Exploring the experiences of care for women during labour and childbirth in health care facilities in Tshwane district, Gauteng province

by

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Submitted to Sefako Makgatho Health Sciences University

Department of Public Health

in partial fulfilment of the requirements for the degree of

Master of Public Health

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February 2019
Declaration

I, the undersigned, declare that this dissertation titled “Exploring the experiences of care for women during labour and childbirth in health care facilities in Tshwane district, Gauteng province” is my own work, and that it has not been submitted before for any degree or examination in any other university. In addition, all the sources I have used or quoted have been indicated and acknowledged in the complete references. This is submitted in partial fulfilment of the requirement for the degree of Master of Public Health in the School of Health care sciences, Department of Public Health, Sefako Makgatho Health Sciences University, Republic of South Africa.

_________________________   __________________
Signature      Date
Dedication

This work is dedicated to the memory of my late grandmother, Mrs Maria Mmatlala Malatji, for believing and having faith in me, for praying for me and for the words of wisdom she instilled in my life. She was one strong woman who nurtured me and taught me that nothing is impossible with God.

The dedication extends to my late father as well, Mr Simon Nchimane Lebepe, for being so proud of me. His encouragement and belief in me made it possible for me to push myself to the limit. May their souls rest in perfect peace.
Acknowledgements

I wish to humbly express my profound gratitude and appreciation to all who “walked” this journey with me. Though the journey was full of a number of challenges, you made it worthwhile and easier.

My special thanks go to;

God almighty, for His favour and grace, and for making all this possible.

My supervisor, Prof S Madiba, for your guidance, encouragement, constructive criticisms, and commitment to the completion of this work. I indeed appreciate the public holidays, weekends and other tight schedules you sacrificed.

My family: My children, Mohau and Chris, thank you for your encouragement and patience; indeed you are a pillar of support. My brother, Elija, for the support and encouragement you gave me. I love you all.

All the mothers (and their babies) who participated in the study. I appreciated the time you sacrificed for this study to be a success.
Abstract

Introduction
Research shows that many women across the globe experience disrespectful, abusive, or neglectful treatment during childbirth in public health facilities. The disrespect and abuse women experience in health facilities during childbirth limit access to safe delivery for most women. The researcher herself has on several occasions witnessed and observed disrespectful care to women while working as a manager in a labour ward, and was most of the time involved in addressing patients’ complaints related to disrespectful care. This prompted the researcher to explore more on the how women experiences their care when they visit health facilities during labour.

Study aims and objectives
The aim of the study was to explore the experiences of women during labour and childbirth and examine their expectations of care in primary health care facilities in Tshwane district.

Study methodology
The study used an exploratory qualitative design to conduct focus group discussions with 36 post-natal women aged between 18 and 41 years. The study was conducted in primary health care facility in Tshwane district, Gauteng province. Thematic content analysis was used for data analysis using Nvivo11 software and nine themes were identified with subthemes.

Findings
The women experienced labour and childbirth negatively; they were treated with disrespect and abuse from midwives. Shouting, harshness, and abusive and rude language were common forms of disrespect received from the midwives. They were neglected and left in blood-soiled linen, ignored, denied pain medication, left alone during labour, gave birth unattended, and not attended to timeously. Discrimination and name calling were common forms of disrespect for foreign national women. Finally, the rights of the women were violated, they were not offered a bed during and after childbirth and denied access to ambulance services.

Conclusion
The findings showed that disrespect and abuse of women during labour occurred despite midwifery practice being guided by the code of conduct for midwives. Communication was
ineffective and characterized by shouting, rudeness, and abusive language. Their expectations were a direct contrast to what they experienced. They expected to be treated with dignity and respect, to be attended to timeously, be offered pain relief, and their voice to be heard. Disrespectful care influenced future utilization of the facility for child birth, as some of the women will not use the facilities in future but will opt for home delivery.

