

**Quality care during childbirth at a midwife obstetric unit in Cape Town, Western
Cape: Women and Midwives' perceptions**

By

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**A thesis submitted in partial fulfilment of the requirements for the degree of Magister
Curationis in the School of Nursing, Faculty of Community and Health Sciences,
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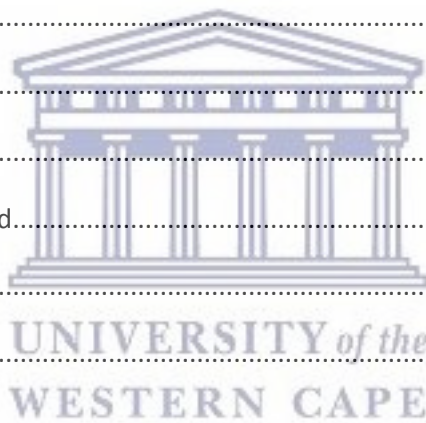


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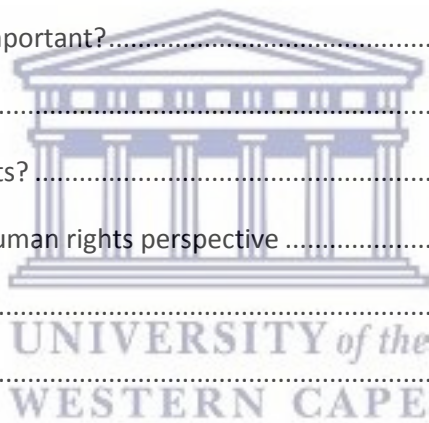
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Declaration

I, **Sedeeka Martin**, declare that the dissertation entitled ‘Quality care during childbirth at a midwife obstetric unit in Cape Town, Western Cape: Women and Midwives’ perceptions’ is my own work, that all sources that have been used or quoted have been indicated and acknowledged by means of a complete reference list, and that it was not submitted for any other degree at any institution.

Sedeeka Martin:

Date:



Keywords

Midwife

Quality care

Childbirth

MOU

Perception

Primary health care



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Abbreviations

ANC	Antenatal care
CIMS	Coalition for Improving Maternity Services
CESCR	Committee on Economic, Social and Cultural Rights
COIA	Commission on Information and Accountability
DoH	Department of Health
FXB	François-Xavier Bagnoud
iERG	independent Expert Review Group
ICN	International Council of Nurses
MDG	Millennium Development Goals
MDHS	Metropole District Health Services
MOUs	Midwife Obstetric Units
NDP	National Development Plan
NGO	Non-Government Organisation
PCMC	Patient Centred Maternity Care
PMNS	Peninsula Maternal and Neonatal Services
RMNCH	Reproductive, Maternal, Newborn and Child Health
SA	South Africa
SANC	South African Nursing Council
UWC	University of the Western Cape
WHO	World Health Organization
WRA	White Ribbon Alliance



Dedication

I dedicate this study to my beloved children, Yumnah and Ebrahim. May this inspire you to succeed in your own studies.



Acknowledgements

Firstly, I would like to thank Allah for blessing me with the strength and the opportunity to make this thesis possible.

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- The participants who took part in the study by sharing their experiences with me.



Abstract:

Globally, there has been significant progress in reducing preventable maternal deaths and disability, and growing attention on improving the quality of care in maternal health care facilities.

The World Health Organization (WHO) describes quality care as delivering healthcare that is effective, efficient, accessible, acceptable, patient-centred, equitable and safe (WHO, 2014). Midwives are the backbone of midwifery and therefore the primary care giver for pregnant women accessing maternal care and women's ability to access quality midwifery care during the antenatal, labour and postnatal period is the key component in midwifery care.

The Primary Level Protocol of South Africa is under the umbrella of the Primary Health Care System, and according to this system low risk women are expected to seek antenatal, intrapartum and postnatal care from the nearest Midwife Obstetric Unit (MOU).

The choice a woman makes regarding access to maternity care depends on the social norms in her society and what services are offered. However, the services that are available may not meet the needs of pregnant women. Women may need detailed information about the availability of the maternity care system in order to make an informed decision on where to access the health system. The gap between the perceived needs of pregnant women and the care provided by midwives can be bridged by listening to women to create a reciprocal understanding of quality care.

In South Africa, limited research has been conducted on midwives and women's perceptions of maternity care. In the absence of such information, this study was conducted at an MOU in the Western Cape, with the aim of exploring women and midwives' perceptions of quality care during childbirth.

Method

A qualitative approach was used to explore and describe the perceptions of the midwives and the women who delivered at the same MOU. Data was collected using unstructured interviews with four women and five midwives. Interviews were recorded and transcribed by the researcher. The data that emerged were coded and categorised to form themes and subthemes.

Results

The results indicated that quality of care is still compromised as there are challenges that affect quality of care in the MOU setting. These findings suggest that to improve quality care it is crucial to build accountability and communication between midwives and women. Women and midwives perceived quality care differently and there is a need to create a reciprocal understanding about what quality care encompasses.



CHAPTER 1

1 OVERVIEW OF THE STUDY

1.1. Introduction & background

People interpret quality care differently and there is no single universally accepted definition (Raven, van den Broek, Tao & Tolhurst, 2015). These researchers suggest that, in order to be committed to providing good quality care, it is crucial to build communication and accountability between the care provider and the care consumer about their expectations and experiences of care. Bhattacharyya et al. (2018), states that women have clear expectations of the quality care from facilities where they go for childbirth. Understanding their expectations and matching them with care providers' perspectives of care is critical for efforts to improve the quality of care and thereby impact maternal outcomes.

The World Health Organization (WHO) describes quality care as delivering healthcare that is effective, efficient, accessible, acceptable, patient-centred, equitable and safe (WHO, 2014). In September 2014, the WHO released a statement on preventing and eliminating disrespect and abuse during facility-based childbirth. The statement is a critical step for improving the reproductive care of women, and it acknowledges that while women may experience disrespectful and abusive treatment throughout their pregnancy, they are particularly vulnerable during childbirth and the postpartum period. WHO further explains that it is the right of every woman to expect the highest standard of health care, delivered in a dignified and respectful manner.

According to the Department of Health (DoH) in South Africa (SA), different levels of care are required for efficient functioning of the health service. In order to manage health more cost-effectively, hospitals and primary healthcare facilities should share the load of patient care (2015). Primary health care is the first level of contact with the health system. The aim of primary health care is to change health service delivery from a curative model to one that promotes cost-effective primary healthcare to the community., as close to work or home as possible (DoH, 2019).

A primary healthcare clinic is a health facility that functions on weekdays during working hours, whereas as a community health centre functions as a 24-hour facility with an obstetric

unit. When it stands alone as a maternity service, it is called a midwife obstetric unit (MOU), which is staffed entirely by midwives and linked by telephone to the base hospital (DoH, 2015).

Midwives thus offer primary healthcare to pregnant women, and are often the first contact for women accessing the health system for the first time. Their professionalism shapes women's perceptions of the quality care they expect from the institution. According to Melese, Gebrehiwot, Bisetegna and Habte (2014) and Panth and Kafle (2018), patients' perceptions of the expected quality care determine their confidence in accessing available health care services.

Amongst the staff at the MOUs are advanced midwives, midwives, staff nurses, auxiliary nurses and a visiting medical officer. In SA, the midwifery profession is regulated by the Nursing Act, Act No 3 of 2005. The South African Nursing Council (SANC) is the regulatory body of midwifery practice in SA and under the provisions of the Nursing Act, they describe the categories of nurses and their scope of practice as follows (SANC, 2015):

A midwife is a person who has met the prescribed education requirements for registration as a midwife and who is capable of assuming responsibility and accountability for such practice. Thus the midwife is to assume full responsibility and accountability for the provision of comprehensive nursing care of persons as well as providing emergency care and delegating of nursing care to competent practitioners.

An advanced midwife is a person who has met the prescribed education requirements for the registration as a midwife and has completed and registered with an additional qualification. Advanced midwifery is a specialized field with a focus on expanded roles and competencies to improve maternal health, reproductive and neonatal health.

A staff nurse is a person who has met the prescribed educational requirements for the registration of a staff nurse. The staff nurse may only provide nursing care and treatment to persons with health problems under the supervision of a professional nurse, thus may not take responsibility and accountability for managing the overall nursing care of persons.

The auxiliary nurse has met the prescribed education requirements and has maintained the competencies to practice as an auxiliary nurse. The auxiliary nurse's scope of practice is to provide elementary nursing care as prescribed and delegated by a professional nurse or staff nurse in accordance with a standardised plan of care.

According to the DoH, it is the priority of modern maternity services to render high quality maternal care that is safe for all women. Health workers must demonstrate respect and a genuine interest in their clients with a non-judgemental attitude. This applies even in the context of a poor working environment or perceived unsafe practices of certain pregnant women. and their partners (DoH, 2016).

Maternity care comprises antenatal, intrapartum and postnatal care.

The WHO defines antenatal care (ANC) as, “the care provided by skilled health-care professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy. The components of ANC include: risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion.” (2016, p. 1).

Intrapartum care refers to the period from the commencement of true labour throughout the first, second, third and the fourth stages of labour, which lasts until one to two hours after delivery of placenta (Lowdermilk, Perry, Cashion & Alden, 2012). Postnatal care when care is provided to the mother and her newborn infant for the period from immediately after the birth until six weeks of life (WHO, 2014).

According to Sacks and Kinney (2015), women are particularly vulnerable during the intrapartum period as they depend on a skilled attendant to assist them to give birth safely. In the case of MOUs, the skilled attendant is a midwife. Wilde-Larsson, Sandin-Bojo, Starrin and Larson (2011) suggest that childbirth is a highly significant emotional event for women. Hence, it is a midwife's explicit goal that each woman has a positive childbirth experience. The positive and negative feelings of women who give birth reveal their perceptions of the quality of the childbirth experience (Sacks & Kinney, 2015).

The SANC's Regulation 2598, The Scope of Practice, outlines the acts and procedures which may be performed by the midwife to safeguard maternity clients by setting standards of

performance for all midwifery and nursing staff. Regulation 387, Acts and Omissions, stipulates that the SANC may institute disciplinary measures against nurse practitioner's adverse conduct, including assault, abuse, harassment of health care users and colleagues or any conduct bringing the profession into disrepute, and disclosure of confidential information (SANC, 2014). Thus, the regulations set out parameters that guide midwives in providing quality care to pregnant and birthing women in South Africa.

South Africa's DoH has developed strategies to alleviate the burden of care and for improved quality service delivery, which includes the development of Patient Centred Maternity Care (PCMC) codes of practice to complement the SANC regulations (DoH, 2013). The PCMC codes form part of a fundamental principle in the Western Cape DoH's strategic plan towards Healthcare 2030, as well as highlighting the Western Cape government's commitment to patient-centred care (DoH, 2013).

According to O'Donnell, Utz, Khonje and van den Broek (2014), in order to be able to provide quality care, one needs to know what it means. Research studies suggest that the perceptions of quality care differ substantially between midwives and the women who receive maternity care. According to van den Broek and Graham (2009) and Norhayati et al. (2017), the use of services and maternal health outcomes are the result not only of the provision of quality care but also of women's experiences of the care. Thus, care rendered to women during childbirth may be deemed to be of the highest quality in relation to the set and recognised standards of care by midwives. However, from the perspectives of the women, their families and the community, that same care may be unacceptable. In South Africa, limited research has been conducted on midwives and women's perceptions of maternity care. In the absence of such information, this study aims to explore and describe women and midwives' perceptions of quality care during childbirth at one of the MOUs in the Western Cape. This is in order to aid policy makers and maternity health providers, especially midwives, to understand whether the care they provide, particularly in MOUs, meets the needs of birthing women.

1.2. Problem statement

There is a global commitment to reducing the unacceptably high rates of maternal deaths in low to middle-income countries. In South Africa, progress towards this goal demands

national co-ordination as well as the cooperation of the major role players in the provision of health services, addressing the causes of maternal and perinatal deaths, and making clinical management protocols available to ensure that high quality services are rendered (DoH, 2015).

Maternity care is a vital component of primary health care and in South Africa it is a free service for pregnant women. Data from the 2010-2013 South African Confidential Enquiry into Maternal Deaths Report suggest that the main causes of maternal deaths are related to challenges of the health care system, failure to use health care facilities, inadequacy of services, and substandard care related to the knowledge and skill of health care providers (DoH, 2015).

In order to improve quality care, it needs to be measured, but this is challenging given the multifaceted and interconnected aspects of women's experiences with the maternal health care system. Factors influencing the quality of care women receive include the availability of infrastructure and supplies, the health care workers' level of training, and provider-patient relationships, and some of these elements are easier to measure than others (Langer, 2010; Tunculp et al., 2015).

Despite the DoH's strategy of implementing PCMC codes of practice to provide birthing women with quality maternity care, there are still complaints from the public, especially during labour and childbirth as that is the period when women are most vulnerable (Fraser, Cooper & Nolte, 2010). Therefore, it is essential to understand perceptions of quality care in maternity care provision from the perspective of both women and midwives.

1.3. Significance of the study

This research on women and midwives' perception of quality care will promote an understanding of what practices occur at an MOU, and the role of a midwife. This information is useful in the development of culturally-sensitive programmes to improve community awareness about what quality care encompasses. The findings also have the potential to aid policy makers and maternity health providers, in particular midwives, to tailor maternity care to meet the needs of women. Management can also use the information to identify the needs of midwives and the challenges they face when delivering quality care to

women. Intervention strategies can then be developed to improve service delivery to the public. The study assisted the researcher to better understand the challenges women and midwives face when it comes to quality care.

1.4. Research purpose

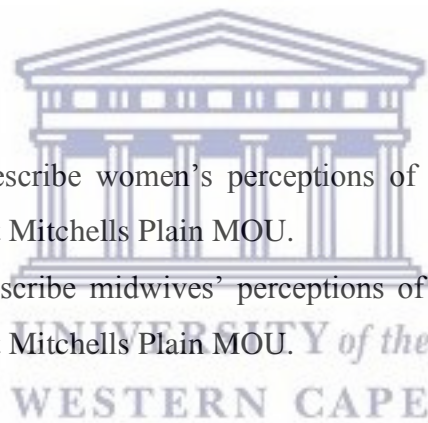
The purpose of this study is to explore and describe women and midwives' perceptions of the quality of care being provided during childbirth at one of the MOUs in Cape Town, Western Cape.

1.5. Aim of the study

The aim of this study is to investigate women and midwives' perceptions of quality care during childbirth.

1.6. Study objectives

- To explore and describe women's perceptions of the care provided to women during childbirth at Mitchells Plain MOU.
- To explore and describe midwives' perceptions of the care provided to women during childbirth at Mitchells Plain MOU.



1.7. Definition of concepts

- 'Childbirth', which is synonymous with the intrapartum period, refers to the period when women experience labour and ultimately give birth (Martin, 2017).
- 'Perception' refers to an individual's interpretation of what they observe, experience and expect from a particular action or reaction (Goldstein, Vanhorn, Francis & Neath, 2011).
- 'Regulations' refer to guidelines that govern the way midwives render maternity care to birthing women (SANC 2015).

