi yaseRhodes.

3. Ndinyanzelekile ndithabathe inxaxheba kwesi sifundo?

Ukuthatha kwakho inxaxheba kwesi sifundo sophando kokuzithandela, nto leyo ithetha ukuba awunyanzelekanga ukuba uthathe inxaxheba. Ukuba uyavuma ukuthatha inxaxheba, ukhululekile ukuba ungarhoxa kwesi sifundo sophando nanini na. Uvumelekile ukuba ubuze yonke imibuzo onayo phambi kokuzibandakanya nesi sifundo. Ukwavumelekile ukubuza

nokucebisa xa kukho into ongayiqondi kakuhle ngalo lonke ixesha uzibandakanye nesi sifundo sophando de luqosheliswe ngokwesivumelwano.

4. Ingaba kukho bungozi ekuthatheni inxaxheba kwesi sifundo?

Esi sifundo sophando asiyi kukulimaza ngokwasemzimbeni. Ungakhetha ukuba iinkcukacha zakho zobuqu zigcinwe ziyimfihlo kwiingxoxo neziphumo zophando. Oku kuthetha ukuba xa uthe wakhetha ukungaziwa, akukho mntu uya kukwazi ungubani nokuba uyinxalenye yolu phando. Iinkcukacha zakho zobuqu zingabonwa ndim: mna mphandi, okwangumhlalutyi weenkcukacha zophando kunye nabahloli besifundo sophando. Kodwa ke ukuba ungathanda ukwaziwa, iinkcukacha zakho zobuqu ziya kwazisa kwiingxoxo neziphumo zophando.

5. Ndiza kufumana ntoni ngokuthatha inxaxheba kwesi sifundo sophando?

Awuyi kufumana nto wena buqu ngokuthatha inxaxheba kolu phando. Kodwa, iziphumo zalo ziya kuba luncedo kwabo banomdla kufundo nzulu malunga nendima edlalwa ziintsomi zesiXhosa ekufundisweni kwabafazi abakhulelweyo ngempilo yabo. ISebe lezeMpilo lingabona ithuba lokuqwalasela iziphumo zesofundo sophando ngendlela enokuba negalelo kwiindlela ngendlela ekunokuqiniswa ukufundiswa kwabafazi abakhulelweyo ngempilo yabo.

6. Ingaba ndingenza ntoni xa kuvele ingxaki?

- Unganxibelelana nabaphandi kule nombolo: 0839733042
- Unganxibelelana ngqo momhloli wesifundo ku-046 - 6037591 ukuba unesinto ezingakonelisiyo okanye izikhalazo ezingaqwalaselwanga ngokwanelisayo ngumphandi oyintloko.
- Uza kunikwa ikopi yale ngcaciso nefomu leyo utyikitye isivumelwano sokuthatha inxaxheba ukuze ube nobungqina obuphathekayo nawe.
- Uya kwaziswa ukuba kubekho iinguqu kwinkqubo yophando.

Ukuthatha kwakho inxaxheba kuya kuba lulutho kumphandilwazi, kwiziko lakho kunye neziko endiphantsi kwalo.

Maz'enethole!

Ozithobileyo



Nompucuko Hluma Zakaza

ICANDELO 3: Ukuqinisekisa komthathi-nxaxheba

Ngokutyikitya apha ngezantsi mna,ndiyavuma ukuthatha inxaxheba kwisifundo sophando phantsi kwesihloko “*Iintsomi zesiXhosa njengandlela yimbi enokuncedisa ekufundisweni kwabafazi abakhulelweyo kwiPrimary Health Care eMpuma Koloni*”

Ndiyaqinisekisa ukuba:

- Ndizicaciselwe ngolwimi endiluqonda ngokupheleleyo injongo nenkqubo eza kulandelwa kwesi sifundo sophando.
- Ndazisiwe ukuba ukuthatha kwam inxaxheba kwesi sifundo sophando kokokuzithandela kwaye ndikhululekile ukuba ndingarhoxa kolu phando nanini na.
- Ndiyayiqonda yonke into endiyicaciselweyo yaye ndiyavuma ukuba iinkcukacha zam zasiswe / andivumi ukuba iinkcukacha zam zasiswe. (*Nceda ucime/ukrwelele loo nto ungayikhethanga.*)

| | | |
|-----------------------------------|------------------|--------------|
| _____ / _____ / _____ | | |
| <i>Igama lomthathi-nxaxheba</i> | <i>Utyikityo</i> | <i>Umhla</i> |
| _____ / _____ / _____ | | |
| <i>Inggina lomthathi-nxaxheba</i> | <i>Utyikityo</i> | <i>Umhla</i> |

Ukuqinisekisa komphandilwazi oyintloko

Mnandiyaqinisekisa ukuba:

- Ndiyicacisile yonke into ekolu xwebhu ku.....
- Ndimkhuthazile ukuba abuze imibuzo ndathatha ixesha elaneleyo ndiyiphendula.
- Ndiyaneliseka ukuba uyiqonda yonke into malunga nesi sifundo sophando njengoko kucacisiwe apha ngasentla.

| | | |
|---|------------------|--------------|
| _____ / _____ / _____ | | |
| <i>Igama lomphandilwazi oyintloko</i> | <i>Utyikityo</i> | <i>Umhla</i> |
| _____ / _____ / _____ | | |
| <i>Inggina lomphandilwazi oyintloko</i> | <i>Utyikityo</i> | <i>Umhla</i> |

Sityikitywe e (indawo).....ngomhla.....2013

C. PREPARATION TOOLS FOR PARTICIPANTS

C1: WELCOMING LETTER TO PARTICIPANTS

Wamkelekile kwesi sifundo-projekthi sokufundiswa kwabafazi abakhulelweyo kusetyenziswa amabali! Ndiyabulela ngokuba uvume ukuba yinxalenye yale nkqubo yokwenza siphanda!