**Recommendations**

An appropriate strategy should be developed to ensure compliance with a code of conduct for midwives to ensure that they provide care by upholding the dignity, respect, and human rights of women during childbirth. In addition, customer care, respectful care, and code of conduct workshops for nurses within the district or and sub district should be conducted. The midwifery code of conduct and Batho Pele principles should form part of the orientation for new midwives and should be incorporated in their job descriptions. The right to access of information must be highlighted as an important principle that should be observed during the midwifery practice.
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>CHC</td>
<td>Community Health Centre</td>
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<tr>
<td>PNC</td>
<td>Post-natal care</td>
</tr>
<tr>
<td>MBFBF</td>
<td>Mother and Baby-Friendly Birthing Facilities</td>
</tr>
<tr>
<td>NCCEND</td>
<td>National Committee on Confidential Enquiries into Maternal Death</td>
</tr>
<tr>
<td>SANC</td>
<td>South African Nursing Council</td>
</tr>
<tr>
<td>SGD</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>SMUREC</td>
<td>Sefako Makgatho University Research Ethics Committee</td>
</tr>
<tr>
<td>SREC</td>
<td>School Research Committee</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Chapter 1: Background and introduction

1.1 Introduction

Globally, an increasing number of women experience abuse and disrespect during childbirth (WHO, 2015b). Some media and anecdotal reports attest that delay in seeking help from facilities by women comes from the perception that they are ill-treated in facilities when giving birth according to the Saving Mothers’ Report for 2014-2016 (NCCEMD, 2018). This is despite respectful care being seen as a vital component of the Sustainable Development Goals (SGD) to improve maternal health. Experts in maternal health and other stakeholders believe that abuse and disrespect during childbirth represents an important cause of women suffering and is a barrier to skilled birth utilization which is an important indicator for SDG 5.

Furthermore, there are general concerns that abuse during childbirth is not only a quality care issue but it is unacceptable and a violation of the human rights of women (Honikman et al., 2015; WHO, 2015a; Kruk et al., 2014; Odhiambo, 2011; Okafor et al., 2015). Labour pain is, according to most women, the most excruciating pain, which cannot be compared to anything. Therefore, pain management and control are important determinants of whether the woman’s birth experience is positive or negative. During labour and childbirth, after a woman is assessed and examined to see how far her labour has progressed, she will then be monitored according to her stage of labour. Once the labour is established, a woman is not supposed to be left unattended, and the midwife must monitor both the mother and the baby. (There is a criterion, which has been developed by the WHO and other partners, which ensures that personnel at birthing facilities attend to women according to the accepted criteria when they are in labour (Miller & Lalonde, 2015).

Failure of the birthing facilities to comply with this strategy is a violation of standards of care and human rights (Miller & Lalonde, 2015). In addition, the Global Alliance for Nursing and Midwifery (2015) points out that birth attendants need to be more than just skilled to attract clients; they also need to be respectful and compassionate. A critical review done by Van der Gucht & Lewis, (2015) found that women feel vulnerable when they are in labour and appreciate the relationship they have with the midwives. In addition, they also reported that
for them to cope with pain they need effective continuous support during labour and childbirth. Similarly, Hodnett (2002) reported that the quality of the relationship with the midwife, the amount of support they get from the midwife and their involvement in decision-making during childbirth are crucial for women when they evaluate their labour pain experiences.

An estimated 303,000 maternal deaths were reported in 2015 throughout the world (WHO, 2015b). According to this report there was a decline of about 44% in the maternal mortality ratio over the past 25 years from 1990 to 2015, from an estimation of 385 to 216 per 100,000 live births. Despite this decline, about 800 women are still dying daily of preventable causes of maternal deaths (WHO, 2015b). Of these deaths, sub-Saharan Africa accounts for more than half of global maternal deaths, with both low and middle-income countries accounting for 99% of the global burden of maternal deaths (WHO, 2015b). South Africa (SA) has reported a decline of about 12.5% of maternal deaths from the triennial reports of 2011/2013 to 2014/2016, with 55 fewer women dying per 100,000 maternal deaths (National Committee on Confidential Inquiries into Maternal Death (NCCEMD), 2018). Despite this decline, Gauteng province still reported the second highest number of maternal deaths in SA according to the report (NCCEMD, 2018).

In trying to reduce maternal mortality, the World Health Organization (WHO) identified delivery in a health facility as an important strategy that can reduce maternal mortality, especially when the delivery is attended by skilled health care professionals (Karlström et al., 2015; WHO, 2015b). Although delivery in facility has been identified as the most important strategy to reduce maternal death, and in South Africa delivery In-facility rate is high at 96% (Statistic South Africa, 2017), some factors still prevent and discourage women from accessing or attending health facilities during childbirth. Such factors include the quality of care received, experience of abuse and disrespect during childbirth, and the fear of maltreatment by the health care providers. These factors can all have an effect on the woman’s choice of childbirth setting (Moyer et al., 2014; Warren et al., 2013). Nonetheless, there is evidence that women’s previous birth experiences play a major role in their choice of current and future birth setting (Karkee et al., 2014; Kruk et al., 2014; Asefa & Bekele 2015).