1.8. Literature review

Literature was obtained from books, internet databases and journals. Keyword searches were conducted on Google Scholar, Cinahl, Pubmed, Science Direct and BioMed Central using the

words: quality maternal care, childbirth, women's perceptions, midwives' perceptions, and women's expectations.

1.8.1. Caring from women's perspectives

McKinnon, Prosser and Miller (2014) conducted a qualitative study in Queensland, Australia to identify women's unmet needs and priorities for maternal care. The findings of the study were that women were concerned with the quality of interpersonal interaction with midwives, and that they experienced lack of empathy, and rude or uncaring behaviour. In a similar study, Raven et al. (2015) conducted a qualitative exploratory study with the objective of examining women's expectations and experiences of childbirth care in rural China. The data, which was obtained through interviews and focus group discussions, revealed that women's expectations of having skilled care providers and privacy during childbirth were met. However, women were not allowed to have a companion during labour and were not given the opportunity to participate in decision making in their care.

Utilising data collected from women who had normal vaginal deliveries in a public hospital in Gauteng, Sengane (2013) conducted a qualitative, explorative, descriptive and contextual study on mothers' expectations of midwives during labour. Using purposive sampling, only mothers who were assisted by midwives during childbirth were recruited. Data were collected using in-depth interviews. The study reported that women regarded emotional support and having good interpersonal skills as the most important aspects for midwives in providing quality care. The expectations were based on practical issues, such as provision of physical comfort, emotional support, clear communication including good interpersonal skills, and encouragement of bonding between mother, father and baby.

In the Netherlands, Janssen and Wiegers (2006) conducted a qualitative, exploratory descriptive study on the strengths and weaknesses of midwifery care from the perspective of women. The aim was to explore women's experiences of midwifery care during the antenatal, intrapartum and postnatal periods. The study found that, by asking clients' opinions on quality care on a regular basis, staff would be able to re-evaluate and monitor the quality of the standard of care being provided. Thus, asking client's opinions was a possible way to implement feedback from women in quality assessment and improvement programmes.

1.8.2. Caring from midwives' perspectives

Chokwe and Wright (2013) conducted a contextual, exploratory and qualitative study to explore caring from the perspective of midwives during the clinical practice of midwifery in private and public hospitals in Tshwane, Gauteng, South Africa. Convenience and purposive sampling methods were used, resulting in a sample size of 40 participants. Questionnaires were distributed, and followed by two focus group sessions. The study revealed that midwives had excellent theoretical knowledge of caring but some of them were unable to apply this knowledge in the clinical practice.

1.8.3. Midwife-woman interaction

In Malawi, O'Donnell, Utz, Khonje and van den Broek (2014) conducted a study to explore the perceptions of mothers and midwives regarding quality maternal care. The setting of the study was four hospitals that had quality-improvement committees and that conducted maternal death audits. Using purposive sampling, all healthcare workers working in the maternity wards were selected as participants, as well as a varied number of postnatal mothers aged from 16 – 36 years who had had uncomplicated deliveries within the last seven days. Data was collected through in-depth semi-structured interviews and focus group discussions. The study highlighted that there is a need to establish a reciprocal understanding of what quality care entails for women and health care providers, and that more focus needed to be placed on better communication between the two parties.

The importance of understanding women and midwives' perceptions in the provision of maternity care was highlighted in most of the reviewed literature, supporting the purpose and objectives for conducting this study in South Africa.

1.9. Research Methodology

1.9.1. Design

Quantitative research is used to describe a phenomenon by generating numerical data or data that can be transformed into useable statistics (Wyse, 2011). Qualitative research is primarily exploratory and focuses on describing a phenomenon in order to gain an understanding of the underlying motives of human behaviour. This approach allows the researcher to analyse various factors which motivate people to behave in a particular manner or to like or dislike particular things (Wyse, 2011).

A qualitative research design was considered appropriate for this study because the researcher endeavoured to gain understanding through exploring participants' meanings, experiences and perceptions of quality care expressed in their own words. Thus, a descriptive, exploratory study with a qualitative approach was used to explore the perceptions of midwives working and the women delivering at the same MOU.

A descriptive research design focuses on studying a phenomenon in its natural setting with no pre-selection of study variables, no manipulation of variables, and no prior commitment to any one theoretical view of the target phenomenon (Lambert & Lambert, 2012). A descriptive design was appropriate because the researcher intended to describe participants' perceptions of quality care as presented.

Exploratory research allows the researcher, who has an idea or has observed something, to gain a deeper understanding in order to generate a formal hypothesis. An exploratory research project is an attempt to lay the groundwork that will lead to future studies or to determine if what is being observed might be explained by a currently existing theory (Babbie, 2007). An exploratory design was therefore appropriate because the researcher intended to gain an understanding of participants' perceptions of quality care during childbirth.

1.9.2. Study setting

The study was conducted at Mitchells Plain MOU in Cape Town, Western Cape. The Metropole District Health Services (MDHS) covers health facilities from coast to coast in Cape Town, from Cape Point to Atlantis, and is divided into eight sub-structures. Each sub-structure manages two sub-districts, and the combination of sub-districts under each sub-structure is based on the size of the population, geographical area and the drainage areas (MDHS, 2004). Mitchells Plain, Hanover Park and Guguletu MOUs function within the Klipfontein-Mitchells Plain sub-structure. Of the three MOUs, Mitchells Plain has the highest population and delivery rate. According to the City of Cape Town Census, 2011, Mitchells Plain had a population of 507 237, with the next census to be held in 2021 (Statistics and Population Census, 2013). The population had increased to approximately 700 000 by 2016 (City of Cape Town, 2016).

Mitchells Plain MOU has a number of satellite clinics offering basic antenatal care and all antenatal women from these clinics utilise the MOU for childbirth services. The MOU has a total of 15 midwives, of which four have been trained as advanced midwives. Since the MOU functions as a 24-hour unit, midwives work day and night shifts. The birth register reflects a total of 250-280 live births per month. High-risk pregnancies are referred to Mitchell's Plain District Hospital that is 10 minutes' drive from the MOU. A high-risk pregnancy is one that threatens the health or life of the mother or her baby and requires specialised care from specially trained providers. Some pregnancies start with no complications and become high risk as they progress (DoH, 2015).

1.9.3. Data collection

Data collection instrument

Data was collected from four women and five midwives, using unstructured interviews with open-ended questions. Using open-ended questions and interviews allowed the researcher to understand participant's perceptions and experiences, and recognize important antecedents and outcomes of interest that may not have surfaced if pre-determined questions were used.

Data collection process

Burns and Grove (2005) suggest that participants should be given the choice of a venue and time which will be convenient and where they will feel safe. Interviews were held at the MOU in a locked office, which was free from interruptions and away from the labour ward, to ensure that the interviews could not be over-heard. The office was arranged with the Unit Manager. To avoid disruption of the daily functions of the MOU, interviews with midwives were conducted during each participant's break time. Interviews were conducted in English and audio-recorded, and began once the participants were at ease. The researcher reviewed the purpose, significance and benefits of the study with participants to establish if they were still willing to participate and have the interview audio-recorded. If they agreed to participate, participants were required to fill in a research consent form which explained their anonymity and the confidentiality of information provided. The researcher also noted non-verbal communication and gestures during the interview process for added analysis.

Population

The study population were postnatal women that gave birth at Mitchells Plain MOU within the seven days prior to data collection, regardless of how many times they had given birth previously, as well as midwives working at the MOU. Their parity did not matter.

Recruitment and sampling

After administrative processes, participants were recruited and sampled by using purposive sampling in the following manner:

Mothers:

- Posters giving information about the study and providing the researcher's contact details were placed in the waiting areas, and flyers were distributed to clients.
- Group talks providing information about the study were given by the researcher to postnatal women in the waiting areas.
- The MOU birth register was utilised to find contact details of women that had uncomplicated deliveries within the last seven days.

Midwives:

- The researcher approached midwives on day and night shifts and informed them of the research study. Contact details of the researcher were provided to the midwives.
- Appointments were made with potential participants.

Inclusion criteria:

- Women of any age who had a normal birth at Mitchells Plain MOU within the seven days prior to data collection, regardless of how many times they had given birth previously.
- Midwives of any age working in the labour ward for a minimum of 12 months.

Exclusion criteria:

- Women who had a normal birth at another MOU, because the study explored and described women's perception of quality care received at Mitchells Plain MOU.
- Women who were admitted to Mitchells Plain MOU within the seven days prior to data collection, but who were transferred antenatally because of complications.
- Midwives working only in the antenatal clinic.

1.1.1.1 Data analysis

Data analysis was done using Tesch's eight steps of data analysis (Creswell 2009):

- All interviews were transcribed verbatim in English. The researcher listened to the audio recorded interviews, and read and re-read all the transcripts. Ideas that emerged from listening and reading were documented on the transcripts. The transcripts were numbered and the researcher selected two transcripts to re-read. Data relevant to the study was written in the margin, and positive and negative perceptions were indicated by using different colour pens. This process was repeated until all transcripts were done. Similar topics were listed and then clustered together. Thereafter, major topics, unique topics and leftover topics were grouped in columns. The list of topics was then used to compare and code the data. These codes were colour coded, red for positive and blue for negative. The coded data was then organised into categories and subcategories, and the researcher was able to identify a specific theme.

1.9.4. Trustworthiness of the study

To ensure trustworthiness, the following principles were utilised: credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985).

Credibility is the confidence that can be placed in the truth of the research findings. It asks the researcher to correctly interpret the original data so that it reflects the participants' original views in the research study's findings (Lincoln & Guba, 1985).

Credibility was ensured by:

- Selecting participants strictly according to the inclusion and exclusion criteria.
- Asking all participants the same initial question.
- Making appointments with mothers at their postnatal visit to view transcripts of their interviews and verify if it was a true representation of the information they gave during the interview.
- Making appointments with midwives when they were on duty to view transcripts of their interviews and verify if it was a true representation of the information they gave during the interview.

Transferability focuses on the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents. The researcher facilitates the transferability judgment by a potential user through thick description of the background and methodology (Lincoln & Guba, 1985). Transferability was ensured by giving a detailed description of the background and methodology of the study so that the research study's

findings can be applicable to other contexts with similar situations, similar populations, and similar phenomena.

Dependability is the stability of findings over time. Dependability involves participants' evaluation of the findings, interpretation and recommendations of the study, such that all are supported by the data as received from participants of the study. In doing so, if other researchers wanted to replicate the study, they would have enough information from the research report provided and be able to obtain similar findings (Lincoln & Guba, 1985). Dependability was enhanced by providing a dense description of research methodology and methods used, as well as the implementation of the methods utilised.

Confirmability is the degree to which the findings of the research study can be confirmed by other researchers. Confirmability is concerned with establishing that data and interpretations of the findings are not fabricated by the researcher but are clearly derived from the data (Lincoln & Guba, 1985).

Confirmability was ensured by documenting the procedures done for checking and re-checking data throughout the study. The researcher showed how her interpretations and conclusions were reached. Confirmability was also ensured by involving the supervisors throughout the study and by having an audit trail which will include all raw data, transcribed interviews, field notes, findings, recommendations and any other documentation available for an external audit and for the supervisors to review.

1.10. Ethical Consideration

Ethics clearance was obtained from the University of the Western Cape's Senate Research Committee (registration number, 15/7/265). Thereafter, permission to undertake the study at the MOU was obtained from the Department of Health, and a letter seeking institutional permission was obtained from the Primary Health Manager.

1.10.1. Informed consent

Informed consent is voluntary agreement to participate in a research study, and must be obtained from a participant before commencement of the study. It is not merely a form that is signed, but is a process in which the participant has an understanding of the research and his

or her rights, the purpose of the study, the procedures to be undergone, and the potential risks and benefits of participation (Shahnazarian, Hagemann, Aburto & Rose, 2017).

The researcher provided participants with information explaining the nature of the study and its benefits (Addendum B), allowing them to make an informed decision about whether or not to participate. Participants were made aware that their participation was strictly voluntary, and that they were free to withdraw from the study at any time and would not be penalised or prejudiced in any way. Written consent was obtained from potential participants once they understood and agreed to participate.

1.10.2. Right to confidentiality

According to the Canadian Institution of Health Research (2010), the ethical duty of confidentiality refers to the obligation of the researcher to safeguard entrusted information. This includes obligations to protect information from unauthorized access, use, disclosure, modification, loss or theft. Fulfilling the ethical duty of confidentiality is essential to the trust relationship between researcher and participant, and to the integrity of the research project.

In order to maintain anonymity, no names appeared on the audio recordings, and recorded interviews were identified by numbers. If a participant mentioned a name during the interview, the name was indicated with a pseudonym when the data was transcribed. All information obtained during the data collection process will be kept confidential and will not be linked to participants. The information was entered into a computer that is password-protected and can only be accessed by the researcher. The information collected will only be accessed by the researcher and her supervisors. Audio recorded interviews will be kept safe in a locked cupboard in the researcher's study at home until the research report is completed, and then be disposed of according to the protocol of The University of the Western Cape (UWC).

1.11. Conclusion

This chapter focused on introduction and background to the study, problem statement, and significance of the study, objectives and aim, purpose of the study as well as operational definitions. The chapter also highlighted the background of the study area. The next chapter will focus on literature review, highlighting research studies that are related to the current study.

CHAPTER 2:

2 LITERATURE REVIEW

2.1. Introduction

The previous chapter provided an outline of this study by discussing the problem statement, purpose and the significance of the study, the aims and objectives of the study, and the research methodology used. Chapter 2 provides a review of the literature related to this study and discusses the role of the midwife, why quality care is important, compassionate birth, human rights, and quality care from a human rights perspective.

2.2. Reviewing and presenting the literature

Fink (2014) describes a literature review as surveying, books, scholarly articles, and any other sources relevant to a particular issue, area of research, or theory, and by so doing, provides a description, summary, and critical evaluation of these works in relation to the research problem being investigated. Literature reviews are designed to provide an overview of sources you have explored while researching a particular topic and to demonstrate to your readers how your research fits within a larger field of study.

Fink further explain that the purpose of a literature review is to guide the development of a study by identifying new ways to interpret prior research without duplication and to reveal any gaps that exist in the literature and point the way in fulfilling a need for additional research. The review of the literature provides a deepening of the researcher's knowledge on the topic and provides information about existing studies on the topic (2014).

Keyword searches were conducted for local and international articles in English on Google Scholar, Cinahl, Pubmed, Science Direct and BioMed Central research databases using the words: quality maternal care, compassionate birth, midwife, human rights. Studies dated between 2010 and 2019 were eligible for inclusion. However, seminal works prior to 2010 were also considered. The search focused on birthing women and midwives, and included published peer-reviewed journal articles, conference presentations, reports, book chapters, abstracts, and evaluations of interventions targeting quality assurance. The search included published and unpublished journals and books which were relevant to the quality of maternal care rendered in health facilities.

2.2.1. The role of the midwife

Globally, about 65 – 75% of births are handled by midwives and happen without the use of drugs or other techniques to trigger labour. Midwives in countries across Africa have offered safe maternal and infant care in situations where there are no doctors and, with the increasing number of trained midwives, healthier babies were born and fewer mothers died from pregnancy and birth related complications. This was reflected in a WHO report, which showed that developed countries reduced maternal deaths by half in the early 20th century by providing professional midwifery care at childbirth (WHO, 2015).