Injongo ephambili kukuzibhenca ukuba singalungisa phi siqinise phi na!

Eyona nto ke siyifunayo kukuqonda ukuba ingaba xa sinokukhe sisebenzise **iintsomi sesiXhosa** apha ekufundiseni abafazi abakhulelweyo njengenye indlela yokwengeza kwezikhoyo kungasancedisa njani.

Makhe sizameni: sibone yozala nkomo ni na!

C2: INKQUBO EZA KULANDELWA LUPPHANDO-SIFUNDO: UKUNCEDA ABATHATHI-NXAXHEBA

| Iindlela ezizakusetyenzi swa ngumphandi ukuqokelela amanqaku ophando | Izinto ezizakwenziwa ngumphandi nababandakanyekayo. | Stage 1: Iveki yokuqala Amalungiselelo | Stage 2: Iveki yesibini Utyelelo kwizifundo | Stage 3: Iveki yesithathu Izimvo ngokuqhubekileyo | Igqityiwe/ayigqitywanga |
|---|--|---|---|---|--------------------------------|
| Umphandi ubukela izifundo | Uyabukela, abhale into ayibonayo eqondene nesifundo ngasinye esifundiswe nguCHW | Amalungiselelo phambi kokuqala kwezifundo | Izifundo ziyaqhubeka ku | | |
| Iingxoxo zeqela | Iingxoxo yokuqala neCHW | Phambi kokuba kuqalwe ukubukelwa izifundo zabo | | Emva kotyelelelo kubo bonke abo bebefundisa | |
| Imibuzo (yomlomo) Imifanekiso (emileyo neshukumayo) | Abafazi abakhulelweyo abafumanekayo nabavumayo ukubuzwa Abaphathi benkqubo yokufundiswa kwabafazi abakhulelweyo (abo bakulungeleyo ukubuzwa ngomlomo) Bonke ooCHW abathatha inxaxheba kuphandolwazi abakulungeleyo ukubuzwa ngomlomo kuthathwa nomfanekiso ngemvume yabo | Phambi kokuba kuqalwe uhambo lokuya apho bafundiselwa khona Phambi kokuqalwa kophando | Emva kwesifundo ngasinye xa befumaneka nexesha livuma.... Emva kwesifundo ngasinye xa ixesha nemeko yakhe ivuma | Emva kokugqitywa kwenkqubo (umphathi obeyinxalenye yeengxoxo kuphela) Iqela lonke elikwazileyo ukuphendula ngale indlela | |
| Imibuzo (ebhaliweyo) | Abaphathi abakwaziyo ukuphendula imibuzo ebhaliweyo Bonke ooCHW ebebethatha | Kwindibano youkuqala | Emva kokufundisa | Emva kokuba bebukele | |

| | | | | | |
|--|---|--|-----------|--------------------------------|--|
| | inxaxheba baphendule kwiincwadana ebezinemibizo | | bebukelwe | iintsomi kwizifundo zabo | |
|--|---|--|-----------|--------------------------------|--|

D: DATA COLLECTION TOOLS

D1: Meeting and Discussion with Maternal Health Managers

Mholo Mama/Tata

Igama lam ndinguNompucuko Zakaza, okwaziwa ngelikaHluma. Ndihlala eQonce, kumhlaba waseMthonjeni eKei Road. Ndiyinzalelwane yaseTsomo kwilali yaseNqolosa.

Ndingumfundi waseRhodes University eRhini. Ndilapha njengoko besikhe sathetha kancinci emnxebeni. Injongo yale ndibano yethu yanamhlanje kukuza kucela imvume yakho yokuba ndisebenze nabo bachongwe ngendlela esiya kuvumelana ngayo ukuba babe yinxalenye yophando olufutshane malunga nendlela ekufundiswa abafazi abakhulelweyo ngempilo yabo. (Onke amaphepha-mvume agqithiswe.)

Ndinganikela kuwe ke nawe uzichaze. (Igama ungalichazi ukuba awuthandi, uxele nje indima oyidlalayo wena apha kwiicandelo leMaternal Health Education & Saving Mothers Saving Babies)

Ingaba ukhona umbuzo onawo kwesi sithuba? Ewe/Hayi

Ndingathanda ukubuza nje imibuzo embalwa malunga nokufundiswa kwabafazi abakhulelweyo apha kule ngingqi yakho. Ndiyathemba ayinakukhathaza loo nto.

1. Bafundiswa ngoobani abafazi abakhulelweyo?
2. Bafundiselwa phi abafazi abakhulelweyo?
3. Ziziphi ezona njongo ziphambili ekufundisweni kwabo?
4. Ziziphi izihloko ekugxininiswa kuzo? Bala nje zibe (4)
5. Ingaba wanelisekile liqondo lokufundiswa kwabafazi abakhulelweyo? Ewe/Hayi (Cacisa)
6. Yintoni enye ocinga ukuba ungayitshintsha kwindlela ekufundiswa ngayo abafazi abakhulelweyo?
7. Ingaba zikhe zibaliswe iintsomi okanye amabali xa kufundiswa abafazi abakhulelweyo kwingingqi yakho? Ewe/Hayi (Cacisa)
8. Ungathanda khe kusetyenziswe iintsomi zesiXhosa kwisifundo sabafazi abakhulelweyo kwixesha elizayo? Ewe/ Hayi (Cacisa)

Ndiyabulela ngexesha lakho lokuphendula le mibuzo nokundivumela ndize kwenza esi sifundo sethutyana.