Despite the high level of abuse for women during labour and childbirth, there is no joint consensus on how to measure care during childbirth at the moment (Bowser and Hill, 2010).
As such, disrespectful care commonly cited includes rudeness of staff, clinical neglect, verbal abuse, psychological abuse, and unkindness (Jewkes et al., 1998; Moyer et al., 2014; McMahon et al., 2014; Ng’ango Phiri et al., 2014; Asefa & Bekele, 2015). The documented types of abuse understate the violation of the rights of women which in South Africa is summarised in the patients’ rights charter and Batho Pele principles.

Research shows that women need to be assured that they will be treated with dignity and respect during childbirth for them to opt to deliver in health facilities (Moyer et al., 2014; McMahon et al., 2014; Asefa & Bekele 2015; Bohren et al., 2015). Therefore, women who experienced disrespect and abuse with the previous childbirth may choose home delivery as opposed to facility-based delivery, or report late for childbirth in the health facility already with complications which could have been prevented with early presentation. Home delivery may have negative consequences to her if she develops complications (Bohren et al., 2014; Mirkuzie, 2014). Several studies on this topic showed that the negative experience of a woman during labour and childbirth damage the trust between the woman and health care providers. This has a negative impact on the woman in making a decision regarding future delivery in a health facility (Jewkes et al., 1998; Moyer et al., 2014; Ganle et al., 2014; King et al., 2015; Mirkuzie, 2014).

The attitudes and behaviours of health care providers are an important element of quality of care during childbirth. Findings from a study conducted in Zambia linked low quality of care to abuse during childbirth by health care providers (Ng’ango Phiri et al., 2014). Staff attitudes such as abusive language, denial of services, and an absence of compassion were some of the many barriers to facility-based care in a study conducted in Tanzania (Mrisho et al., 2007). Perceptions of low quality care during childbirth have also been reported as a factor for non-utilization of health facilities by mothers (Karkee et al., 2014). Women may choose home birth instead of facility birth due to the support system and privacy they receive during home birth as opposed to the mistreatment they receive in health facilities. This will lead to an increase in home deliveries, and women may choose facility birth only as a last resort (Ganle et al., 2014; Bohren et al., 2014). The choice of home birth may at times be problematic because there are no skilled birth attendants, as this have been found to be one of the strategies to reduce maternal mortality.
Bowser and Hills (2010) argue that disrespect and abuse during childbirth are sometimes normalised in some settings. As a result, women generally expect to be shouted at, beaten, or neglected when attending public health facilities during childbirth. Nevertheless, most women’s expectations with regard to childbirth is quality of care, being respected, given immediate attention during labour, access to alternative choices, privacy and confidentiality, and being involved in decision making regarding their care during childbirth. Further studies also reported that women expected compassionate care, guidance and respect from midwives. They value respectful care, and need their choices to be considered during childbirth (McKinnon et al., 2014; Ng’anjo Phiri et al., 2014; Karlström et al., 2015). According to a statement by WHO, every woman has a right to receive the highest attainable standard of health care; this includes the right to receive dignified and respectful care (WHO, 2015a). However, research shows that many women across the globe experience disrespectful, abusive or neglectful treatment during childbirth in primary health facilities (Silal et al., 2012). Studies conducted in sub-Saharan Africa highlighted that women are often exposed to high levels of abuse and disrespectful care in public health facilities during childbirth (Asefa & Bekele, 2015; McMahon et al., 2014; Moyer et al., 2014; Ng’anjo Phiri et al., 2014). Abuse and disrespectful care have also been identified in some primary health facilities in South Africa (Jewkes et al., 1998; Chadwick & Foster, 2014; Silal et al., 2012).

1.2 Problem statement

South Africa is part of the WHO better birth initiative strategy of Mother and Baby-friendly Birthing Facilities (MBBF). The implementation of the MBBF strategy qualifies birthing facilities to be accredited as mother-baby friendly Miller & Lalonde, 2015). Although most of the facilities in the sub district have been accredited with a better birth initiative, most are not following the standard of care as prescribed by the better birth initiative. There is anecdotal evidence of cases of disrespectful care of women by the health care providers during childbirth in primary health facilities.