In South Africa, primary maternity services are provided by midwives in the public sector as part of the National Health Plan. Midwives in the public sector work interdependently with medical doctors from the referral hospitals in secondary and tertiary healthcare settings, while in the private sector, midwives are employed by a hospital and work interdependently with an obstetrician. Some midwives practice independently and only require assistance from an obstetrician for emergencies.

The Primary Health Care Package for South Africa (2001. p. 17) states that midwives working in an MOU are responsible for:

- Taking a history and performing physical examination and tests according to the Antenatal Care (ANC) protocols and guidelines.
- Providing routine management, observations and services according to the ANC protocol at each stage of the pregnancy.
- Providing education and counselling to clients and partners on the danger signs in pregnancy, nutrition, child feeding and weaning, sexually transmitted diseases, HIV, delivery, newborn and child care, advanced maternal age, family planning and child spacing.
- Provide appropriate counselling, advice and services to pregnant women requesting termination of pregnancy.
- Delivering uncomplicated pregnancies.
- Managing clients according to the postnatal care protocol.
- Counselling and administering the appropriate family planning method to women according to the national protocol.
- Screening, advise and refer infertility cases as per national guidelines.

- Conducting breast cancer and cervical screening for women older than 30 years according to protocols.
- Recording all information on cases and outcomes deliveries correctly in the register and the register are kept up to date.

The role of the midwife in ensuring the clinical safety and wellbeing of both the mother and baby is well defined, but the reality is that the midwife's role extends far beyond the clinical component and impacts both the initial and long-term bonding between mother and baby (Knapp, 2015). In 2013, the South African Nursing Council (under the provisions of the Nursing Act, 2005) developed the Code of Ethics for Nursing Practitioners in South Africa to provide a framework for reflection on the influence of ethical values on the behaviour and interaction between nurses and the public, stakeholders and healthcare users. This Code of Ethics also serves as a declaration by nurses that they will always provide optimal care to the public to the best of their ability while supporting their colleagues in the process. It was developed on the principle that the nursing profession promotes respect for life, human dignity and the rights of other persons and its application is to be considered in conjunction with all applicable South African laws, as well as international policy documents. These include, but are not limited to, the Universal Declaration of Human Rights, International Council of Nurses (ICN) Code of Ethics, the Patients' Rights Charter, and all other nursing and healthcare policy frameworks providing direction and guidance for responsible practice in nursing. Although the ICN Code of Ethics provide an ethical frame in which nurses practice, it does not provide solutions to day-to-day ethical dilemmas, and the individual nurse practitioner will need to rely on his/her own personal integrity to make the right decisions (SANC, 2013).

In a study conducted by Thelin, Lundgren and Hermansson (2014), results revealed that midwives not only connect with women, but connect with their partners and the unborn child as well by creating a trustful relationship through a caring attitude. This trustful relationship was guided by shared responsibility between midwife and women in which women had the opportunity to prepare themselves for labour in a calm, safe environment.

Childbirth is a highly significant emotional event for women and it is an explicit goal that each woman experience the childbirth process as positive (Wilde-Larsson, Sandin-Bojo,

Starrin & Larsson, 2011). Midwives are known to improve the outcomes of births and yet here in South Africa, our maternal mortality rates do not reflect this. Since the Millennium Development Goals were set in 1990, with one goal being decreasing maternal mortality by 75% by 2015, South Africa's maternal mortality has in fact risen.

During a qualitative research study conducted by Hastings-Tolsma, Nolte and Temane (2016), women were interviewed to describe their experiences receiving care during childbirth. Patients either knew from prior experience, or had heard from friends, that midwives were not to be trusted and mostly did not care. Some women expressed little knowledge of midwives, their professional role and qualifications.

2.2.2. Why is quality care important?

“There is no universally accepted definition or model of quality of care. It is widely acknowledged that quality is multi-faceted, incorporating a number of dimensions, including safety, effectiveness, patient-centeredness, and that a range of perspectives are relevant, including patients as well as health care providers and managers” (Raven, Tolhurst, Tang & van den Broek, 2015 p. 2). According to Halldorsdottir and Karlsdottir's (2011) theory, the quality of midwifery services is a key aspect of the woman's experience of childbirth.

In 2000, world leaders gathered at the United Nations Summit and together adopted the United Nations Millennium Declaration, committing their nations to a new global partnership to improve the lives of the world's poorest people. At that time, eight goals were set, ranging from providing universal primary education to avoiding child and maternal mortality, with a target achievement date of 2015. These eight goals have become known as the Millennium Development Goals (MDGs) (United Nation Foundation, 2013).

In South Africa, the National Department of Health has identified maternal health care as a priority area requiring urgent action. This is in line with the targets to achieve MDG4 and MDG5, and targets set in the National Development Plan (NDP) (National Department of Health, 2015). MDG 4 refers to Millennium Development Goal 4 which aimed to reduce child mortality by 2/3. This includes reducing the under-five mortality rate and infant mortality rate, and increasing the proportion of one year-old children immunised against measles (Millennium Development Goals Report, 2015). MDG 5 refers to Millennium

Development Goal 5 which aimed to improve maternal health by reducing 3/4 of the maternal mortality ratio. The other aim is to increase the proportion of births attended by skilled health personnel (Millennium Development Goals Report, 2015).

High quality maternal care consists of care led by midwives for all women who need care at every stage, i.e. for normal pregnancy, birth and the postnatal period. The midwife cares for women by making decisions based on their clinical need, values and preferences, using evidence-based practices that will ensure optimal care is provided. In both the short term and the long term, pregnancy and early years have a decisive impact on the health and well-being of mothers, children and families. The midwife therefore plays a vital role in helping to ensure not only the immediate health of mother and baby, but in their future health and well-being and that of society as a whole (The Royal College of Nursing, 2014).

Maternal health care is potentially one of the most effective health interventions for the prevention of maternal and neonatal morbidity and mortality, in areas where the general health status of women is very poor (National Motherhood Conference, 1991). Although we expect pregnant women to maintain good health through their pregnancy, delivery and postnatal period, studies revealed that there are a lot of discrepancies in the quality and utilisation of maternal health care services.

2.2.3. Compassionate birth

Compassion means the sensitivity shown in order to understand another person's suffering, accompanied by a strong desire to alleviate that suffering (Perez-Bret, Altisent & Rocafort, 2016).

Ménage, Bailey, Lees and Coad (2017) describe compassionate midwifery as the interrelations of authentic presence, noticing suffering, empathy, connectedness/relationship, emotion work, motivation to help/support, empowering women and alleviating suffering through negotiation, knowledge and skills. The White Ribbon Alliance (WRA) of 2011 stated, "A woman's relationship with her maternity providers is vitally important. Not only are these encounters the vehicle for essential lifesaving health services, but women's experiences with caregivers can empower and comfort or inflict lasting damage and emotional trauma" (p. 1).

A study conducted by Thelin, Lundgren and Hermansson (2014) suggested that the purpose of caring by midwives is to promote women's capacity to have a positive birthing experience. The study described how the midwives caring for women developed into a mutual relationship and how this relationship changed during the birthing process and after birth. Midwives adjusted their care to cater to the unique needs of women and their partners, thus creating the opportunity for the childbirth experience to contribute to growth and development in the lives of the families, as well as for the midwives. Caring also seems to play an important role in fostering midwives' professional growth and the development of excellence.

According to Sheldon (2015), when women give birth in an environment where they are terrified, their parenting abilities are affected, along with their relationship with their children. These women find it difficult to bond with the infant as they are unable to forget the negative experience of childbirth. However, women who delivered their babies in a compassionate and supportive environment are reminded that their children are precious, and this is echoed in the relationship they build with their children. This finding is similar to those of Bastos, Furuta, Small, McKenzie-McHarg and Bick (2015), and Larkin, Begley and Cdevane (2012), who suggested that when women perceive childbirth as a traumatic event, it has the potential for long term emotional effects, and midwives have the ability to enable or disempower positive experiences for women.

2.2.4. What are human rights?

Human rights are the basic rights every individual has simply because they are human. In South Africa, the list of human rights is described in the South African Constitution, the highest law in the country, in Chapter 2 which is named The Bill of Rights. The Constitution protects and promotes human rights for all people in South Africa (Western Cape Government, 2018).

According to the Center for Reproductive Health (2018), "Every woman has the right to safe and respectful maternal health care. Human rights standards surrounding safe pregnancy, childbirth, and respectful maternal care are rooted in the human rights to life, health, equality, and non-discrimination" (p. 9). The Center further states that, "governments must ensure these rights are protected by creating conditions that support healthy women, healthy

pregnancies, and healthy births. Fundamental human rights are violated when pregnant and birthing women endure preventable suffering, including death, illness, injury, mistreatment, abuse, discrimination, and denials of information and bodily autonomy” (2018, p. 9).

2.2.5. Quality care from a human rights perspective

The WHO’s (2016, p. 1) vision defines quality of care as “the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable, and people-centred”. Quality care during childbirth in health facilities requires physical infrastructure, supplies, management, and human resources with the knowledge, skills and capacity to deal with pregnancy and childbirth and that can manage complications that may require prompt life-saving interventions (Tunc et al., 2015).

The Commission on Information and Accountability (COIA) for Women’s and Children’s health created a time-limited independent Expert Review Group to operate until 2015, with the WHO hosting the secretariat for an independent Expert Review Group, known as the iERG. The iERG’s second report states that, to end preventable maternal and newborn morbidity and mortality, every pregnant woman and newborn need skilled care at birth with evidence-based practices delivered in a humane, supportive environment. Good quality of care requires the appropriate use of effective clinical and non-clinical interventions, strengthened health infrastructure, and optimum skills and attitude of health providers, resulting in improved health outcomes and positive experience of women and providers. Furthermore, quality of care is considered a key component of the right to health, and the route to equity and dignity for women and children (COIA, 2013).

Maternal health is a human rights issue that has implications for the rights to life, health, equality, non-discrimination, privacy, freedom from cruel or degrading treatment, and equitable distribution of the benefits of scientific progress, among others (Taylor, Hartman, Guillen & Ayala, 2012).

The WHO describes the “Continuum of Care” for Reproductive, Maternal, Newborn and Child Health (RMNCH) as an integrated service delivery for mothers and children from the pre-pregnancy stage to delivery to the immediate postnatal period. The “Continuum of Care”

recognises that safe childbirth is critical to the health of both the woman and their newborn infant, and that a healthy start in life is an essential step towards a sound childhood and a productive life (WHO, 2014).

Several studies show that women benefit from a consistent, continuing relationship with midwives during the childbearing process (Fontein, 2010; Sandall, Devane, Soltani, Hatem & Gates, 2010; Williams, Lago, Lainchbury & Eagar, 2010; Gagnon, 2011). Continuity of care means that the same midwife (or midwives) is responsible for the follow-up visits of women and the delivery of their babies. This is associated with the fact that women feel better prepared for the birth when the midwives are familiar to them, and they are more confident and experience a positive birth (Sandall et al., 2010). However, in MOU's, antenatal and intrapartum care provided to an individual are given by different midwives and this means that the midwife who is responsible for care during labour is unfamiliar to the women giving birth, and this may contribute to their anxiety about childbirth.

2.1.1.1 The right to equality and non-discrimination

The human rights principle of non-discrimination and equity states that an individual's human rights are exercised without discrimination of any kind, including race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, national, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation (Committee on Economic, Social and Cultural Rights, 2009). This right is reiterated in the South African Bill of Rights, which makes clear that neither the State nor any person can “unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth” (Constitution of the Republic of South Africa, 1996, p. 1247).

Research findings by D'Ambruoso, Abbey and Hussein (2005) and Perera, Lund, Swahnberg, Schei and Infanti (2018) revealed that treatment that is disrespectful and abusive deters women from accessing healthcare. Furthermore, women choose where to deliver based on the way they will be treated in the facilities available to them (Freedman & Kruk, 2014). For example, Watson and Downe (2017) carried out a review of the published evidence on discrimination against Romani women in maternity care in Europe, and on interventions to

address this. The study revealed that Romani women encountered barriers to accessing maternity care and when they do seek care, they experience discrimination in the form of mistreatment on the basis of their ethnic group, economic status, place of residence or language. This discrimination by the caregivers led to women receiving poor care in the form of abandonment during childbirth, and verbal abuse.

2.1.1.2 Right to a healthy and safe environment

The DoH, in consultation with various other bodies, developed a Patients' Right Charter which states that every individual has the right to a healthy and safe environment, to contribute to their physical and mental health or well-being (DoH, 2008).

Abuse of women by healthcare staff in maternity settings has been reported globally, in both high- and low-income settings. A WHO statement in 2014 emphasised that the problem of disrespect and abuse of women during facility-based childbirth is a global phenomenon requiring urgent attention (WHO, 2014). In South Africa, the problem has been documented and researched for decades. Studies in maternity facilities by Kruger and Schoombee (2010) and Khalil (2009) discovered that abuse by staff includes rudeness, acts of unkindness, clinical neglect, verbal abuse, psychological abuse, physical assault, and sexual violence. These studies also suggested that negative experiences occurred when women were treated insensitively or rudely, were left alone, did not receive explanations or were shouted at by midwives.

Verbal abuse is the use of language to control, frighten or insult someone. It usually involves shouting and swearing to criticise, humiliate, or blame a person, or to order that a task be carried out (Woods & Dyer, 2011). The victim of verbal abuse may experience fear and anxiety, or a loss of self-confidence and sense of worth. The abused person may also feel ashamed and guilty and believe that they deserve abuse. This is the most common form of abuse and is usually not taken seriously because there is no visible proof. However, repeated verbal abuse may lead to physical abuse (Goer, 2010).

2.1.1.3 The right to privacy and confidentiality

Article 14 of the Constitution of South Africa states that, "Everyone has the right to privacy". In health services, this includes the obligation to ensure that patient confidentiality is protected, information on health status is not disclosed to third parties without the consent of

the individual, health personnel are trained to respect privacy rights, and women and girls are not subject to procedures or treatment without their full and informed consent (Constitution of the Republic of South Africa, 1996). Similarly, the Committee on Economic, Social and Cultural Rights (CESCR, 2009) states that all health facilities must be designed to respect the right to confidentiality, thus making it impossible to potentially violate the right to health.

Confidentiality is defined as an “ethical principle in which information about individuals is made available only to those who need it” (Tiran, 2012, p. 49). In South Africa, according to the National Health Act (Act 61 of 2003), all patients have a right to confidentiality and this is consistent with the right to privacy in the Constitution (Act 108 of 1996).

Edwards (2010) stated that confidentiality is one of the most important issues to be considered during a consultation between midwife and woman. Protection of confidential information is crucial in midwifery; however, there are instances when confidential information will be shared by the midwife as s/he acts in the best interests of women and infants.

2.1.1.4 The right to informed consent

Informed consent is the ability to make a voluntary decision after sufficient information has been provided, which protects the right of the patient to be involved in medical decision-making, and assigns duties and responsibilities to health care providers (Nijhawan et al. 2013).