.....

Uyandivumela ndithathe imifanekiso, ndisebenzise irekhoda kunye nomfanekiso oshukumayo xa ndibukele izifundo eklinikhi/emaronteni njalo-njalo? Ewe/Hayi

Singatyikitya esi sivumelwano sexeshana sentsebenziswano. Nawe uza kufumana eyakho ikopi. Ndiyaqinisekisa ukuba konke esikuxoxe apha kukhuselekile kwaye zonke iziphumo, imifanekiso njalo-njalo; azinakusetyenziselwa njongo zingezinye ngaphandle kolu phando.

Utyikityo lwakho:.....Utyikityo lomphandilwazi oyintloko.....Umhla:.....

D 2: INDIBANO-NGXOXO YOKUQALA (First Focus Group Discussion Meeting)

Q1: Nibafundisa ngantoni abantu enihlangana nabo, ingakumbi abafazi abakhulelweyo?

Q2: Xa ndicela ukuya kubukela isifundo ungakwazi ukufundisa ndikubukele?

Q3: Nibafundisa kanjani ke xa sele beseklinikhi?

Kulungile ke makhe sithethe ngokufundisa oku...

Q4: Nisebenzisa ntoni, nifundisa kanjani xa niceba ukufundisa abafazi abakhulelweyo?

Q5: (Ephamisa ipamphlet) niyayazi le?

Q6: Senivile ngeClinical Supervisor ukuba ndinqwenel ukusebenza nani before ndiye ekrismesini neh?

Q7: Niyazazi iintsomi?

Q8: Nikhe nizisebenzise iintsomi xa nifundisa?

Q9: Ningathanda ukukhe nizibone xa zisetyenziswa kwixesha elilandelayo kufundiswa abafazi abakhulelweyo?

D3: INCOKO PHAKATHI KWE (PPR) NOMFAZI OKHULELWEYO

ISIHLOKO: INGABA BAZIVA NJANI NGENDLELA ESIBAFUNDISA NGAYO EKLINIKHI/EMARONTENI

Izinto ocetyiswa ukuba uzenze ixeshana uncokola naye:-

- ✓ Zazise naye azazise (igama lakhe usengangalichazi xa engafuni, iminyaka, uklinikha phi? imfundo yakhe, utshatile okanye akatshatanga ibalulekile xa ukwazi ukuyifumana loo nto)
- ✓ Xela ukuba kutheni unomdla wokuncokola naye
- ✓ Mqinisekise ukuba incoko yethu ikhuselekile
- ✓ Mbulele ngexesha lakhe xa nigqiba

QALISA KE UBUZE MALUNGA NOKU KULANDELAYO

1. Buza ukuba ebekhe wafundiswa ngempilo yokukhulelwa?

2. Ebefundiselwa phi? Khetha indawo: eklinikhi/ekhaya/esikolweni/ekuhlaleni
3. Zeziphi izihloko asazikhumbulayo, uyibona njani le nkqubo yokufundiswa kwabo, imncede kanjani /okanye ayimncedi kanjani indlela afundiswa ngayo ngunesi /okanye unomakhaya. Uyayithanda/akayithandi(acacise)
4. Unqwenela ukufundiswa kanjani, ingamnceda njani loo ndlela ayicebisayo yena nabanye abakhulelweyo/nabangekakhulelwa, (abasekuhlaleni okanye abasezikolweni)
5. Ubukhe wabaliselwa ibali okanye intsomi ngexa ufundiswa ngempilo yokukhulelwa kwakho eklinikhi? Ewe/Hayi

D4: IMIBUZO YAPHAMBI KOKUSETYENZISWA KWEENTSOMI (PRE-STORYTELLING)

1. Nika isihloko sesifundo obusifundisa (ngamagama ambalwa bhala ezona zinto ziphambili kwesi sifundo).
2. Uziva njani emva kwesi sifundo sakho ubusifundisa namhlanje?
6. Wanelisekile yile ndlela ubafundise ngayo? Ewe/Hayi (Cacisa)
7. Zeziphi iimpawu oziqapheleyo kubafundi bakho ebezibonisa ukuba banomdla kwisifundo sakho? Bhala zibe (4)
8. Zeziphi iimpawu oziqapheleyo kubafundi bakho ebezibonisa ukuba bebengenamdla kwisifundo sakho? Bhala zibe (4)
9. Yintoni enye ocinga ukuba ungayitshintsha kwindlela ofundisa ngayo oomama abakhulelweyo?
10. Ingaba indlela obufundisa ngayo yenze ukuba bathathe inxaxheba bonke abafundi bakho? Ewe/Hayi (Cacisa)
11. Wakha wayibalisa intsomi xa ufundisa abafazi abakhulelweyo? Ewe/Hayi(Cacisa)
12. Ungathanda ukukhe uyibone xa intsomi yesiXhosa isetyenziswa kwisifundo sakho kwixesha elizayo? Ewe/ Hayi (Cacisa)
13. Nika imizekelo ibe mibini yeentsomi ozaziyo nendlela ocinga zizalana ngayo nezifundo ofundisa ngazo abafazi abakhulwweyo. Kusenokwenzeka ukuba awunayo eminye imizekelo oyaziyo, kwamkelekile ukubhala andazi/andiqinisekanga/andinayo.