Despite the recent calls by the WHO for greater attention, research, and advocacy around the maltreatment of women during childbirth, there is consensus among researchers and experts in maternal health care that disrespect and abuse in facility-based childbirth are barriers to skilled care utilization for women. Nevertheless, there is limited qualitative research in this topic in the district.
1.3 Study aim
The aim of the study was to explore the experiences of women during labour and childbirth and examine their expectations of care in primary health care facilities in Tshwane district.

1.4 Research questions
The study set out to answer the following questions:
1. What are the experiences of care for women during labour and childbirth in primary health care facilities in Tshwane district?
2. What do women expect from midwives during labour and childbirth?

1.5 Study objectives
1. The study explored the experiences of care for women during labour and childbirth in primary health care facilities in Tshwane district.
2. The study examined the type of care expected by the women in primary health care facilities during labour and childbirth.

1.6 Study significance
The findings of the study will alert managers of primary health facilities about the bad experiences women endure in the public health facilities.
The study will help develop guidelines and protocols to promote respective care in Maternity units in public health facilities.
Furthermore, the study findings will be used as a baseline for intervention to reduce abuse and disrespect of women during childbirth.
The study will further be used to promote awareness of women’s rights regarding maternity care.
The study will help ensure that facilities adhere to the mother and baby-friendly maternity services strategies with staff who are conscious of patients’ rights and their responsibilities in providing quality maternity care.
Chapter 2: Literature Review

2.1 Introduction
This chapter presents the review of literature on the birthing experiences of women. This review focuses on the experiences of women during labour and childbirth in primary health facilities and hospitals. Many articles reviewed in this study were conducted in developing countries; however, some studies from developed countries were included in order to see the disparities with regard to care of women during childbirth from the developed countries in comparison with developing countries. Although most of the articles used were less than ten years old, there are other articles which are more than 20 years old but are still relevant today. The findings still apply even now as there has not been any change in the way women are treated from when the studies were conducted until now.

2.2 Overview of disrespectful care
Childbirth experience is a critical and intimate event in the life of a woman, which relates to psychological development and wellbeing. The experience is subjective, personal, and depends on the way an individual interprets and perceives it (Larkin et al., 2009). Although women may have different experiences, the most important childbirth experiences relate to the support from the midwife and being involved throughout the birth process of their child (Van der Gucht & Lewis, 2015). Despite this, several studies conducted in African countries and globally reported that most women experience abuse or disrespectful care during childbirth. This is especially common and prevalent in low-income countries such as South Africa (Abuya et al., 2015; Asefa & Bekele, 2015; Bohren et al., 2014; Bohren et al., 2015; Jewkes et al., 1998; Okafor et al., 2015; Kruk et al., 2014; Mirkuzie, 2014).

The WHO and other partners implemented a better birth initiative strategy called Mother and Baby-friendly Birthing Facilities (MBFBF), which qualifies birthing facilities to be accredited as mother-baby friendly. South Africa is part of this initiative (Smith et al., 2004; Miller & Lalonde, 2015). The criteria used to audit facilities to ensure they comply with the strategies include the following:

- Every woman has the right to be treated with dignity and respect regardless of her background.
• The birthing woman must be offered food and drinks, and be allowed to walk around during early labour, and to assume positions they prefer during delivery unless when it is contra-indicated.

• Birthing facilities should have clear non-discriminatory policies which support birthing women.

• Birthing facilities should not allow physical, verbal or emotional abuse of women in labour.

• They must allow the birthing mothers to have at least one birthing partner or companion of their choice, which can be the father or family member, throughout their birthing process.

• Ensure that staff are able to provide non-pharmacological and pharmacological pain relief when there is a need.

• Provide culturally-competent care that respects women’s customs and allows practices that will not harm both mother and baby.

• Ensure women are afforded privacy during labour and birth.

Respectful care is a vital component to improve maternal health to meet the sustainable development goals. Despite acknowledgement of disrespect and abuse of women during childbirth by society groups, human rights stakeholders, and policy makers around the world, its prevalence is still not well documented (Warren et al., 2013). Furthermore, policies to promote respectful non-abusive maternal care have not yet been adopted into meaningful action globally (WHO, 2015a).