Informed consent is a legally enforceable right in South Africa according to the Constitution, which protects the rights to bodily integrity and well-being. In terms of the law, patients cannot be involved in medical treatment or research without informed consent. Health care providers are obligated to inform patients about their diagnosis, risks, benefits, treatment options, and right of refusal of treatment in a language that patients understand based on their literacy levels (Chima, 2015). Informed consent requires that information must be provided voluntarily, without coercion, undue influence or misrepresentation, and mandates disclosure of the benefits, risks and alternatives associated with any offered medical procedure or treatment (François-Xavier Bagnoud (FXB) Center for Health and Human Rights, 2018).

2.1.1.5 Right to information

The FXB Center for Health and Human Rights (2018) suggests that patients are often unaware of their rights, including the right to information on their condition and the right to access their medical records. Patients have the right to information about their health status, treatment options and reasonable alternatives, and the likely benefits and risks of proposed treatment and non-treatment. Patients also have the right to access their medical chart and medical history.

Along with this, all individuals have the right to seek and receive information and ideas concerning their health issues. The right to health includes the obligation to provide education and access to information concerning the main health problems in the community. Respectful care is an essential component of safe care. Caregivers who listen to women, provide them with accurate information and respect their choices make a fundamental contribution to a safe maternity service (Prochaska, 2015).

In a qualitative study performed by O'Donnell, Utz, Khonje and van den Broek (2014) in Malawi, women and midwives were interviewed to investigate their perceptions of the quality of care provided during childbirth. Throughout the interviews, participants identified lack of autonomy in the way care was given as a key barrier. Women described how they were not allowed to make decisions about their own care, they did not understand why they were given certain treatments, and their consent was not sought before procedures. This left women with feelings of powerlessness in deciding the care they required or expected during childbirth. On the other hand, midwives felt they were never involved in policymaking regarding strategies to improve care. This lack of autonomy for women was also found by D'Ambruso, Abbey and Hussain (2008), where health workers stated that they knew what was best for their patients. Jewkes, Abrahams and Mvo (1998) presented similar findings, where women were prohibited from making decisions about their care, thus reinforcing caregivers' authority. However, Langer and Villar (2002) explained that having autonomy is not merely an ethical principle, it is a human right. Individuals will make responsible decisions when given adequate information about their sexual and reproductive health, thus resulting in an informed choice.

2.1.1.6 The right to the highest attainable standard of care

The right to the highest attainable standard of physical and mental health is reflected in several international instruments that South Africa has signed and ratified, as well as the South African Constitution. These international instruments include the WHO Constitution of 1946, and the Declaration of Alma-Ata which was adopted in 1978 to affirm the right to the highest standard of health (Hunt & Backman, 2008).

Findings by Kumbani, Chirwa, Malata, Odland and Bjune (2012) revealed that although women could describe what they perceive as quality care and what was not satisfactory for them, they did not know what quality care they could expect as they were not well informed. Women's perception of quality care is essential in encouraging pregnant women to seek health care for childbirth, where skilled attendants will promote the wellbeing of not only the mother but also of their neonate. The study also discussed the need for health workers to realise that their attitudes will affect the health seeking practices of women, and that they should not use women's ignorance to provide poor quality of care.

Bohren et al. (2015) explain that every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination.

Mistreatment, neglect, abuse, or disrespect during childbirth is a direct violation of a woman's fundamental human rights, as described in internationally adopted human rights standards and principles. In particular, women have the right to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health free from discrimination. Women also have the right to be treated equally to maintain their dignity and be free to seek, receive and convey information (WHO, 2014).

2.3. Conclusion

This chapter presented the literature review, which highlighted how women and midwives perceive quality care in order to provide a basic idea of the topic that was researched. The next chapter highlights the methodology of the study, which includes: the research design, setting of the study, population, sampling and sample size, data collection process and data analysis process.



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CHAPTER 3

3 RESEARCH METHODOLOGY

3.1. Introduction

This study aims to explore and describe women and midwives' perceptions of the quality of care being provided during childbirth at an MOU in Cape Town, Western Cape.

Babbie, Mouton, Vorster and Prozesky (2001) describe research methodology as the systematic, methodical steps the researcher implements to solve the research problem, along with the logic behind them. It focuses on the research process and the procedures and tools used. The research method is a strategy of enquiry, which moves from the underlying assumptions to research design and data collection (Myers, 2009).

3.2. Research design

The research design is the plan and procedures that the researcher follows to answer the research question. The plan involves making decisions so that the research will make sense, and the procedures will include various strategies and specific methods of data collection, analysis and interpretation. A research design is considered the blueprint for conducting a study which enables the researcher to control factors that may interfere with the validity of the findings and the researcher needs to find an appropriate research design based on the nature of the problem being studied (Creswell & Poth, 2018) Thus the research design refers to the overall strategy that you choose to integrate the different components of the study in a coherent and logical way, thereby, ensuring the researcher will effectively address the research problem; it constitutes the blueprint for the collection, measurement, and analysis of data.

There are three types of research approaches: quantitative, qualitative, and mixed methods. Quantitative research is used to quantify the research problem by generating numerical data which can be turned into statistics. The quantitative approach tends to generalise results from a larger sample population by quantifying attitudes, opinions, behaviours and other defined variables. Quantitative data collection methods include surveys and questionnaires (Wyse, 2011).

Qualitative research is used to gain an understanding of underlying reasons, opinions and motivations, and is therefore primarily exploratory research, with the data collection producing observations, notes, and descriptions of behaviours and motivations (Wyse, 2011). Qualitative research involves asking participants about their experiences of things that happen in their lives. It enables researchers to obtain insights into what it feels like to be another person and to understand the world as another experiences it (Austin & Sutton, 2014). The strength of qualitative research is its ability to provide simple written descriptions of how people experience a certain issue, and by doing so to provide information about the “human” side of an issue (Crossman 2019).

Mixed methods research utilises the strengths of both quantitative and qualitative research to broaden understanding of the research problem, or to use one approach to explain or build on the results from the other approach (Creswell, 2009).

This study utilised a descriptive, explorative, qualitative research design. This method allowed the researcher to explore and describe women and midwives’ perceptions of the quality of care being provided during childbirth at MOUs in the Western Cape. The design is appropriate for the study as it allowed the researcher to study the phenomena by describing the perceptions of the participants in their natural setting (Babbie et al., 2011). In this study, midwives were interviewed at their workplace, i.e. Mitchells Plain MOU, which is also the facility where women delivered their babies.

Descriptive research is conducted to explore new areas of research and to describe situations as they present in the world, to count how frequently something occurs, and to categorize information. The researcher observes and can then describe what was observed (Burns & Grove, 2007). A descriptive design was appropriate in this instance because the researcher intends to describe participants’ perceptions of quality care as presented.

An exploratory design was utilised for this study because the researcher explored the perceptions of midwives and women with the aim of determining how they view and understand quality care during childbirth at the MOU. According to Babbie et al. (2011), exploratory research usually leads to insight and understanding of the phenomenon, rather than the collection of detailed, accurate, and replicated data.

3.3. Reasoning in research

People make sense of their thoughts and experiences by processing and organising ideas to reach a logical conclusion. The science of logic includes inductive and deductive reasoning, according to Burns and Grove (2007). “A deductive approach is concerned with developing a hypothesis (or hypotheses) based on existing theory, and then designing a research strategy to test the hypothesis” (Wilson, 2010, p. 7). Deductive reasoning is considered by many researchers to be the standard for scientific research. The researcher begins with a theory and hypothesis, and then conducts research through the implementation of relevant methodology. The study will then prove the formulated hypothesis right or wrong. This form of research begins at a general abstract level when the researcher collects observations to form the hypothesis, and then works its way down to a more concrete level where the hypothesis is tested with specific data to confirm or reject the original theories (Crossman, 2016). Burney (2008) explains that deductive reasoning works from a general to a more specific notion of thinking and is sometimes called a “top down” approach. Conclusions are drawn logically from available facts.

Inductive reasoning begins with specific observations or real examples in the world and progresses systematically to broader generalisation and theories based on those observed cases. It is also sometimes referred to as a “bottom up” approach because it starts with specific observations and measures, then detects patterns and consistencies amongst a set of data which leads to the formulation of a hypothesis that can be explored, and finally develops some general conclusion or theories (Crossman, 2016). Burney (2008) suggests that conclusions are likely based on available facts, and involve a degree of uncertainty. The facts available in inductive reasoning do not prove their conclusion but rather support it.

Qualitative research does not need to begin with a hypothesis, as it employs inductive data analysis to provide a better understanding of the interaction of “mutually shaping influences” and to explain the interacting realities and experiences of researcher and participant. It allows a design to evolve through the research process, rather than requiring a complete design to begin, because of the difficulty in predicting the outcome of the study. This is due to the different perceptions and values systems of the researcher and participants, and their influence on the interpretation of reality. In comparison, all quantitative research requires a hypothesis before research can begin (Lincoln & Guba, 1985. p. 40).

In this study, the researcher took an inductive approach rather than beginning with an existing theory or hypothesis. The researcher started by engaging with participants in a natural setting and describing the perceptions of the participants as accurately as possible. The raw data was collected during the interviews was then organised into a summary format to develop a framework of the underlying structure of experiences of the participants that were evident in the raw data to develop a hypotheses. A theory was then developed to make sense of the observations

3.4. Study setting

The research setting is the location where the study is conducted, and there are three common options for establishing a research setting: natural, partially controlled, and highly controlled (Gray, Grove & Burns, 2013).

A research study conducted in a natural setting is an uncontrolled, real-life situation or environment where the researcher does not manipulate or change the environment for the study (Miller, 1991 & Cresswell, 2013). In a partially controlled setting, the researcher manipulates or modifies the environment in some way, while a highly controlled setting is an environment artificially constructed for the purpose of conducting research (Burns & Grove, 2007).

The current study was conducted in a natural setting at Mitchells Plain MOU in Cape Town, Western Cape. Mitchells Plain MOU operates in the Mitchells Plain Health District of the Metro Region. The Metropole District Health Services (MDHS) covers health facilities across the Western Cape, and is divided into eight sub-structures, with each sub-structure managing two sub-districts. The combination of sub-districts per sub-structure is based on the size of the population, geographical area and the drainage areas (MDHS, 2004). Mitchells Plain, Hanover Park and Guguletu MOUs function within the Klipfontein-Mitchells Plain sub-structure. Of the three MOUs, Mitchells Plain has the highest population and delivery rate.

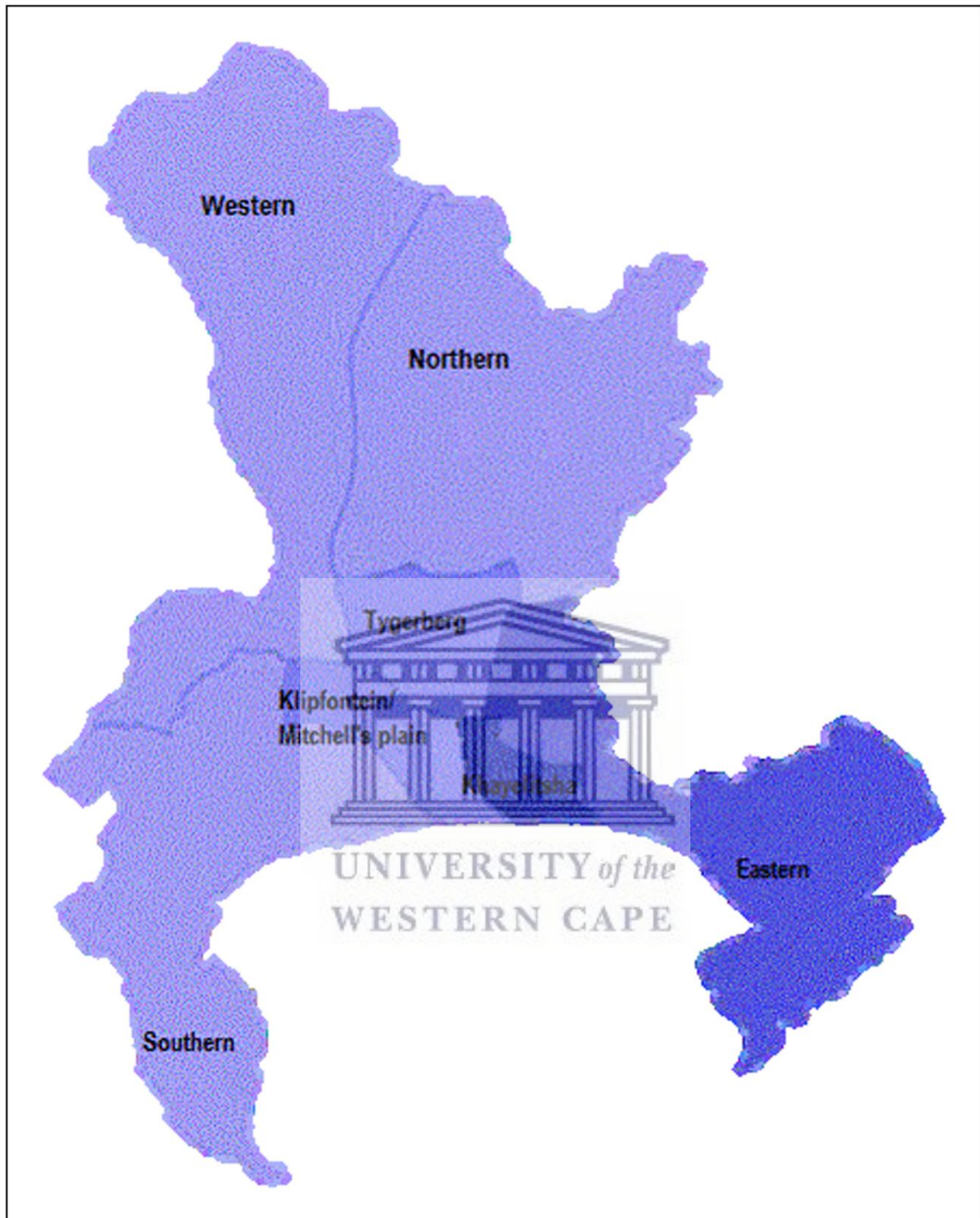


Figure 3.1: Health sub-districts of the Cape Metropole District.

Mitchells Plain MOU has a number of satellite clinics offering basic antenatal care, and all antenatal women from these clinics utilise the MOU for childbirth services. The MOU has a total of 15 midwives, of which four have been trained as advanced midwives. Since the MOU functions as a 24-hour unit, midwives work day and night shifts. The birth register reflects a

total of 250-280 live births per month. High risk patients are referred to Mitchell's Plain District Hospital, which is 10 minutes' drive from the MOU.

3.5. Population

The study population is all the people or items with the characteristics that the researcher is interested in studying. Because gathering information from every person in a population would be time-consuming and costly, the goal is to find a representative sample of that population.

The current study population was postnatal women that gave birth at Mitchells Plain MOU within the seven days prior to data collection, as well as midwives working at the MOU.

3.6. Sampling

Sampling is way to find a “sub group” which is representative of the broader population. There are two types of sampling: probability and non-probability sampling. With probability sampling, often referred to as random sampling, each unit in the population has an equal chance of being selected for the research study. In non-probability or non-random sampling, selection is based on assumptions regarding the population of interest, which forms the selection criteria (Prasad, 2015).