Ukuba ikhona enye into onqwenela ukuphawula ngayo malunga nendlela ofundisa ngayo oomama abakhulelweyo, ocinga ukuba ibalulekile kolu phando uvumelekile ukuyithetha/ukuyibhala apha ngezantsi.

D5: (Post-storytelling Questions) NDIQAPHELE NTONI NGEXA EFUNDISA UGXA WAM

1. Nika isihloko sesifundo obusibukele (ngamagama ambalwa bhala ezona zinto ziphambili kwesi sifundo)
2. Uziva njani xa ubukele omnye umntu efundisa namhlanje?
3. Wanelisekile yile ndlela afundise ngayo? Ewe/Hayi (Cacisa)
4. Zeziphi iimpawu oziqapheleyo kubafazi abakhulelweyo ngexa bebephulaphule esi sifundo (ebezibonisa ukuba banomdla kwisifundo)? Bhala zibe (4)

5. Zeziphi iimpawu oziqapheleyo kubafazi abakhulelweyo (ebezibonisa ukuba bebengenamdla kwisifundo)? Bhala zibe (4)
6. Yintoni enye ocinga ukuba ibingatshintshwa/iphuculwe kwindlela ebefundisa ngayo abafazi abakhulelweyo ugxa wakho namhlanje?
7. Uyithande njani iintsomi yesiXhosa njengoko uyibonile ibaliswa esifundweni sanamhlanje?
8. Ucinga ungakwazi/awungekwazi ukukhe uyisebenzise nawe iintsomi kwisifundo sakho sexesha elizayo? Ewe/ Hayi (Cacisa)
9. Ukuba ikhona enye into onqwenela ukuyiphawula/uyibuze malunga nokusetyenziswa kweentsomi ekufundisweni kwabafazi abakhulelweyo namhlanje, nocinga ukuba ibalulekile kolu phando lwethu, uvumelekile ukuyithetha.

D6: Final Focus Group Discussion Questions

1. Ingaba niyibone njani yonke le nto besiyenza kwiveki edlulileyo? *What is your perception of what we were doing in the previous week?*
2. Bathini abafazi abakhulelweyo (aba benibafundisa kule veki) ngendlela enibafundise ngayo? *What are the perceptions of pregnant women on how we have taught them?*
3. Nibone kusenzeka ntoni xa nidibanise izifundo zenu neentsomi? *What did you observe when folktales were integrated in your lessons?*

Additional questions for the moderator-observer:-

4. Ingaba uve ntoni kule ngxoxo malunga nolu hambo besikulo lokufundisa abafazi abakhulelweyo?
5. Ubona kungenziwa ntoni ukuxhasa abanoxanduva lokufundisa abafazi abakhulelweyo ukuze bakukhuthalele ukusebenzisa amabali neentsomi xa befundisa?
6. Ungashwankathela ngelithini malunga nokusetyenziswa kweentsomi namanye amabali ekufundiseni abafazi abakhulelweyo?

E: Lesson Preparation Brochures

Resource 1

AS A FOLLOW UP TO CARMMA, UNFPA IS...

- ...supporting government-run Maternity Waiting Homes in a bid to bring healthcare closer to pregnant mothers. These are residential facilities located within hospital premises for pregnant women who live far from health service points.
- Many of the women who use these services live in deep rural areas and cannot access maternity services easily or cheaply. With the support of UNFPA, the Eastern Cape Department of Health will be expanding the services offered by existing Maternity Waiting Homes in order to reach and ensure that more pregnant mothers and their babies survive childbirth.

"I stay so far from this hospital, and in my village we do not have transport. I am happy I came here when I was still able to walk to the nearest bus stop. I did not pay a lot money to get here, and look I have delivered my little boy without any problems."

A mother who had delivered at a Maternity Waiting Home in the Eastern Cape.

THE NEXT STEPS FOR CARMMA ARE TO...

- ...implement the CARMMA operational plan, which includes the following:
 - Establish a Task Team to monitor CARMMA;
 - Implement the 5-point Contraceptive Strategy;
 - Train health workers in Essential Steps in Management of Obstetric Emergencies and allocate obstetric ambulances to every facility with a maternity unit;
 - Provide further support for existing Maternity Waiting Homes in the Eastern Cape;
 - Provide accommodation for breastfeeding mothers whose children are admitted to health facilities;
 - Improve referral mechanisms and sensitize communities on ante- and post-natal care as well as prevention of

mother-to-child transmission of HIV (PMTCT).

- Promote Kangaroo Mother Care, a method of care for preterm babies, improve the coverage of immunization and Vitamin A supplementation, and strengthen Integrated Management of Childhood illness;
- Improve access to treatment for mothers and children with HIV, manage co-infections, intensify PMTCT and provide information on contraception and condom use during pregnancy.



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NO WOMAN SHOULD DIE GIVING LIFE

The Campaign on Accelerated Reduction of Maternal and Child Mortality (CARMMA) in South Africa



CARMMA IS...

an initiative by the African Union and UNFPA to curb Africa's high maternal and child death rates. It was launched during the African Union Conference of Ministers of Health in May 2009 in Ethiopia. The campaign swiftly spread across the continent, with national launches taking place in 38 countries between 2009 and early 2012.