2.3 Categories of abuse and disrespect

There is no joint consensus on how to measure care during childbirth at the moment, despite evidence of its prevalence in many settings. In trying to define abuse and disrespectful care, Bowser and Hills (2010) proposed seven categories of disrespect and abuse during labour and childbirth which are physical abuse, non-consented care, non-dignified care, discrimination, abandonment, detention and non-confidential care. The categories were initiated in order to stimulate a dialogue and implement a research agenda. However, Bohren et al. (2015) realized that the categories lacked operational definition with regard to the behaviour of the health care worker, the conditions of the facility and other factors that may contribute to abuse and disrespect.
Consequently, Bohren et al. (2015) came up with a comprehensive typology to understand and describe mistreatment of women during childbirth. They were able to develop seven themes, which are: (1) physical abuse, (2) sexual abuse, (3) verbal abuse, (4) stigma and discrimination, (5) failure to meet professional standards of care, (6) poor rapport between women and providers, and (7) health system conditions and constraints of abuse and disrespect (Bohren et al., 2015). This typology is evidence-based and will assist in the development of global based typology for mistreatment of women during labour and childbirth.

2.4. Neglect and abuse
Several studies conducted globally and in Africa revealed that the problem of abuse and neglect by midwives and other health care providers was most dominant during labour and delivery (Abuya et al., 2015; Asefa & Bekele, 2015; Bohren et al., 2014; Bohren et al., 2015; Jewkes et al., 1998; Okafor et al., 2015; Kruk et al., 2014; Mirkuzie, 2014). Neglect was also identified by students in a study conducted in South Africa as part of harmful practices that they witnessed in public hospitals where women were left unattended by the midwives during labour (Farrell & Pattinson, 2004).

Several studies revealed that some of the women utilizing primary health facilities have experienced verbal abuse such as being shouted at and scolded; subjected to physical violence, neglect and abandonment; being denied a birth companion; and women in early labour have been turned away and experienced general rudeness. In some instances, midwives referred to abuse as “verbal Pitocin” which they believe will make women behave during labour (Jewkes et al., 1998; Chadwick & Foster, 2014; Silal et al., 2012; Farrell & Pattinson, 2004).

2.5 Perceived quality of care
The women’s perception of quality care during childbirth is influenced by many factors. Oyerinde et al., (2012) reported that poor quality of care might be worsened by the poor working conditions, disrespectful care, and lack of food in the health facility. The woman’s expectations and experiences, whether current or prior, influence her perceptions of the quality of care she received (Larson et al., 2014). Low or poor quality of care has been linked
to abuse, discrimination, and neglect of women during childbirth. In essence, the way the woman perceives the quality of care she received during labour and childbirth plays a major role and influences her choice and that of her family regarding their future birth settings. They equated quality of care to being close to their families (Karkee et al., 2014; McKinnon et al., 2014; Kruger & Schoombee, 2010; Sorensen et al., 2011).

2.6 Consequences disrespectful care

As already stated, there is evidence that women’s experiences of care during labour and childbirth may influence the decisions of choice of delivery place in future (Mirkузие, 2014; Ganle et al., 2014; King et al., 2015). The quality of care received and, more specifically, the women’s experience of care during childbirth can have an effect on the women’s choice of childbirth setting and can even cause mental health problems for the women (Ganle et al., 2014; Moyer et al., 2014; McMahon et al., 2014; Kruk et al., 2014). Women who have had unpleasant experiences with their previous childbirths may choose home birth due to the support system and privacy they receive during home birth.

This shows that the mistreatment women receive during childbirth will lead to an increase in home deliveries. Women may choose facility birth only as a last resort (Ganle et al., 2014; Bohren et al., 2014). This is in contrast to the WHO’s guidelines where facility delivery is recommended as a strategy to provide safe maternal health care. In addition, lack of involvement of the women in the planning of their care as well as that of their babies has been associated with poor utilization of primary health facilities (Wilunda et al., 2014). Therefore, low quality is as an important factor in non-utilization of health care facilities by mothers during childbirth.

2.7. Women’s expectations of care

Although women generally experience disrespectful care during labour and childbirth, data from several studies revealed that most women’s expectation with regard to childbirth is quality of care, both interpersonal and technical. They need to have access to alternatives, and desire to be involved in decision making regarding their care and that of their babies during childbirth. They further require and expect responsiveness of health care providers (McKinnon et al., 2014; Ng’anjo Phiri et al., 2014).
A study conducted in five countries on both immigrant and non-immigrant women revealed that women expect to receive safe high quality, attentive, individualized care (Small et al., 2014). In addition, women also expect to receive adequate information regarding available choices as well as their care as they want to participate in decision making concerning their childbirth. They expect support from health care providers irrespective of whether they are immigrant or not (Small et al., 2014; Diorgu et al., 2016; Lally et al., 2008). The study by Karlström et al. (2015) found that a supportive environment promotes the women’s feeling of being safe which is important for them to gain control during their birth experience.