In this study, the researcher utilised non-probability sampling to select participants. In purposive sampling, which is a form of non-probability sampling, the researcher specifically selects the participants and site for study because they can assist in understanding the research problem and central phenomenon in the study (Creswell, 2007).

Participants were selected according to the following criteria:

Inclusion criteria:

- Women who had normal births at Mitchells Plain MOU within the seven days prior to data collection, regardless of how many deliveries they had previously.
- Midwives employed at the MOU and working in the labour ward for a minimum of 12 months.

Exclusion criteria:

- Women who had normal births at MOUs other than Mitchells Plain MOU.

- Women who had complicated births at Mitchells Plain MOU.
- Midwives employed at the MOU that only work in the antenatal clinic.

3.7. Data collection

According to Brink (2010), data collection is of critical importance to the success of the study. Data collection is the process of selecting participants and gathering data from those participants. Data for this study was collected at Mitchells Plain MOU, Cape Town by utilising semi structured interviews.

3.7.1. Data collection instrument

The research instrument for data collection is the fact-finding aspect of a research project. It is essential that the researcher ensures that the instrument chosen is valid and reliable, as the validity and reliability of any research project depends to a large extent on the appropriateness of the instruments. Whatever instrument is used to collect data, it must be critically examined to check the degree to which it is likely to give you the expected results (Annum, 2016).

Unstructured interviews with open-ended questions were used to collect data for the study. An interview involves verbal communication between the researcher and the participants, during which information is provided to the researcher and data is collected to learn about the ideas, beliefs, views, opinions and behaviours of the participants. It allows a researcher to see the world through the eyes of the participant (Burns & Grove, 2011). In the unstructured interviews, the participants were asked one broad question, and the researcher then generated questions spontaneously based on their responses to that question. By doing so, the researcher was able to develop a better understanding of the participants' perceptions (McCann & Clark, 2005, McLeod, 2014). Qualitative interviews allow the interviewer to follow his/her general plan of inquiry without having to ask a specific set of questions or in a specific order. It therefore enables the interviewer to steer the conversation in a general direction and pursue specific topics raised by the respondent (Babbie et al., 2011).

3.7.2. Preparation for the interview

After permission was obtained from the DoH to collect data at Mitchells Plain MOU, the researcher contacted all participants to arrange an appropriate time and venue for conducting

the interviews. Interviews were held in an empty room opposite the labour ward, and although the door could not be locked, a notice saying “Do not disturb, interview in progress” was placed on the outside of the door to ensure there would be no interruptions during the interviews. Using this room ensured that the daily functioning of the labour ward would not be disrupted, and it allowed participants privacy without fearing that the interview would be overheard by others.

3.7.3. Interview process

The success of an interview depends on the interviewer’s ability to generate questions in response to the context and to move the conversation in a direction of interest. The researcher will do this by asking probing questions to gain more information from the participants and to clarify certain aspects of the study (Hennink, Hutter & Bailey, 2011).

At the start of the interview, the researcher reviewed the purpose, significance and benefits of the study with the participant, to establish if they were still willing to participate and have the interview audio-recorded. Prior to giving written consent, participants were made aware that their participation was strictly voluntary, and that they were free to withdraw from the study at any time and would not be penalised or prejudiced in any way as a result. It was also explained that when the data was analysed, no names of any of the participants would be used, in order to maintain anonymity. Interviews were conducted in English and were audio-recorded, to enable the researcher to transcribe them verbatim. The one-on-one interview allowed the researcher to observe the participant’s facial expressions and body language in relation to their verbal responses to the interview questions. Observational data were captured as field notes and added to the data collected about specific participants.. Interviews lasted 45 to 60 minutes.

Midwives were asked one open-ended question:

- Describe for me the quality of care you as midwife provide to women during childbirth at Mitchells Plain MOU?

Women were asked one open-ended question.

- Describe for me your experience having delivered your baby at Mitchells Plain MOU?

3.8. Data analysis

According to Burns and Grove (2009), data analysis is conducted to reduce, organise and give meaning to data collected and is done concurrently with data collection. The data analysis process included the compilation of all relevant field notes, demographic information, and transcribed interviews.

Babbie et al. (2011) describe data reduction as a technique for analysing an unmanageable volume of qualitative data, by creating manageable summaries to facilitate examination. The data reduction process was used in this study, following Tesch's 8-step model (1985) and using the open coding method of analysing data as described by Creswell (2009).

Tesch's steps are described as follows:

All interviews were transcribed verbatim in English. The researcher listened to the audio-recorded interviews, then read and re-read all the transcripts. Ideas that emerged from listening and reading were documented on the transcripts. The transcripts were numbered and the researcher selected two transcripts at a time to re-read, noting any data relevant to the study. Positive and negative perceptions were indicated by using different colour pens. This process was repeated until all transcripts were done. Similar topics were listed and then clustered together, and major topics, unique topics and leftover topics were grouped in columns. The topics were listed and, by going back to the data, the topics were abbreviated into codes. Using this preliminary organisation, the researcher was able to see if new categories and codes emerged. Topics that related to each other were then grouped together, and the most descriptive word was used for the topic. A final decision was made on the abbreviation for each category. If it had been necessary, the existing data would have been recoded.

The above-mentioned steps allowed the researcher to utilise a systematic process of analysing data (Creswell, 2009).

3.9. Trustworthiness of the study

The term 'rigour' is often used to describe the desirable characteristics of both the process and the product of qualitative research, and refers to the adherence to high standards in conducting research (Davies & Dodd, 2002 & Cypress, 2017). Some researchers, like

Speziale, Streubert and Carpenter (2011), use the terms 'reliability' and 'validity' to define rigour in qualitative research, while others argue that the underlying philosophy and criteria are different, meaning that different terms should be used (Tappen, 2011). For example, Lincoln and Guba (1985) use alternative terms to describe trustworthiness in qualitative research.

In this study, the researcher described trustworthiness using the principles of credibility, transferability, dependability and confirmability.

Credibility refers to the quality of the research process, and measures the extent to which the data collection and analysis is believable and trustworthy and matches reality. The reader will judge the study's credibility based on his/her understanding of the study (Creswell, 2007).

Credibility in this study was ensured by:

- Selecting participants strictly according to the inclusion and exclusion criteria.
- Asking all participants the same open-ended question.
- Allowing participants to view their transcripts and verify if it was a true representation of the information they gave during the interview.

Transferability refers to the degree to which the results of the study can be generalised and transferred to other contexts or settings (Creswell, 2007). In this study, the researcher provided sufficient background information about the fieldwork process and experience so that readers could compare and apply it in another context or setting.

Dependability refers to the reliability of the study, i.e. the likelihood of observing the same findings under similar circumstances (Creswell, 2007). Reliability poses a problem in qualitative research because human behavior is not static and changes continuously depending on various influencing factors, such as the skillset of the researcher collecting data. It is further complicated by the fact that each individual has his/her own interpretations of reality. Merriam (1998) suggest that reliability in qualitative research should be determined by whether the results are consistent with data collection. Using Merriam's (1998) strategies, dependability in this study was enhanced by:

- Triangulation: This refers to using multiple techniques or sources of data to confirm findings. Data was collected in this study through both interviews and field notes.

- Prolonged engagement with subject matter and persistent observation: This was ensured by allowing participants to ask questions after the interviews to verify the data collected, which helped to build a trust relationship with the participants. During the interviews, the researcher was able to observe non-verbal responses, such as facial expressions and gestures.
- Peer Review. The researcher consulted with her supervisor throughout the study.
- Member checks: This was done by allowing participants to view the transcribed interviews to verify that it was a true reflection of the information given by them.

Confirmability refers to the objectivity and neutrality of the data, not the biases of the researcher, and is the degree to which the research findings can be confirmed or corroborated by others (Creswell, 2007). Confirmability was ensured in this study by:

- Documenting the procedures for checking and rechecking data throughout the study, as well as how the researcher's interpretations and conclusions were reached.
- Involving the supervisors throughout the study, and making all raw data, transcribed interviews, field notes, findings, recommendations and any other documentation available for an external audit and for the supervisors to review.

3.10. Ethical clearance

Ethical clearance was obtained from the University of the Western Cape's Senate Research Committee, and thereafter permission to undertake the study at the Mitchells Plain MOU was granted by the Department of Health. Finally, institutional permission was granted by the Primary Health Manager.

In qualitative research, the researcher is entering the personal domain of the participants when he/she is exploring their values, behaviours, attitudes, etc, thereby entering their private space. To respect this space, there are certain professional, legal, and social obligations the researcher needed to adhere to.

3.10.1. Informed consent

Informed consent means that the researcher has given potential participants all relevant information regarding the study and they comprehend that information, enabling them to make an informed decision whether or not to participate. Obtaining informed consent helps to

ensure that participants are not coerced into participating in the research (Nijhawan et al., 2013), but the amount of information that needs to be given depends on the subject's knowledge of research and of the specific topic (Burns & Grove, 2007).

In this instance, the researcher provided participants with information explaining the nature of the study and its benefits, thus allowing them to make an informed decision. Written consent was obtained from potential participants once they understood and had agreed to participate.

3.10.2. Right to self-determination

The right to self-determination is based on the ethical principle of respect for persons, and implies that every person has the right to control his/her own destiny, and the freedom to conduct their lives as they choose without any external control (Burns & Grove, 2007). Researchers are obligated to ensure that participants have the right to self-determination by informing potential participants that they have the right to decide whether or not to participate in the research study. Furthermore, participants have the right to withdraw from the study at any time without fear of penalty (Barrow & Gossman, 2018).

Participants in this study were made aware that their participation was strictly voluntary and that they were free to withdraw from the study at any time without being penalised or prejudiced in any way.

3.10.3. Right to privacy and confidentiality

According to Mosby's Dictionary of Medicine, Nursing and Health Professions, confidentiality means, "the protection of study participants such that an individual's identity cannot be linked to the information provided to the researcher and is never publicly divulge" (2010, p. 434).

The concept of confidentiality is closely connected with autonomy. In research, confidentiality means that the information provided by the participant will not be discussed with others and, when the findings of the study are presented, the individuals cannot be identified (Brown & Quigley, 2012).

All information obtained by the researcher during the data collection process was treated in a confidential manner and could not be linked to participants, as their names were not used. The information was entered into a computer that is password protected and could only be accessed by the researcher, and participants were assured that such information would not be given to anyone else. If a participant mentioned a name during the interview, the name was indicated with a pseudonym when the interview was transcribed. The information collected was only accessed by the researcher, the independent coder and her supervisor.

3.10.4. Beneficence and non-maleficence

The ethical principle of beneficence and non-maleficence refers to the researcher's obligation to ensure the research study will generate maximum benefit for the participants, and that the researcher must be competent to carry out the proposed research activities. Beneficence forbids deliberate infliction of harm on individuals, and is sometimes expressed as a separate principle: non-maleficence (DoH, 2015). According to Burns and Grove (2007), discomfort and harm can be physiological, emotional, social and economic in nature.

Interviews with women coincided with their follow-up visits to the MOU to avoid any additional financial costs. Midwives were interviewed during their break time so as not to disrupt the daily functioning of the labour ward. During the interviews, the researcher ensured that participants were at ease and were aware that they could stop the interview at any time should they feel uncomfortable.

3.10.5. Justice

The principle of justice pertains to participants' right to fair treatment and right to privacy. Selection of the types of participants desired for a research study should be guided by research questions and requirements so as not to exclude any group. The right to fair treatment also relates to researchers treating those who decline to participate in a study fairly without any prejudice (Barrow, Paras & Khandhar, 2019)..

In this study, all participants were selected strictly according to the set criteria without coercion.

3.10.6. Veracity

The Regis University states that the principle of veracity involves truth about the research study and the absence of deception. In order for the individual to make an informed choice, he or she must have all the information relevant for his or her decision. This information must be clear and understandable (Gelling, 2015).

In the current study, the researcher explained the purpose and aim of the study to ensure that the participants understood what was expected of them should they agree to participate. Before the interview started, the researcher again reviewed the purpose and aim of the study and ascertained that the participant was still willing to participate and have the interview audio-recorded. Interviews were transcribed verbatim and analysed with no manipulation of the data.

3.10.7. Fidelity

Fidelity relates to the concept of trust. Participants place trust in the researcher and this necessitates a commitment to protect them. It is essential that researchers gain the trust of the participants in their research by being open and honest about possible risks and burdens of the research study, and thus foster a trusting relationship (Gelling, 2015). Individuals have the right to act as free agents, and in doing so exercise their right to autonomy. Lack of fidelity in dealing with others limits their right to autonomy as it denies them the opportunity to free choice (Syracuse University School of Education, 2018). Here, the researcher explained the study to the participants and assured them that they would remain anonymous.

3.11. Dissemination of study findings

The findings of the study will be published, with the guidance of the research supervisor after completion of the project. The researcher will present study findings to health workers, mainly midwives and during one of the training workshops for health service providers. A copy of the research report will be made available Mitchells Plain MOU as well as UWC Library

3.12. Conclusion

This chapter presented a detailed overview of the research methods used in this study. Justification for selection of the methods and techniques are provided. In the following chapter the findings and discussions will be presented in detail.

CHAPTER 4

4 FINDINGS AND DISCUSSION

4.1. Introduction

In this chapter, the findings of the research are presented and discussed. The discussion is structured according to the themes and categories that were identified through the data analysis, in order to address the research objectives:

- To explore and describe women's perceptions of care provided by midwives during childbirth at Mitchells Plain Midwife Obstetric Unit.
- To explore and describe midwives' perceptions of care provided to women during childbirth at Mitchells Plain Midwife Obstetric Unit.

4.2. Themes that emerged

Table 4.1 represents a summary of the themes that emerged from the data, and the respective subthemes which form the main findings of this study. The themes represent women and midwives' perceptions of quality care during childbirth, and verbatim quotes were used to support the results.

Theme	Subthemes
Quality care	<ul style="list-style-type: none">• Communication• Pain relief• Safety
Negative experiences by women regarding professional conduct by midwives.	<ul style="list-style-type: none">• Verbal abuse
Need for support during childbirth.	<ul style="list-style-type: none">• Support from midwife• Support from companion• Support from management
Experiences midwives faced when delivering quality care.	<ul style="list-style-type: none">• Workload

Table 4.1: Themes and subthemes

The experiences of the participants were described in many ways, and related to both positive and negative impressions that midwives and women had about the quality care rendered during childbirth.

The identified themes are discussed individually, and quotations of participant's responses are presented, and supported by literature as far as possible.

4.3. Demographic profile of the participants

Demographic information was considered essential as it provides a socio-cultural descriptive profile of the factors that contribute to the experiences of women and midwives. The age, parity, level of education, and race group of the women were recorded.

Age	Parity	Education	Economic status	Race
32	4	Grade 10	Unemployed	Coloured
27	2	Grade 12	Employed	Black
21	2	Grade 12	Unemployed	Coloured
17	0	Grade 12	Employed	Coloured

Table 4.2: Demographic profile of women

The age, years of experience and qualifications were recorded for midwives

Age	Years of experience	Qualification
25	2	Midwife
37	1	Midwife
27	4	Midwife
37	10	Advanced midwife
58	30	Advanced midwife

Table 4.3: Demographic profile of women

4.4. Quality care

Quality care is the extent to which the health care service provides care to the individual and the patient population to improve desired health outcomes. In order to render quality care the health care must be safe, effective, timely, efficient, equitable and people-centred (WHO, 2016).