South Africa is the latest country to join this widespread initiative. It launched CARMMA on 4 May 2012 under the theme *South Africa Cares: No Woman Should Die While Giving Life*. The campaign will help South Africa accelerate existing strategies and programmes to improve maternal, neonatal and child health and survival.

Many African countries will not be able to meet the Millennium Development Goal (MDG) 5 on reducing maternal mortality and MDG 4 on lowering under-five mortality if efforts are not redoubled. CARMMA therefore calls for intensified implementation of the Maputo Plan of Action to improve sexual and reproductive health and save the lives of mothers, babies and young children.

Although maternal survival is CARMMA's main focus, the campaign also includes child survival because of the impact a mother's death has on her children and family. Children who lose their mothers are up to 10 times more likely to die within two years of their mother's death than those whose mothers are alive.

CARMMA is designed to be nationally driven and owned. It enjoys strong support and partnership from several United Nations bodies, bilateral interests, foundations and non-governmental organizations, and they support governments in implementing post-launch action plans.

"It is important to note that maternal mortality is not just the death of a woman - it is the death of a woman because she dared to fall pregnant!"

Dr. Aunso Mabuza, South African Minister of Health

CARMMA MATTERS FOR SOUTH AFRICA BECAUSE...

maternal and child mortality rates are unacceptably high in the country. One out of every 322 South African women does not survive pregnancy or childbirth and one in 25 babies dies before his or her first birthday. The tragedy is that most causes of death are preventable.

In fact, 40 percent of maternal deaths could be avoided with better quality and timelier healthcare in hospitals, clinics and communities. For example, haemorrhage during or after a caesarean section is emerging as a major avoidable factor. This points to the urgent need of addressing knowledge and skills in managing obstetric emergencies.

South Africa mirrors the continental trend of slow progress towards MDG 5, and maternal mortality is on the rise.

IN SOUTH AFRICA CARMMA AIMS TO...

speed up progress in reducing maternal and child illness and death by accelerating the implementation of healthcare and other services proven to improve maternal health and child survival.

CARMMA WILL ENSURE THAT WOMEN AND CHILDREN:

- Have better access to comprehensive sexual and reproductive health services, with a specific focus on family planning services.
- Go for early antenatal care within the first twelve weeks of pregnancy.
- Have improved quality of care during and after childbirth.
- Benefit from strengthened human resources for maternal and child health.
- Have access to high impact interventions that improve child survival.
- Benefit from intensified management of HIV and AIDS.

Why are mothers and children dying in South Africa?

The top five causes of maternal death:



The major causes of child death:



Resource 2

death is a significant step towards poverty eradication. Strategies to reduce maternal death and disability strengthen health systems to the benefit of all. Maternal health indicators are used to gauge health system performance in terms of access, gender equity and institutional efficiency. Investing in maternal health holds the promise of improving overall health service delivery.

WHAT MUST BE DONE?

Efforts to prevent maternal deaths require political and financial commitment. They also require a broad range of partners: men as well as women, international organizations, governments, civil society and the media need to be involved.

In the required long-term and targeted efforts, these should include:

- Access to contraception and sexual health and reproductive rights counseling for both men and women.
- More structured and improved services targeting pregnant women and those in labour, whether in villages, clinics or district hospitals. This includes access to transportation, facilities and skilled personnel.
- Strategies to address lack of personnel and to ensure functioning procurement and the distribution of drugs and equipment, quality of care, and financial accessibility.
- Skilled basic and emergency



services before, during and following child birth especially in areas where poverty, conflict, great distances and overloaded health systems obstruct such efforts.

- Efforts to ensure that young women postpone first pregnancy
- Providing young people with the opportunity to make informed choices regarding their sexual lives, marriage and pregnancy.

Advocating for a national and local debate focusing on the rights of men and women in relation to their bodies, health, education and access to resources. It is estimated that, by 2015, between US\$5.5 billion and \$6.1 billion in additional funding will be needed from domestic and international sources to accomplish Millennium Development Goal 5 to improve maternal health. In 2004, the world's major donors invested only \$530 million in maternal and newborn health.

Maternal health is at the core of the UNFPA mission. The Fund supports activities to prevent maternal mortality in about 89 countries through technical and financial assistance for reproductive health programmes. This is undertaken in close partnership with national governments, sister United Nations agencies, as well as the World Bank.

Activities range from providing family planning, advocating for health reforms and upgrading health facilities, improving curricula, training of midwives and doctors, mobilizing communities and promoting women's rights.

International goals for maternal mortality At the 1994 International Conference on Population and Development (ICPD), the participating countries agreed to reduce maternal mortality to 75 per cent below 1990 levels by 2015. The agreement was re-affirmed in 2000, when the international community also agreed on this target for the Millennium Development Goal 5. Progress is measured by tracking the maternal mortality ratios in each country, as well as the proportion of births assisted by skilled attendants.

The additional target for MDG5 is "universal access to Reproductive Health" by the year 2015. Collectively, The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), ICPD Programme of Action, Beijing Platform for Action and the MDGs constitute the commitments behind multilateral, bilateral and local efforts to reduce maternal mortality. Main sources for this fact sheet: The Lambert's Maternal Survival and Women Deliver Series (2006/2007), the 2005 World Health Report and UNFPA public

The international community has a responsibility to increase investment levels and offer long-term financial support. Countries need to adopt and effectively implement policies that protect poor families from the cascading consequences of unaffordable maternity care.