In addition, women expect a friendly service from the health care providers during childbirth. They expect empathy, respect from the health care provider, given immediate attention when in labour, as well as privacy and confidentiality during childbirth (Bowser & Hill, 2010; Diorgu et al., 2016; King et al., 2015; Ng’anjo Phiri et al., 2014).

2.8. Health workers’ perspectives of disrespectful care

Abuse of women during childbirth has also been studied from the health care worker’s perspective. A study in Nepal revealed that either most health care workers have witnessed abuse of women during childbirth or some of them were victims of abuse themselves. It is evident that health care workers are aware of the abuse that is happening in the facilities but they are ignoring it or treating it as normal (Milne et al., 2015). In addition to the above, a South African study found that lack of sanctions of nurses leads to them seeing their practice as normal (Jewkes et al., 1998).

Although health workers are aware of the poor quality of care provided in health facilities for the laboring mothers, they still put the blame on the women and label them as ignorant and negligent, which may often lead to women opting to deliver at home where they believe their dignity is respected (Sorensen et al., 2011; Okafor et al., 2015). Although it is important to understand that midwives may unintentionally conduct themselves in a disrespectful manner, which may at times be accompanied by respectful practices, Bohren et al. (2015) argue that the women’s experiences must be taken into considerations whether the midwives intentions were good or bad.
2.9. Pain management and control during labour

Pain relief during labour is associated with birth experiences and women who are not given pain medication may report negative experiences (Stark et al., 2016) and may lead to psychological trauma (NICE, 2011). A study conducted in the USA found that most women who were provided with pain relief during labour had positive birth experiences (Tunçalp et al., 2015). A study conducted in South Africa by Farrell & Pattinson, (2004) found harmful practices such as midwives performing episiotomy on the women without the use of pain relief. The study further found that the women were not provided with pain relief during labour with a belief that women must endure the labour pains and get what they deserve.

2.10 Midwives’ attitudes and support

However, a systematic review done by Hodnett (2002) showed that midwives’ behaviour and attitudes towards a woman in labour are more influential than pain and pain medication. A systematic review by Lally et al., (2008) found that women underestimated the labour pains they would experience, and they reported that they hoped for labour without pain relief. However, when they were in labour, they required it. Therefore, it is important for the midwife to provide support to a woman in labour regardless of the environment and conditions where the birth is taking place because they are equipped to provide care and support to the woman in labour irrespective of the environment she is in (Hodnett et al., 2013).

Several studies have found that women value feeling safe from the continuous support they receive as it enhances their ability to cope and relieves the feeling of fear. A mother-provider relationship based on care as well as open communication facilitates labour and reduces the need for interventions during childbirth (Stark et al., 2016; Hodnett et al., 2013). This means that if the midwife can provide a supportive environment to the woman, she can reduce the chances of the need for analgesia (Hodnett et al., 2013).

2.11. The presence of a birth companion during childbirth

Every woman must have the continuous support of a midwife during labour to advise and inform the woman about the labour progress. Support during labour also includes social support, which may be from the husband, a relative, or a trained birthing partner (Larkin et al., 2009). The importance of midwife support during labour was identified as contributing
factor to the woman’s perception of having either a positive or a negative experience (Crissman et al., 2013). The presence of a birth companion can help provide the support the midwife is unable to provide and may assist the woman in coping with pain and emotional support. In addition, the birth companion may provide comfort, help the woman with coping strategies during labour, assist her when walking around, and provide light food and water. In addition, when a birth companion is available, midwives tend to treat women in labour with dignity, compassion, and respect (Okafor et al., 2015; Hodnett et al., 2013; Bohren et al., 2016).

There are significant benefits to the provision of a birth companion during labour and childbirth. These include that women with birth companions are less likely to need pain relief during labour, to complain, to need instrumental or caesarean delivery, and are less likely to have babies with low Apgar scores. In addition, they more likely to have spontaneous vaginal birth and may have a shorter labour (Hodnett et al., 2013; Bohren et al., 2016). There is substantial evidence that having a birth companion during labour helps women cope with labour pains and relieves them from feeling lonely and fear (Van der Gucht & Lewis, 2015). According to Chadwick & Foster (2014), women who are not supported may feel isolated and disconnected, which often leads to them feeling more distress and anxiety.