Managers, staff and patients may interpret quality care differently. For example, patients could believe that they received quality care if their perceived needs are met on time (Raven et al., 2015):

My, my experience was quite like (slight pause) very horrible because I came in at 05h00 and was like for a long time in pain and when I actually gave birth there was nobody around me and the child's head was already out when I was calling and so the sister only came afterward... all they said is that they were busy. I won't ever come here again this place is horrible. (Woman 1)

I didn't have a bad experience here. (Woman 3)

According to the South African Nursing Council (SANC, 2005), midwives in South Africa are nurses who focus on the care of pregnant women and the delivery of babies. Midwives have the ability to work independently in cases of healthy pregnancies and problem-free deliveries; however, they refer patients to secondary hospitals for further care when complications are diagnosed. The majority of pregnant women in South Africa use the public healthcare system, and most of this care is provided by midwives (Reid, 2007 & Pattinson, 2015).

Midwife 1 explains what she perceives as rendering quality care:

...holistically. Their needs. You address their needs and you make sure you carry out what is required like and you would treat them with respect like you would treat any other human being.

The midwives have diverse and flexible functions which depend on the legislative, structural and economic factors that influence their midwifery practice. However, according to

Dippenaar and Da Serra (2012), midwives face challenges in their practice, such as fragmentation of care, obligation to perform non-nursing duties, and lack of support from the managers.

Midwife 2 stated that quality care is affected by certain factors:

It is definitely affecting, not my care but the care as a whole as a MOU because it's supposed to be a holistic thing.

When asked why she thinks these factors affected the care provided, she answered:

I think that the care of this facility is down because it is not proper staffed you can't say that one person because it is all, all of us is affected by this... The care is not, it is not of quality because we can give a much better service like I said maybe it's a small thing but it can give you much better results.

Midwife 4 disagreed, based on the fact that there is continuity of care that aids in building a trust relationship with the patient, and she highlighted the importance of teamwork.

The care we give, me specifically is very well because most of the time the patients I see in labour ward is the patient I see in the antenatal clinic. So there is already a rapport and the patient already trust you so I feel it's very good especially if you have a nice team working with you.

According to The Coalition for Improving Maternity Services (CIMS, 2016), the Mother-Friendly Childbirth Initiative states that each caregiver carries the responsibility of the quality of care he or she provides, and maternity care practices should only be based on the needs of the mother and child, not on the needs of the caregiver. The CIMS (2016) is based in the United States of America, and is a coalition of individuals and national organizations who promote the care and wellbeing of mothers, babies and families by ensuring that health professionals practice according to evidence-based standards. This is important since it affects the quality and cost of care that patients receive.

In South Africa, according to the DoH, primary health care workers are expected to be caring and compassionate towards their patients, but the department also identifies that becoming patient-centred and improving the quality of care is a challenge. Therefore, Vision 2020 of the Western Cape DoH adopts values of caring, competence, accountability, integrity, responsiveness and respect that every health care worker should have. However, there may be inconsistency between the organisational values and the experience of the health care workers because of the actual values held by the health care worker that may manifest in personal behaviour (Western Cape Government, 2011).

...as the midwife to make sure that the baby is delivered safely and that the baby gets the care that the baby needs and the mother gets the post-delivery care...now an emergency will explain to the mother that she needs to put in more effort because there is certain complications that can happen but I don't try to make her alarmed or scare her and I will do whatever is necessary without causing her to feel, without causing her to become liked panicked. (Midwife 2)

I normally just explain to the patient like the consequences of her not cooperating with us and what can go wrong and what can go wrong and all that then we take it from there. (Midwife 3).

Similar findings were presented in a qualitative study conducted by Yakubu, Benyas, Emil, Amekah, Adanu, and Moyer (2014), with the data indicating that midwives perceive themselves to be acting in women's best interests, and such motivations may serve as important drivers in programmatic efforts to improve the care of women.

Midwife 5 stated that when delivering quality care:

...your attitude plays a role...

When asked to elaborate on this, she said:

Talk softly, you smile and respect, that means all the values, respect, be accountable, care, integrity and responsiveness.

Midwives perceived quality care as being able to assist women to have a safe delivery, whereas women perceived quality care from midwives when their basic needs were met.

4.1.1. Communication

Mosby defines communication as, “any process in which a message containing information is transferred, especially from one person to another, by any number of media” (2009, p. 420).

Communication in health care, particularly between midwives and their patients, has attracted an increasing amount of attention in recent years. The DoH and other statutory bodies have all been involved in initiatives to promote good communication and to improve record keeping. These initiatives are the result of research studies providing evidence that the quality of the interaction between patients and their carers may have a significant effect on numerous aspects of patient wellbeing. These aspects include patient satisfaction, knowledge and understanding, compliance with advice given, adherence to treatment, and psychological and other health outcomes (Rowe, Garcia, Macfarlane & Davidson, 2002).

In a qualitative study conducted by Larsson, Hildingsson, Ternström Rubertsson and Karlström (2018), women that feared childbirth was offered counseling from experienced midwives. These women reported that gaining information and knowledge from the counseling sessions improved their confidence and it provided them with a greater sense of calm and preparedness. This in turn, positively affected their birth experience as they experienced a feeling of safety which was linked to the professional support during childbirth.

The work of Tinti, Schmidt and Businaro (2011) confirmed that the provision of constant information on the progression of labour provided the women with a sense of personal empowerment and gave them complete control of the childbirth process, which is a predictor of childbirth satisfaction. This sense of empowerment set the spiritual ontology in motion to pursue the unique and unpredictable journey of labour.

According to Veltman and Larison (2010, p. 1), respectful communication is “safe, balanced and non-intimidating”, and creates an environment where women have more freedom to

participate in making decisions about their care without fear. Effective communication amongst team members when making plans on how to care for their patients or seeking advice shows that each individual woman is worthy of attention and care and empowers the staff to provide better care (Matthews & Callister, 2004). Women want health professionals that combine their clinical knowledge and skills with interpersonal and cultural competence (Renfrew, McFadden, Boston & Campbell, 2014).

The Substance Abuse and Mental Health Services Administration (2011, p. 1) defines cultural competence as, “being respectful and responsive to the health beliefs and practices of different cultures and the ability to interact effectively with these individuals to ensure that the needs of all community members are addressed”. Thus, women want midwives that are skilled and understand their culture and beliefs.

Some of the women felt that the information they received to prepare themselves for childbirth was inadequate, as it did not cover some of the challenges they had to face in their birthing process. However, the midwives stated that they informed women adequately during labour to aid them through the birthing process.

Woman 1 explained what happened after she gave birth:

They first took him away to see if he was fine and yes then afterwards they did skin to skin.

When asked what the midwives did to check the infant, she replied:

No, all they said is that they were busy.

They should also tell you that after you give birth you need to help yourself. (Woman 3)

...it was my first time I didn't know what to expect or you know if they are doing their job properly or not... (Woman 4)

Respondents described a number of unmet information needs during the antenatal, intrapartum and postnatal periods. The most common problems reported by women were

receiving inadequate information from staff to prepare them for childbirth and the postnatal period.

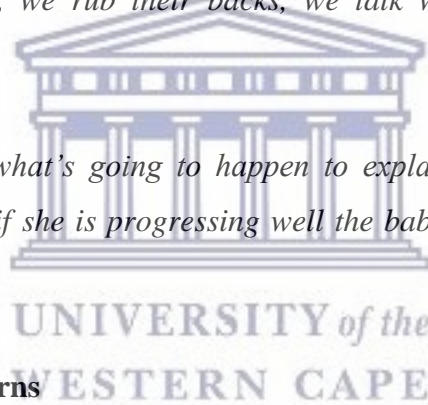
Midwives disagreed, stating that women are given sufficient information during childbirth, as reflected in the statements:

Every time you examine her, me personally as a midwife I would tell the patient you are so far dilated and you can expect. (Midwife 1)

The thing that we do normally like we explain to the patient what to expect. (Midwife 3)

The nurses even especially if the labour ward is not busy and we got that time we walk with the patient, we rub their backs, we talk with them, we sit with them. (Midwife 4)

...so she must know what's going to happen to explain for the knowledge and to explain that the baby if she is progressing well the baby will be delivered vaginally. (Midwife 5)



4.1.1.1 Interpersonal concerns

Most women preferred midwives who were confident, could make them feel relaxed, comfort them during labour, and “be responsible” (show concern and commitment to providing care) for women and their babies. Treating women with respect was a particularly important attribute, demonstrated through showing concern and being kind.

Uncaring behaviours included laughing at them, being spoken about in a negative way within hearing distance, and being ignored. One of the participants described her experience during an interview:

My experience was very hard, very difficult... I realised that to bring someone is... very hard, it's something not easy. (Woman 3, referring to giving birth)

She was not prepared for childbirth and, with further probing, explained why the midwife was shouting at her:

I don't know maybe she was helping me, maybe I wasn't doing the exactly what they expect of me (shrugging her shoulders).

She also described feeling ill-prepared for the postnatal period:

They should also tell you that after you give birth you need to help yourself.

Woman 4 was admitted to the labour ward numerous times and sent home because she was found not to be in labour:

I was here for the whole weekend basically. I went back and forth, went home came back, went home came back and I gave birth this morning at 4 o'clock...it was my first time I didn't know what to expect or you know if they are doing their job properly. They joke around sometimes when it's not a joke like when you're in pain or something not with me but I am talking about what I've seen or heard.

The midwives disagreed with the women, stating that they provide adequate information to help prepare women for childbirth. When asked about preparing women for childbirth, Midwife 1 stated:

...it starts antenatally. Correct we educate them antenatally when they come for their visits and usually when they are in the cubicle when we see them we tell them about what they can expect... [During labour] I would tell the patient you are so far dilated and you can expect.

However, Midwife 2 felt that the workload does not allow for properly educating women. She stated the following:

Not really. In the antenatal side we don't have the time talk, talk to our patients. An antenatal sister sees 40 people a day so how can you speak to... how much time can you spend with one person talking to them about childbirth when you need to be focussing on your antenatal care... What I try to do if I'm in the clinic, I at least ask

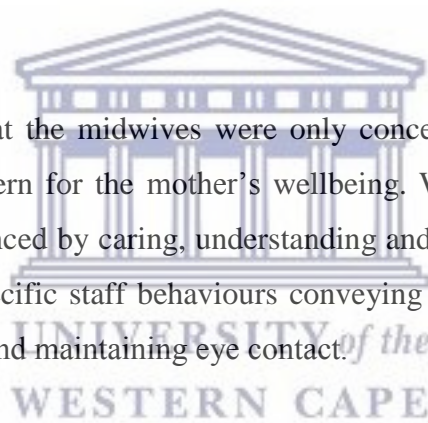
the mother if they are ready to push that's like a small two cents then that is at least something for them to think about... then I can at least tell them practice this, do this, do that.

The following two statements by midwives described what they perceive to be their role in the labour wards:

We explain to the patient what to expect... if there is anything that happens she is not sure of, she must just come to us. (Midwife 3)

You prepare your patient mentally, physically and spiritually so that the patient can relax and she may have the knowledge what is going to happen because it can be a prime-up that never got a baby so she must know what's going to happen. (Midwife 2)

Some women commented that the midwives were only concerned with the welfare of the baby, and showed little concern for the mother's wellbeing. Women emphasised that their birthing experience was enhanced by caring, understanding and empathetic staff that ensured they were well-informed. Specific staff behaviours conveying genuine care included taking women's concerns seriously and maintaining eye contact.



4.1.1.2 Failure to respond to information

During childbirth, the midwife is obligated to provide women with constant information about the progress of their labour to help create a sense of personal empowerment. In doing so, it gives women complete control over the childbirth process, which contributes to their childbirth satisfaction Tinti, Schmidt and Businaro (2011).

Midwives failed to acknowledge information that women provided or concerns that they expressed, and women frequently described staff as “not listening”. In particular, women were frustrated at “not being believed” regarding their reported stage of labour.

The following experiences were described by women:

I was alone, no students, no sisters, nobody to help me. I was actually shouting for help but nobody was there. (Woman 1)

I was telling them that I am feeling faint it was like I'm lying. They told me everything is fine, they told me my blood pressure and sugar is fine but for them it was like I'm not right in my head. (Woman 3)

Midwives contributed their inability to optimally care for every individual to their workload as stated below:

...in this unit it gets very busy so there is a whole lot of patients you need to care and it slips your mind to keep the patient informed about her progress of labour. Which is wrong but we try our utmost best.” (Midwife 1)

Midwife 2 believed that administrative duties interfered with the care they provided, stating:

We have a lot of paperwork to do as the labour ward sisters... The stuff we really need to make sure of is our delivery notes is documented, our nursing notes that is but other admin stuff is not supposed to be and that is also taking from our time of actual nursing care...

Midwife 3 explained that, because of their workload, the midwives ask women to report if they have any problems:

...we don't have a lot of sisters in the labour ward so each and every patient can't have a sister looking after for each patient that why we say if there is a problem then she must come to us...

Women, intentionally or unintentionally, develop a birth plan to prepare for childbirth (Cook & Loomis, 2012). It was only in the 1980s that the use of formal birth plans was implemented as a means for women to discuss their desired birth experiences with their care providers (Kuo et al., 2010). Cook and Loomis' (2012) qualitative study suggested that the increased availability of care by midwives is an important aspect in ensuring that women have a healthy and positive birth experience.

4.1.2. Pain relief

Mosby (2009) defines pain as a distressing feeling caused by noxious stimulation of the sensory nerve endings, which resolves once the noxious stimulus is removed. Every individual experiences pain differently, and this is influenced by the individual's physical, psychological, social, cultural and emotional factors. Although perception of the pain is determined to some extent by cultural patterning, there is unquestionably a physiologic basis for pain during labour.

According to the Perinatal Education Programme (2009), one of the health worker's primary responsibilities is to relieve pain and suffering. Although pain during labour is regarded as part of the normal process, women in labour should be asked frequently if they need pain relief and if the most appropriate and effective form of analgesia available must be given. According to Peninsula Maternal and Neonatal Services (PMNS, 2011), one of the primary responsibilities of health care workers is to relieve pain and suffering, meaning that if women ask for pain relief during a normal labour, the midwife is obligated to administer pain relief as per protocol. The relief of pain often allows labour to progress more rapidly by reducing the anxiety which is caused by pain. This was emphasised by the DoH in their Maternal Guidelines (2015), which states that pain relief should be offered to all women in labour.

Four of the five midwives interviewed identified pain relief as one of the factors when rendering quality care to women during childbirth. Two midwives referred to pharmacological pain relief, whereas the other two midwives mentioned other means of pain relief.

Midwife 2 explained why she was unable to administer pain relieve:

Pain relief is not practiced and I mean the pain is so you can't handle the pain and with the youngsters you might want to consider at least them you might not give everybody but that might open a can of worms why is that mother getting and you can't get pain relief... Because we don't have the manpower to monitor the baby closely and after that the baby because of the respiratory distress you might have to spend more time post-delivery with the baby... I don't even want the mothers to even ask me for pain relief because I don't want to be the one to give them the news that we don't give you anything for pain.