Definition of maternal mortality

Maternal mortality is defined as the death of a woman while pregnant or within 42 days after termination of pregnancy of any cause related to or aggravated by the pregnancy or its management. This includes death as a complication of abortion at any stage of pregnancy.

social development

Department
Republic of South Africa



G: Folktale 1: The jackal and the wolf

Kwathi ke kaloku ngantsomi!
Chosi Ntsomi!
Kwakukho uDyakalashé noMvolofu
Babengabahlobo abakhu-u-lu,
abathandana kunene,
nditsho kwakungangeni kwamoya
phakathi kwabo!
Ngeminazana ithile
UDyakalashé wacela uMvolofu
Ukuba amkhaphe baye ebukhweni bakhe.
Nangona wayengathandi ncam uMvolofu
ngale mini, umhlobo wakhe wamcenga.
Hayi ke bagqiba ukuba bahambe ekuseni.

Bahamba! Bahamba! Bahamba!
Bahamba! Bahamba! Bahamba.
Kwala xa bephi-phiii-phi,

UDyakalashé wabona umthi wama-apile.
kodwa wazicingela ngaphakathi
ukuba akangekhe amxelele
umhlobo wakhe eyona nto ithwelwe ngulo mthi.
Wavakala emkhwaza ngobubele obukhulu,

“Whaa Mvolofu ntanga, kukho umbhalo kulo mthi
Kangangendlela awayedinwe ekruquke ngayo uMvolofu!
“Kubhalwe ntoni? Ndilambile mna!”

Kubhalwe, “Yikha amagqabi!”
Uyazazi ke wena awukwazi noko kufunda!
Sondela khawuleza nengxowa yakho.
Yima, ngaphaya, mna ndime ngapha.
Yikha amagqabi nam ndiz’okh’amagqabi

Bawakha ke amagqabi!
Kodwa ke yena uDyakalashé
wayesikha ama-apile ngexa
uMvolofu elibele kukuzalisa ingxowa ngamagqabi.
Ukusuka apho ke uDyakalashé uye wacinga
ukuba amdungudlise ngengoma,
eyona nto ayaziyo ayithanda kanobom.

Once there was *intsomi!*
Yes to the intsomi! (Audience)
There was Jackal and Wolf
They were the best of friends
who loved each other so much
I say not even the wind
could separate them
One day
the Jackal asked the Wolf
to accompany him to his in-laws
Although the Wolf was not really keen
on this day, his friend begged him.
and so they agreed to leave very early
in the morning
They walked and walked and walked
They walked and walked and walked
It happened that when they were some
where, further away!
The jackal saw an apple tree
but he thought to himself
that he is not going to tell,
His friend, wolf what the tree holds
He called him with great generosity

“Wolf my friend, there is a writing on this
tree
The way wolf was tired and bored.
What is written, I am hungry!

It is written, *pick the leaves!*
You know very well you cannot read!
Come closer with your bag
Stand this side, I stand this side
Pick the leaves I will also do the same

They picked the leaves
But the jackal picked apples
while wolf picked the leaves
filled his bag with leaves
From there the jackal cunningly tried to
make the wolf forget everything by
singing
Knowing very well how he loved singing

Yikh'amagqabi nam ndiz'okh 'amagqabi!
Yikh'amagwabi nam ndiz'okh' amagqabi!

*Pick the leaves I will also do the same
Pick the leaves I will also do the same*

Hayi ke umvolofu, waxhentsa wabila xhopho!
Edwaba loo magqabi engenaxesha lakuphumla

*The wolf danced until he was sweating!
unconsciously picking those leaves
without stopping.*

Wathi ukuba anele uDyakalashé ukukha ama-apile
wamxhesha ukuba bashenxe ngakulo mthi.

*When the jackal felt he picked enough
apples
He hurriedly instructed the wolf that they
must go away from the tree*

Bahamba, bahamba, bahamba
Bahamba, bahamba, bahamba.

*They walked, walked, and walked
They walked, walked, and walked*

Kwala xa bephi-phi-i-i-phi,
uDyakalashé wacebisa ukuba baphumle.

*When they were far far away
The jackal advised that they must take a
rest*

Watsho esithi, "Masitye ke ngoku ntangam!
Yhuu! Umothuko kaMvolofu
ukubona ama-apile endaweni yamagqabi!

*Let us eat my friend, said the jackal
What a shock!
When the wolf saw apples instead of
leaves*

Na-antso ke eyakhe ingxowa yamagqabi imxakile,
phakathi kwemilenze yakhe!

*There lies his troubling bag of leaves
in between his legs.*

Yhini mhlobo wam ukundikhohlisa kangaka?
Uthi mna mandikhe amagqabi
kanti wena ukha ama-apile?
Ndim ndedwa umhlobo wakho
ekukudala sihamba kunye.

*How dare you deceive me like this?
You tell me to pick the leaves
while you are picking apples?
I have been your only friend
for such a long time we travel together*

"Mvolofu, sebenzisa ingqondo!
Sebenzisa ingqondo!
Sukuthi xa ndithi yenza into,
nawe wenze loo nto ungabuzanga!"
Wadana uMvolofu, wacela uxolo,
wacela ukuba aphiwe i-apile.
Nangona wafumana lalinye, waxola!