The state of public health facilities in South Africa and other countries on the continent is characterised by overcrowding and shortage of staff. Therefore, it is most difficult for a midwife to provide individual care to women in labour, and this often results in women experiencing neglect and abandonment. Therefore, the birth companion can fill the gap of the midwife who is not available (Crissman et al., 2013; Kaibe, 2011). Despite the benefits of a birth companion, a study conducted in Nigeria by Okafor et al., (2015) revealed that women were denied a birth companion, which resulted in some of them delivering alone without the presence of a midwife. There is enough evidence that shows that women value and benefit from having a birth companion or support person during labour (Bohren et al., 2016; Banda et al., 2010; Kaibe, 2011; ; Hodnett et al., 2013; Van der Gucht & Lewis, 2015). Therefore, it is important to inform the woman during antenatal care about the importance of having a birth companion. This will ensure that the woman has the chance to choose the person of her choice, someone they prefer, and someone who will be ready and has capabilities of taking the role of a supporting partner during labour and childbirth (Banda et al., 2010).
2.12. Providing information to women during labour
An observational study conducted in east and southern Africa using seven universal rights of childbearing women from the White Ribbon Alliance (2011) revealed that there was lack of communication between the midwife and the women during labour. Consequently, the laboring women do not realize their right to information, right to refusal of hospital treatment, right to informed consent and right to respect for their choice and preferences (Rosen et al., 2015). Access to information is important and enables women during labour to participate actively in decision-making that involves their care as well as that of their newborn babies (Chadwick & Foster, 2014; Mselle et al., 2011).

Therefore, it is important for the midwife to give information that is adequate to the woman in labour to help her make informed choices. However, several studies highlighted that women reported that they were either not given enough information, or were not given information at all (Farrell & Pattinson, 2004; Larson et al., 2014; Wilunda et al., 2014; Diorgu et al., 2016). In other studies, women reported that they were denied information about aspects of the birth process which were very important to them (Chadwick & Foster, 2014; Mselle et al., 2011). Denying women access to information constitutes abuse of patient rights, as all patients, according to the White Paper on Transformation of Public Service Delivery (WPTPSD) have a right to information concerning their health (Crous, 1997).

In addition, literature shows that women are not happy with the reasons given by the midwives for performing an episiotomy. They believed that communication between them and the midwives was poor and they were left in the dark with regard to their care. The women also felt that midwives did not communicate with them, but were rather speaking to them. According to them, communication will give them the chance to ask questions and get clarity as compared to being spoken to (Chadwick & Foster, 2014 and Mselle et al., 2011).

2.13 Conclusion
The literature review about the experiences of women during labour and childbirth indicates that women experience abuse and disrespect during labour and childbirth. From the literature, abuse of women during childbirth is common, despite the guidelines that govern the nursing or midwifery practice such as rules and regulations, scope of practice of a registered midwife, and code of ethics, which talks about how nurses or midwives must conduct themselves when dealing with women in labour and childbirth.
Most common forms of abuse from literature include verbal and physical abuse, neglect and abandonment, non-consented care, lack of privacy, and lack of communication. From the women’s perception of quality of care, the literature found that women perceive quality of care as being responsive to their needs and being involved in decision-making that involves her and her baby. With regard to pain management, the literature review found that most women are not given pain medication during labour and most of the findings highlighted that birthing partners are not allowed in most facilities. From the literature in general, women are not treated with respect and dignity. Further research on issues of respectful care is needed and, lastly, further research into the implementation of better birth initiatives in the labour wards.
Chapter Three: Methodology

3.1 Introduction
This chapter presents the study methodology and materials used during data collection and analysis. The chapter will outline the methods and materials used in the study which includes the study design, study population, study setting, data collection methods, sampling, recruitment procedure, data collection procedure, data analysis and ethical considerations. In addition, the strategies to ensure trustworthiness will be outlined in this chapter.

3.2 Research designs
The study used an exploratory qualitative design to conduct focus group discussions with post-natal women. Focus group discussion was selected as a method of data collection because it provides a safe environment for participants to speak about sensitive information like birthing experiences without personalizing the experiences (Ayala & Elder, 2011).

3.3 Study setting
The study was conducted in one of the primary health care facilities in sub-district one of Tshwane district. The sub-district has four primary health facilities offering low risk deliveries. The facility was selected for convenience because the researcher was made aware that some of the postnatal mothers who come in for a six weeks postnatal check-up had delivered in the other surrounding health facilities, which are included in the study. This was important for data collection because there were enough participants to form focus groups for the interviews that informed the study. The health care facility offers primary health care services, including deliveries of low risk pregnant women, three days postnatal care and six weeks postnatal care for women who delivered in different health care facilities around the area.