The Perinatal Education Programme (2011) explains that when women experience anxiety during childbirth, or fear and uncertainty of what is about to happen, this lowers their pain threshold. Pain increases the patient's anxiety, which in turn reduces her ability to tolerate pain. However, some women experience little pain during labour and do not require pain relief.

Midwife 4 stated:

The patient will sometimes request or say sister not so much a request it's asking can't I have something for the pain and if we feel that the patient needs it we do give it like I said protocol said we need to phone doctor we need to have a doctor's permission to say no sister it's fine give the patient pain relief.

Some women have little pain during labour and, may therefore not need pain relief. Other women may feel that they are able to tolerate the pain and may choose not to have pain relief. However, the attending midwife is obligated to offer all birthing women pain relief (DoH, 2013).

The following two midwives described their experiences with women and pain during the birth process, both focusing on non-pharmacological pain relief:

...when she is having pain where as we encourage the patient to walk up and down and breath in. (Midwife 3)

...if she is progressing well the baby will be delivered vaginally and the pain will be there and if she can relax herself and it won't take time. (Midwife 5)

The attitudes and support of the care givers and birth companions or doulas play an important role in how women cope with pain during labour, which may result in childbirth without pharmacological pain relief (Fraser, Cooper & Nolte, 2010).

Of the four women interviewed, only one participant considered pain relief an important factor of quality care during childbirth but disagreed with the way in which she was told to handle her pain, especially as she was not allowed to have her husband with her for support:

...what I didn't like is when you have pain here they say you have to walk around I don't think it is okay, you must walk around but you need support with you. (Woman 3)

Midwives were inconsistent in administering pain relief to women, as some of the midwives opted for non-pharmaceutical methods instead.

4.1.3. Safety

The safety of patients is a global concern that involves all healthcare workers. Nurses spend a great deal of time with their patients and function as essential members of a healthcare service in ensuring patient safety. However, high workloads, insufficient nurse staffing, and low levels of motivation contribute toward an environment in which errors can occur and cause harm to patients (Pazokian, Tafreshi & Rassouli, 2014).

A workplace environment with sufficiently-qualified staff and staff members supporting each other contributes to a feeling of security and provision of quality care (Hallin & Danielson, 2006). While safety is an essential component of care, this goal may be prioritised at the cost of effective interpersonal interaction when external demands on care providers are increased. This principle was enshrined in The White Ribbon Alliance Respectful Maternity Care Charter (2011), which stated that the concept of safe motherhood must be expanded beyond the prevention of morbidity or mortality, to include respect for women's basic human rights, autonomy, dignity, feelings, choices and preferences. Thus, according to the DoH (2007), the maternity service's priority is to provide a choice of safe, high-quality maternity care for all women and their partners.

All the midwives interviewed expressed a genuine concern for the wellbeing of the women to deliver safely.

This is supported by the following statements from midwives:

We have protocols and guidelines that we need to follow to ensure that our patients are getting what they need. (Midwife 1)

...as the midwife to make sure that the baby is delivered safely and that the baby gets the care that the baby needs and the mother gets the post-delivery. (Midwife 2)

Midwife 4 stated that she always works according to protocol:

...if they ask for pain relief we usually phone doctor we follow the protocol and we give like Pethidine to the patient [when short-staffed]... there is protocols in place where we can divert our patients to another hospital where we know that there is staff.

Midwife 5 explained what safety during childbirth means to her:

First of all, you make the environment for the patient in order to be, to know that she belongs... you prepare drugs but with the drug you must see that they are not expired and you see that the drugs are not lying around... If a patient is on the programme, the PMTCT programme you keep documentation, all documents confidential.

Midwives defined safety measures when delivering safe maternity care as having appropriate equipment, a clean environment, adequate staff, working within the set protocols, and women being well-informed about what to expect.

4.2. Negative experiences for women regarding professional conduct by midwives

The Nursing Act (Act 33 of 2005) defines professional misconduct or unprofessional behaviour as a conduct which is improper, disgraceful, dishonourable or unworthy to the profession of a practitioner. The SANC developed a Code of Ethics which serves as a declaration by nurses that they will provide due care to the public and health care consumers to the best of their ability while supporting their colleagues. The midwife will be personally accountable for his/her acts and omissions while carrying out their responsibilities in their profession and must be able to justify all decisions taken and carried out (SANC, 2005).

4.2.2. Verbal abuse

The institution is accountable for the treatment of women during childbirth, by ensuring that clear policies on rights and ethical standards are developed and implemented by all staff members.

One of the participants reported that she felt pressured, judged and discriminated against by midwives for her decision or preference, particularly in relation to decisions about antenatal care and place of birth. The following quote highlights her experiences:

...they were complaining that I am from Gugulethu why am I not using the clinic there and come here. So every time when I scream, You came here, you make us work, work hard because you leave your Gugulethu and come here... (Woman 2)

After careful probing, the participant further explained what happened when she gave birth:

... the lady there she was shouting at me... 'Shut up! This is not Gugulethu, you see... you don't have to cry, you have to shut your mouth, open your legs, push! You think now... I'm not going to tell you anything now, I'm waiting for you!'... I don't know maybe she was helping me, maybe I wasn't doing the exactly what they expect of me.

Jewkes and Penn-Kekana (2015) suggest that the negative behaviour stems from what is acceptable within the environment, which is influenced by both practice and expectations of power, and are largely taken for granted. This may lead to the belief that staff will be in control of patients and entitled to use a range of strategies to achieve this, and to punish disobedience. The lack of repercussions for unacceptable health worker behaviour can fuel a sense of entitlement.

Another participant stated that she had issues with the care she received but was not a victim of verbal abuse, and believes it is how you as individual communicate that determines the way in which the midwife will react. The following quote highlights her experience:

but from my first experience I never, they never shouted at me and even with her also because I wasn't rude with them like I said it's how you are with them and they will react back with you. (Woman 3)

Yabuku, Benyas, Emil, Amekah, Adanu and Moyer (2014) state that the power relations between some health professionals and women in maternity settings is because this is where midwives feel they have authority over women which strongly parallels the societal dominance of men. As noted above, social norms within these environments strongly influence how both staff and patients behave. This can lead to the belief that staff will be in control of female patients and are entitled to use a range of strategies, including physical violence, to achieve this control and punish perceived disobedience. Yabuku et al. (2014) suggested there are certain situations that may serve as triggers for maltreatment, during which midwives feel as though the best way to obtain compliance from a labouring woman is to yell at or hit her. It also suggested that maltreatment may arise out of midwives' sense of maternal responsibility for the labouring women in their care, and this maternal responsibility and the added responsibility of caring for the unborn babies results in harsh treatment in the name of encouraging a safe delivery.

These findings are slightly different from Abraham, Jewkes, and Mvo's (1998) study of midwives in South Africa, which found that along with seeking to control patient behaviour, midwives in their setting used violence and maltreatment as a way to establish and maintain social distance between themselves and their clients. Maintaining social distance was not the primary motivator in this study, and the midwives genuinely seemed motivated by the desire to see a positive birth outcome and to avoid being blamed for a negative outcome.

In the current study, one of the participants explained that after being shouted at, the care she received improved, while one of the midwives stated that being abusive towards women can cause women to become uncooperative:

*when the baby is coming out she cooled down and treated me very well until the end.
(Woman 3)*

we are not expected to like shout at the patient or beat the patient that doesn't want to because that can also make the patient more how can I say? Instead of working with

you but then he will be afraid to that's I'm trying to say you but if you just explain to the patient clearly that if there is a pain then you just push. (Midwife 3)

Although the midwives stated that they are aware that they may not verbally abuse their patients, it is still happening. The findings from this study point to the urgent need to educate women and other family members about their right to respectful care, and empower them to report and challenge disrespectful and abusive practices. It also highlights the importance of sensitising and training midwives in providing respectful care.

Ending disrespect and abuse during childbirth can only be achieved through involving all stakeholders, including women, in efforts to improve quality of care.

4.3. Need for support during childbirth

The Cambridge English Dictionary defines support as, “to agree with and give encouragement to someone or something because you want him, her, or it to succeed.” (2019).

Women are more likely to feel respected when they trust that their caregivers have the knowledge and skills to care for them. The competence of midwives and nurses is further enhanced by honouring requests by women for pain medication, working to achieve physical comfort in labour, encouraging words and attitudes (Doran, 2010). Midwives that display skills and knowledge while rendering care will create a feeling of respect amongst women which will be enhanced if their needs are met.

4.3.1. Support from midwife

Birthing women are very vulnerable, especially when they do not have the support of a birth companion who can act as an advocate for them and therefore have little choice but to submit to the power that professionals have in this setting (Jewkes et al., 2015). Women depend solely on midwives during childbirth for support if they do not have a birth companion to rely on.

The following quotes highlight the different experiences of participants:

I was alone, no students, no sisters, nobody to help me. I was actually shouting for help but nobody was there. (Woman 1)

At that time I wasn't feeling very well but because I was desperate and there is nothing else I can... I mean I was very, very... ready to deliver. So I feel like there's no choice I have to do what she says, I must do... (Woman 3 reported that although she experienced verbal abuse from the midwife, she was dependant on her)

The one (midwife) came sometimes and left and the other one was there to help me and she was good, she was great helping me get through it. (Woman 4)

Findings by Lundgren and Berg (2007) from a secondary analysis of qualitative studies suggested that trust serves as a source of strength and security supporting the woman's self-esteem, allowing them to manage the childbirth process. Two midwives agreed, stating:

You empathise with the patient because she is going through pain. We must not like pressurise the patient because some of the patients they get tired easily and then they will say 'I can't take it any more sister I can't push!' (Midwife 3)

...but overall I feel we are very compassionate when it comes to the patient, sympathise with them because most of us have had children we tell them this is the normal thing, this is childbirth and I feel the anxiety levels comes down a bit and it helps the patient but not only the patient it helps us as sisters because the patient is more relaxed... The nurses even especially if the labour ward is not busy and we got that time we walk with the patient, we rub their backs, we talk with them, we sit with them. (Midwife 4)

Midwife 4 also explained that as a midwife you need to be able to support women in other areas too:

...we play social worker sometimes she's complaining that she is in labour she is term but at the end of the day nothing is wrong the patient is not in labour and then we need to probe and probe to find out her boyfriend is hitting her or the boyfriend has a

relationship with someone else and it is only a physical thing and more emotional and she can't anymore and to her is let me just go to the labour ward.

Women explained that there was a lack of support from midwives but the women who did receive support were appreciative.

4.3.2. Support from birth companion

The MOU is set up with an admission room where women are examined and the diagnosis of labour is made. From here, they are moved to the antenatal ward to await active labour. It is the policy of the MOUs to allow one companion per patient in active labour (Peninsula Maternal and Neonatal Services, 2011).

The Patient Centred Maternity Care principles offer all birthing women unrestricted access for the birth companions of her choice to the labour ward, as well as to continuous emotional and physical support from a birth companion (DoH, 2013).

However, the following participant had a negative experience:

I asked if my husband can come in they said no which is not a nice thing because you need someone with you at that time... actually the pain was so bad that I grabbed the sister's hand where my husband could have been there to support me. (Woman 3)

Midwife 1 explained that, because of the facilities infrastructure, birth companions are sometimes not allowed:

...we allow patients to have companions, doulas, but because our facility is so small and especially in the antenatal ward that is like limited so we don't allow the doulas to be in with them from 1 to 3cm but as soon as they hit 4cm and we put them in the labour ward and we make sure the doula is there to comfort them and to support them during childbirth.

Midwife 2 further explained that,

The partner is allowed for every patient in the labour ward yes so once they are in active phase they are allowed to be there.

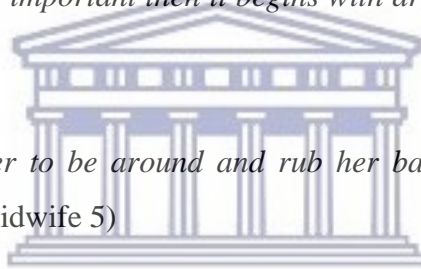
However, Midwife 4 stated,

...we allow them to go into the labour ward from labour ward and from labour ward they are allowed to be there all the time up until delivery.

He or she can also talk to the patient like to calm her down and make her understand more what we are trying to do. (Midwife 3)

...you can guide that companion and say rub her back just try to get her to eat something, walk with her up and down. It takes the pressure in a way away from you so that you might see more patients. On the other side it is a bad thing because this companion is watching everything you are doing and some people believe you must only be with their person that person is the most important and we can't be that way because each person is important then it begins with arguments with sisters and staff. (Midwife 4)

You allow the partner to be around and rub her back and wipe her face and to support the patient. (Midwife 5)



The Perinatal Education Programme (2009) states that non-pharmacological measures of reducing pain, such as keeping women informed of what to expect during childbirth, the support of midwives, birth companion or doula, and allowing patients to mobilise during labour, are of great value to birthing women as it reduces their anxiety levels (Woods & Dryer, 2011). Support and companionship have been shown to reduce the need for analgesic medication in labour, therefore companionship in labour should be promoted.

4.3.3. Support from management

Midwives practice in an environment where they are prone to traumatic practice experiences which can have physiological and psychological effects, and can be exacerbated by dysfunctional health organisations and the counterproductive behaviours therein. It is suggested that the stress experienced would have been reduced if support in the form of professional supervision had been available (Calvert, 2014). However, Meyer (2010) argues that it is unreasonable to expect staff to give compassionate care if they do not feel respected

and supported by the organisations in which they work. If health care workers do not feel respected by management, they may mirror this attitude when caring for their clients. Therefore, the nature of the health care worker-manager relationship may influence the patient-health care worker relationship (Jewkes et al., 2015)

Midwives explained that they felt unappreciated by management and it affected the level of care they rendered. The following experiences were reported by participants:

(Midwife 1 was very emotional during the interview and started crying when she spoke about the lack of support from management)... *you come to work it's like you feel incompetent because management they don't appreciate you, you just have to do what they tell you to do and if you raise concerns it's never met.*

I don't know whether the sick leave is actually addressed at management level because for me it seems that it is getting worse and certain people get to abuse it... It is definitely affecting, not my care but the care as a whole as a MOU because it's supposed to be a holistic thing. You as one person can't take everything on you so there is a postnatal section that is being neglected and I think that the care of this facility is down because it is not properly staffed you can't say that one person because it is all, all of us is affected by this. (Midwife 2)

...at the end of the day it is an administrative thing with short staff we can only say, we are struggling, we are tired, we are burnt out and from there it goes to management and management decides I think they try to relieve it by getting agency people but the problem is the agency people can say they not coming tonight then we stuck you as the permanent staff member cannot say you not feeling well because then there will be nobody on duty. (Shrugging her shoulders) (Midwife 4)

4.4. Experiences of midwives when delivering quality care

In reaching the Millennium Development Goals (MDGs), developing countries in Africa face challenges in the availability of human resources for health. In light of this shortage, African countries have implemented policies to retain staff in rural areas. However, parallel to the retention policies, countries like South Africa have also implemented policies to relieve the

financial burden of seeking health services, such as free access or subsidies. This resulted in an increased use of health services, especially by women and children under the age of five years (Antarou, Kouanda, & Ridde, 2014). According to Witter, Aikins and Kusi (2007), studies have shown that in South Africa these policies are accompanied by a shortage of health workers and by adverse effects on their practices. These factors combined mean that health workers often complain of being over-worked

Health workers' perceptions of insufficient staff or time to carry out their work can be a key variable concerning motivation and attrition, which results in sub-standard care and poor attitudes towards women, which will discourage women from seeking maternity care (Bradley et al., 2015).