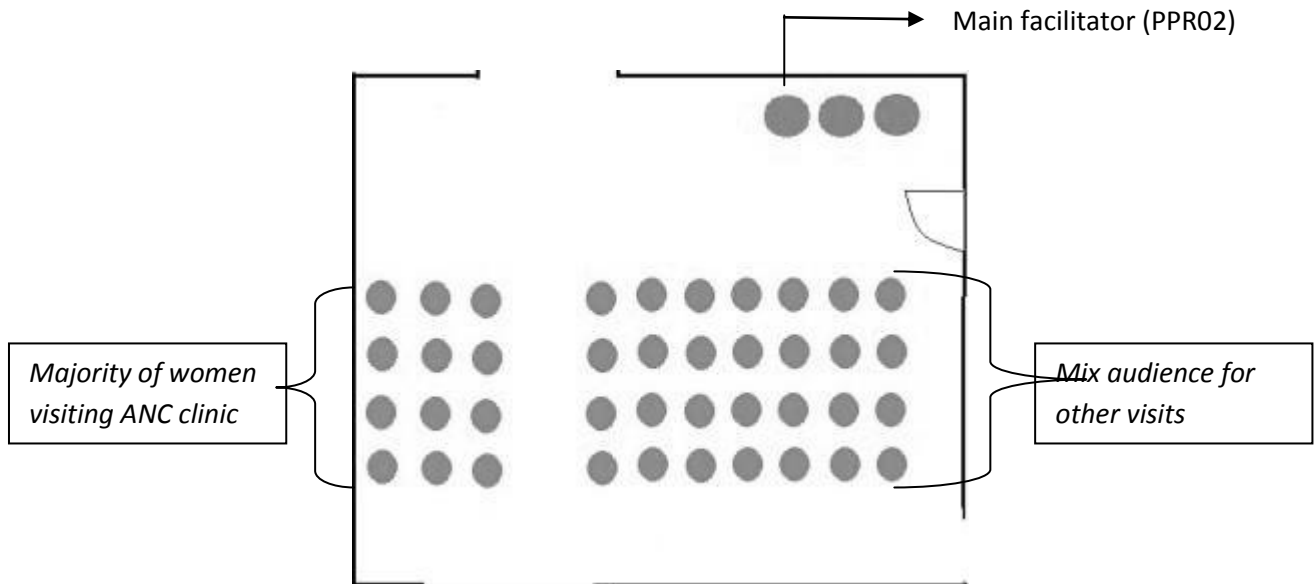
*Wolf, you must use your common sense!
Use your common sense!
Do not do everything that I tell you to do
Without asking!
The wolf was so disappointed
he apologized and begged for an apple
He was fulfilled although his friend gave
him only one apple.
The folktale ends.*

Phela-phela ngantsomi

H: Diagrams and pictures: MHE Space and Lesson Types

Diagrams: Examples of teaching and learning arrangement in PHC context

- a) **Diagram 1:** Presentation by PPR02 (CHW) and her co-presenters (Nurse Assistant and Lay Counsellor)



- b) **Diagram 2:** Intsomi narration by Researcher and audience member (+12 year old girl)

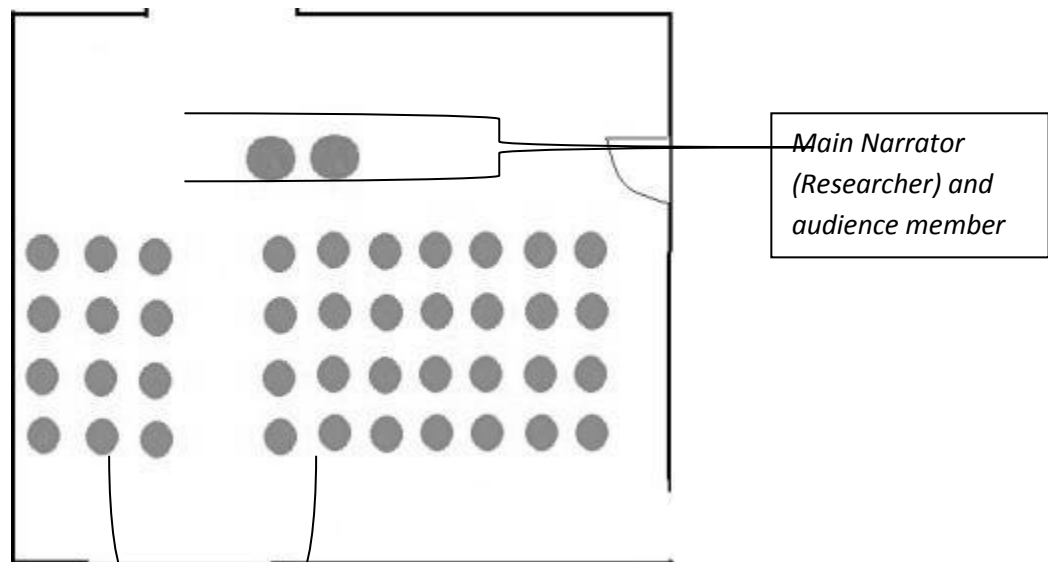


Diagram 3: Presenting a lesson
Main facilitator (PPR02) and Co-Facilitators joined audience from both sides

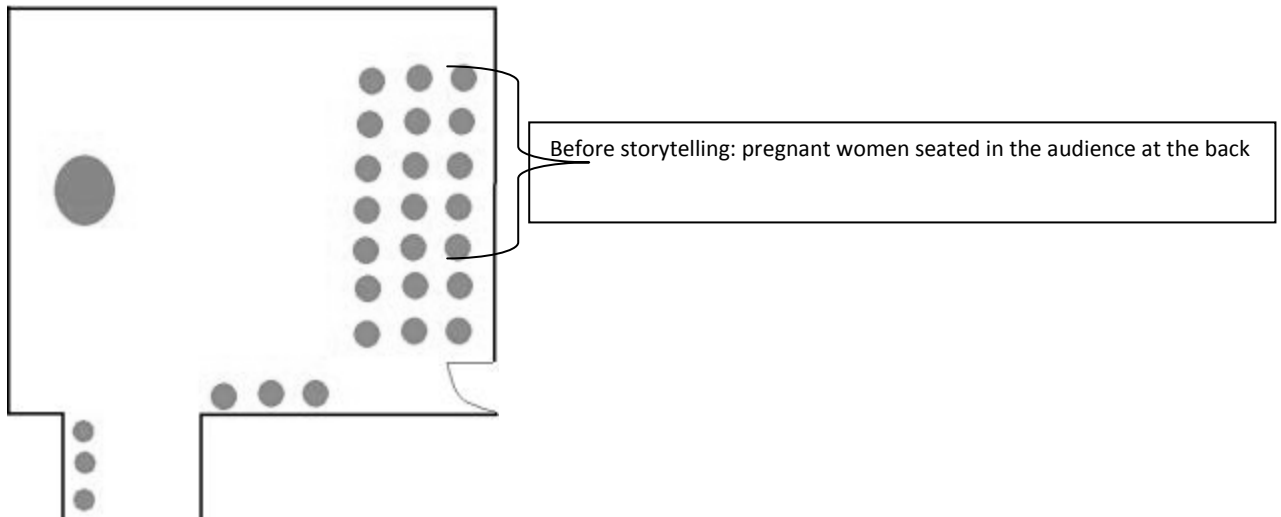


Diagram 4: Presenting a lesson to a group of pregnant women

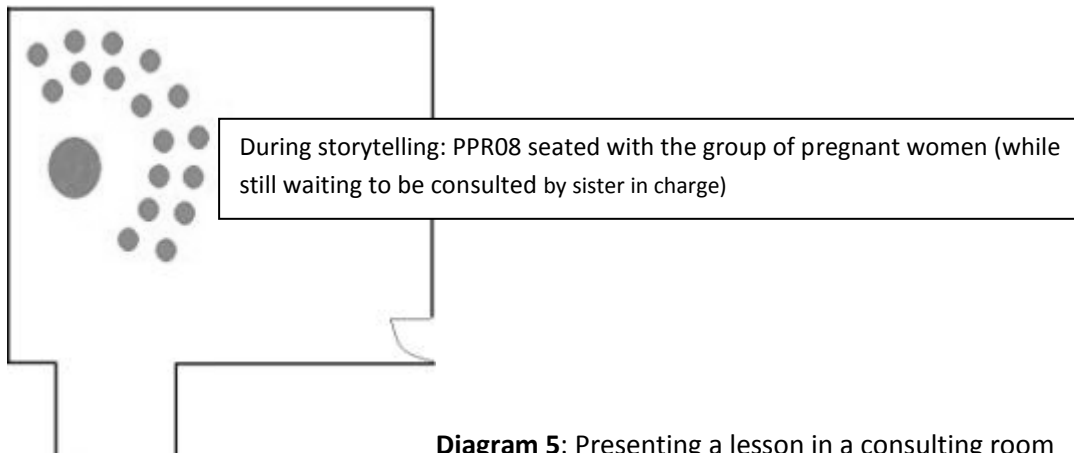
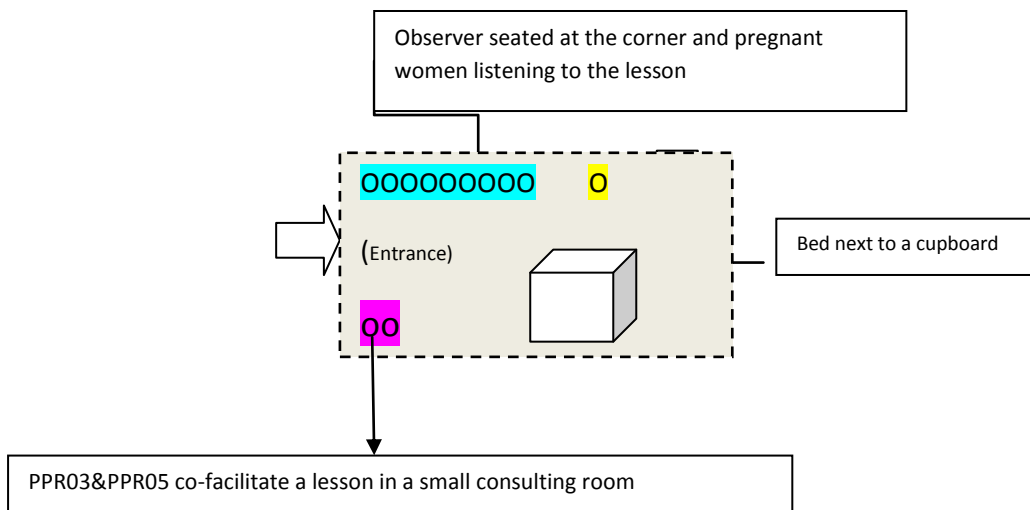


Diagram 5: Presenting a lesson in a consulting room



Pictures: illustrating the learning environment in PHC contexts



Picture 1: inside a small consulting room



Picture 2: Under trees



Picture 3: In Waiting Rooms (mixed audience)



Picture 4: At the Maternal Waiting Home