Many women reported that their care suffered due to staff being too busy, or an inadequate number of staff on duty. They also identified factors such as not being listened to or being left alone, causing them to feel afraid or anxious because of the limited contact with midwives. Participants had the following experiences:

So they told me they were busy, the sister them. (Woman 1)

There was other sisters that would just walk pass and didn't take note... or maybe they were busy with something else or something. (Woman 4)

Midwives reported the clear impact of the lack of adequate, skilled staff on their performance and ability to meet professional standards and expectations. They described the circumstances that affected the care they could render.

...getting a proper break in between because why you can't get burnt out you making mistakes errors is made... (Midwife 2)

...we don't have a lot of sisters in the labour ward so each and every patient can't have a sister looking after for each patient. (Midwife 3)

Unfortunately, sometimes we are short staffed, unfortunately it's full we can't we try our best but we can't always get to everything. (Midwife 4)

Maternity care workers are demotivated and dissatisfied, which results in poorer care for women. In order to break this vicious cycle, health care managers need to support

and enable health care providers to deliver the high-quality care that women deserve. Managers were reported to rigidly apply policies regarding staffing norms, with little account taken of actual workload (Bradley, Kamwendo, Chipeta, Chimwaza, de Pinho & McAuliffe, 2015).

4.5. Conclusion

This chapter presented the results of the study, and integrated them with the relevant literature to support the discussion of the findings. The findings reflected both the positive and negative experiences of women and midwives regarding quality care during childbirth.

The findings suggest that women and midwives perceive quality care differently. Midwives perceived quality care when they possess adequate resources and time to practice according to guidelines and protocols. Women perceived quality care when the midwives are skilled and supportive, and are able to meet their basic needs.

The next chapter provides the conclusions, limitations and recommendations from the findings.



CHAPTER 5

5 SUMMARY OF FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1. Introduction

In the previous chapter, the results of the study were presented and discussed. In this chapter, the summary of findings and the limitations of the study are provided, and recommendations are presented based on the study findings.

5.2. Summary of findings

The findings of this study revealed that there are differences between women and midwives in their perception of quality care. Women prioritised having support during childbirth, while the midwives highlighted the lack of support and resources as the most important factors when rendering quality care. Women were able to describe what they perceive as quality care, as well as what they perceived as inadequate or unsatisfactory care, but were not aware of what to expect in terms of quality of care, as they were not well-informed about the standards of care provided at the MOU and the duties of the midwives. Midwives expressed a genuine concern about women during childbirth and were able to describe what they perceive as quality care. However, while midwives were well aware of their duties as care givers and the protocols in place to safely guide women during childbirth, they are facing daily challenges that they feel could impact the standard of care they provide.

Four themes emerged from the analysis of the interviews conducted with the participants. These themes describe the midwives' and women's perceptions during childbirth in an MOU setting. The themes are:

- Quality care.
- Negative experiences by women regarding professional conduct by midwives.
- Need for support during childbirth.
- Experiences midwives faced when delivering quality care.

By using a qualitative approach, this study reflected the views of both women and midwives and could describe components that were considered “quality care” by the participants. The study highlights the need to create a reciprocal understanding of what quality care entails, and notes factors that need to be addressed in order to strengthen the quality of care in a maternity facility.

5.3. Limitations

This study is limited to one Midwife Obstetric Unit in the Western Cape. The relatively small sample of the study population also affected the transferability of the findings. However, the field notes and data from the interviews combined to provide an in-depth understanding of women and midwives’ perception of quality care during childbirth.

The study was conducted by interviewing women that delivered their babies during the day and midwives that were on duty on day shift and the results therefore cannot be generalised to all women and midwives at the MOU.

5.4. Recommendations

The following recommendations are proposed, based on the findings of the study:

5.4.1. Quality care

Communication

There is a definite need to improve community awareness through extensive information, education and communication campaigns.

It is recommended that preparing women for childbirth must start in the antenatal period. The average waiting time for women to be examined by a midwife in the antenatal clinic is 1 to 2 hours. During this time, women can be informed about preparing themselves for childbirth. The midwives have repeatedly stated that they have an increased workload, which limits the time they have to render information to women. These sessions can therefore be run by the Health Promoter, with the help of Non-government organisations (NGO). These sessions can be attended by women and their birth companions to address their concerns and prepare them for childbirth. Mothers should be given full and accurate information about the childbirth process and midwifery care that they are entitled to receive.

Pain relief

It is suggested that women be informed about natural pain relief methods during labour. Ideally this information should be provided antenatally but must be reiterated during labour. Women who have a birth companion cope better during labour and are less likely to ask for pain relief, as the birth companion's support relieves some of the anxiety. The birth companion can rub their back during a contraction, which also helps in coping with the pain.

Women described how they were encouraged to walk around during labour but were reluctant to do so. It is therefore suggested that midwives not only encourage mobility during labour, but also explain to women that mobilising and changing positions releases the hormone oxytocin that helps to trigger and regulate contractions, which makes pain more tolerable. If the women get tired from walking around, midwives should encourage them to sit on the birth ball and not to go back to bed, as lying on their backs will make the pain worse.

Mitchells Plain MOU has a bath in the admission room that has never been utilised by midwives, as they have not received training to conduct water births. Until they receive training, the bath can be used by women to relax to help with pain relief. There are also showers in the MOU that are underutilised by women as they are unaware that a hot shower during labour can help massage their backs and thereby reduce the pain.

Protocols regarding pain relief need to be adhered to by all midwives so that no woman is deprived of her right to pain relief during childbirth.

Safety

It is suggested that the institution should keep midwives well-informed about the formal measures in place that ensure professional accountability for the safety and wellbeing of patients. In addition, the ethics of care should be further reinforced in the professional training of all midwives. Regular refresher training should be offered and possibly mandated for all midwives. It is also important to develop and implement a quality improvement programme in order to determine the nature, scope and intensity of nursing care in the unit.

The manager assigning the midwives to a shift should consider each midwife's years of experience, and pair more experienced midwives with those who have less experience, so that

s/he can be guided. Along with this, periodic auditing of patient and ward records by the quality assurance team should take place to identify performance gaps between the expectations of services and actual service delivery.

5.4.2. Negative experiences by women regarding the professional conduct of midwives

Midwives should take responsibility for working on their negative attitude, as a positive attitude or a good response shows women that the midwife is concerned about both their wellbeing and that of their unborn child. Along with this, communication between staff members should be improved. Thus, midwives should give one another a proper report about patients whenever the shift changes and document all care given, to ensure that there is continuity of care. Similarly, improving teamwork amongst midwives so that they assist one another during decision-making and confirmation of findings will minimise mistakes.

Managers should provide workshops on value clarification for midwives. According to Mosby's Medical Dictionary, "Value clarification are methods whereby the person can discover his/her own values by assessing, exploring and determining what those personal values are and how they affect personal decisions" (2009, p. 1930). This process will enable midwives to clarify their own values in order to facilitate effective decision-making to provide optimal care to women during childbirth.

The Compassionate birth project is offered by an NGO and is a system-based programme which is offered to all categories of staff working in the public maternity units. The programme helps staff members to discover the human compassion within themselves, thus empowering them to provide more holistic patient-centred care, ensuring that every woman and every infant matters.

5.4.3. Need for support during childbirth

Recommendations for support from midwives

Midwives need to inform women about the level of midwifery care they will receive during childbirth, so that they know what to expect and are able to participate in the decision-making about their care.

Mothers should be treated with courtesy and consideration, and should be allowed to practice their preferences during childbirth, such as their preferred birthing position or the administration of pain relief.

Support from companion

Health care institutions, policy makers, and professionals should recognise the significance of having support during childbirth. This should form part of antenatal education, enabling women to make informed decisions and meaning that, together with their companions, they will be knowledgeable, adaptable and prepared for the actual childbirth experience. Many women present at the MOU when they are already in active labour and deliver soon after admission, while their birth companion is in the waiting room. Proper education during the antenatal period about the onset of labour can help to eradicate this problem. If there is a shortage of midwives, the companion can act as an efficient alternative by providing continuous support during childbirth.

Support from management

Midwives need support from management, but some of the midwives in this study described feeling unappreciated by management. Managers should create a positive working environment for midwives where good work is recognised and midwives are not only addressed by management if they have done something wrong. Although policies and protocols are decided at a provincial and government level, the introduction to new policies should be discussed with staff instead of being dictated to them, as midwives already feel that decisions are made by management without their input.

Midwives should be debriefed after every serious adverse event so that all parties involved can discuss the matter. In doing so, midwives can offer each other support and identify gaps in the care that was provided, and quality improvement plans can be developed to avoid similar occurrences.

5.4.4. Implementation of the national guidelines and policies for maternity care

Policy makers and programme managers need to be mindful of the fact that women's views on the quality of care provided will determine their utilisation of the health facility. Similarly, in order to promote positive attitudes of midwives that are commitment to providing good

quality care, their perspectives needs to be carefully evaluation before the introduction of new policies.

The national guidelines and policies for maternity care should be implemented and enforced by midwives when rendering patient care. Patients should be assessed comprehensively, diagnosed and managed according to these guidelines and policies to ensure quality patient care. In so doing complications may also be avoided. Midwives are in a unique position to reintroduce these care practices that supports quality care. It is recommended that evaluation of these care practices should therefore include tools such as having internal and external auditing of patient's records on a regular basis by the quality assurance team to assess the performance of primary midwifery care.

5.4.4. Recommendations for further research

Further research in this area, especially when conducted with a larger sample, may serve to provide a broader and more generalized view of issues pertaining to the differences in perception of quality care from women and midwives.

5.5. Conclusion

The aim of this study was to investigate women and midwives' perceptions of quality care during childbirth. The results indicated that quality of care is still compromised as there are numerous challenges in the MOU setting. These challenges include a shortage of staff, increased workload, and the differences between what women and midwives perceive as quality care. The results have shown that the challenges that were identified in this study were both managerial and clinical in nature.

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Addendum A: Approval Letter



DEPARTMENT OF RESEARCH DEVELOPMENT

10 December 2015

To Whom It May Concern

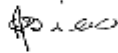
I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Mrs S Martin (School of Nursing)

Research Project: Quality care during childbirth at a Midwife
Obstetric Unit in Cape Town, Western Cape:
Women and Midwives' perceptions.

Registration no: 15/7/265

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.



Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape



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a place to grow, from hope
to action through knowledge

Addendum B: Information sheet



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271 Fax: 27 21-959 2679

E-mail: 3515420@myuwc.ac.za

INFORMATION SHEET

Project Title: Quality care during childbirth at a Midwife Obstetric Unit in Cape Town, Western Cape: Women and Midwives' perceptions.

What is this study about?

This is a research project being conducted by Sedeeka Martin at the University of the Western Cape. We are inviting you to participate in this research project because you will have the chance to share your perceptions. The purpose of this research project is to explore and describe women and midwives' perceptions of quality care during childbirth at a MOU.

What will I be asked to do if I agree to participate?

You will be asked to attend an interview at a convenient place and time. The interview is expected to last 45 – 60 minutes and will be tape- recorded. You will be required to share your perceptions of quality care during childbirth. Your participation in this research is entirely voluntary. It is your choice whether to participate or not. Whether you choose to participate or not, all the services at this clinic will continue. You may change your mind later and stop participating even if you agreed earlier. There is no right or wrong answer to the questions because the study explores your perceptions.

Would my participation in this study be kept confidential?

To ensure your anonymity, the entire interview will be tape- recorded, but your name will not appear on the tape. No one will be present in the interview unless an interpreter is needed and the interpreter also signed a form stating that he/she will keep the information confidential. To ensure your confidentiality, all information recorded is kept confidential and in a locked cabinet, and no one outside the research team will have access to the tapes. These tapes will be kept safe and be destroyed according to the UWC protocol.

When a report or article about this research project is written, your identity will be protected.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be some risks from participating in this research study.

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about your perception of the quality care provided at the Midwife Obstetric Unit. You will not be given any money or gifts to take part in the research.

We hope that, in the future, other people might benefit from this study through improved understanding of the perceptions of women and midwives regarding quality care during childbirth. The findings of this study have the potential to help policy makers tailor standards of care to meet the needs of women and midwives.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Sedeeka Martin and is supervised by Dr. Fielies at the School of Nursing at the University of the Western Cape. If you have any questions about the research study itself, please contact :

Sedeeka Martin at: 3 Moira Street,
Tafelsig
Mitchells Plain
7785
073 282 5541
e-mail address 3515420@myuwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Dr. G.C. Filies
University of the Western Cape
Private Bag X17
Bellville 7535
gfilies@uwc.ac.za

Prof Anthea Rhoda
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
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Addendum C: Consent form



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CONSENT FORM

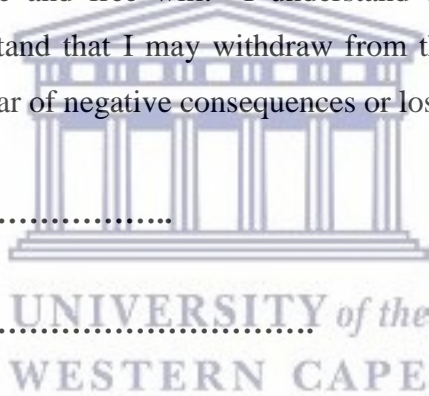
Title of Research Project: Quality care during childbirth at a Midwife Obstetric Unit in Cape Town, Western Cape: Women and Midwives' perceptions.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name.....

Participant's signature.....

Date.....



Addendum D: Declaration by interpreter

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Declaration by Interpreter

I, declare that: I assisted the researcher (name) to explain the information in this document to (participant's name)..... using the language medium of

I will keep all information confidential.

We encouraged her to ask questions and took time to answer her questions.

I conveyed a factually correct version of what was related to me.

I am satisfied that the participant fully understands this informed consent document and the content of the study.

We encouraged her to ask questions and took time to answer her questions.

I conveyed a factually correct version of what was related to me.

I am satisfied that the participant fully understands this informed consent document and the content of the study.

Signed at on (date)

Signature of interpreter

.....

Signature of witness

.....

\

Addendum E: letter from editor

10 October 2018

To whom it may concern,

Dear Sir/Madam

RE: Editorial Certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, and spelling as well as overall layout and style by myself, a native English-speaking editor.

Thesis title

Quality care during childbirth at a midwife obstetric unit in Cape Town, Western Cape: Women and Midwives' perceptions

Author

Sedeeka Martin

The research content and author's intentions were not altered in any way during the editing process; however, the author has the authority to accept or reject my suggestions and changes.

Should you have any questions or concerns about this edited document, I can be contacted at the listed telephone number or email address.

Regards



Karen Graaff

Editor

021 437 1197

karendvgraaff@gmail.com