3.4 Study population
The study population consisted of postnatal women who delivered live babies in primary health care facilities of sub-district one in Tshwane district six weeks prior to the study. About 300 women delivered in the four primary health facilities, and women who participated in the focus group discussions delivered in the primary health care facilities
around the sub-district but chose to come to Kgabo clinic for post-natal care for various reasons.

3.5 Recruitment of study participants
The researcher, after obtaining ethical clearance from Sefako Makgatho Health Sciences Research Committee (SMUREC), from the National Department of Health and the District Research committee, went to the facilities to explain the purpose of the study and to obtain permission from the facility managers of the four health facilities mentioned above. After obtaining approval from the facility managers, the researcher went to the facilities to arrange for data collection. The researcher was introduced by the facility manager to the professional nurses who were conducting six weeks postnatal care.

Women were recruited while attending their six weeks postnatal care in the primary health care facility. Most of the recruitment took place in the mornings and the women were recruited in the waiting areas when they brought their babies for their six weeks immunization. The timing for the research ensured that women had a chance to recover from the emotional labour they went through and still remember their experiences of childbirth.

The researcher gave a brief presentation to the mothers in the waiting area to explain the purpose of the study and invited them to participate. All recruitment was done while the mothers were waiting to be seen. Those who verbally agreed to participate were redirected to the researcher after they were attended to by the clinic staff. Mothers who volunteered to be in the study were asked to assemble in the room set aside for the focus group discussion (FGD) where they waited to form a focus group. Mothers were offered some snacks and drinks after the interview because they had to spent around two hours after their consultations and were hungry.

3.5.1 Inclusion and exclusion criteria
The study included women who delivered live babies six weeks prior to the data collection in the primary health care facilities in Tshwane district sub-district one. Only mothers who were 18 years and above were included in the study. Women who delivered still birth babies and those who were critically ill were excluded from the study. In addition, mothers who did not consent were not included in the study.
3.6 Sample and sampling technique

Mothers were selected using the convenient sampling technique to participate in FGDs because most of the mothers who visit the health facility for six weeks’ immunization meet the inclusion criteria. Thus most mother who were at the waiting area at any given time during recruitment and data collection were able to respond to the research question. The study sample was heterogeneous in nature, which means that mothers from different backgrounds such as educational level, socio-economic status, and different age groups were selected and included in the sample in order to minimise selection bias.

While there are no set rules for sample size in qualitative research, the rule of thumb suggests three to five focus group discussion participants depending on the homogeneity or heterogeneity of the study population. Nonetheless, data collection in qualitative research is guided by saturation (Patton, 2002). Data is regarded to have saturated when no new themes emerge from the subsequent interviews or focus group discussion (Patton, 2002). In the current study, the researcher felt that data saturation was reached with the third focus group discussion; however, another two focus group discussions were conducted to saturate some of the emerging themes. In total, the researcher conducted five FGDs and each focus group consisted of seven to eight mothers.

3.7 Data collection and tools

Data was collected by the researcher and a research assistant trained in qualitative research and in conducting focus group discussions. Despite the fact that the research assistant was experienced, a training workshop was conducted and the research assistant was trained by the supervisor and the principal researcher on the objectives of the study and the focus group guide.

The researcher moderated the FGDs using a self-developed focus group guide with open-ended questions. The guide was developed in English and translated into the Setswana language as the majority of the women in the study setting and surrounding areas are Tswana speaking. The guide explored the women’s experiences of care, their views about care during labour and childbirth, how they were attended to during labour, what they liked or did not like about their care, and their views on their expectations of care from midwives.
All the FGDs were conducted in a consulting room that was not used by the staff in the facilities to ensure privacy. To avoid disruption of clinic routine, the researcher waited for mothers to finish their check-ups before conducting the focus group discussions. Mothers who verbally agreed to participate in the study were taken to the room allocated for the focus group discussions, the purpose of the study was further explained to them, and an informed written consent was obtained from each member of the focus group. The FGDs were conducted after the mothers gave informed consent. All the FGDs were audio recorded with the permission of the mothers to enable the researcher to accurately capture all information from the interviews. The FGDs lasted about 60 minutes and consisted of 7-8 mothers.

In addition, a questionnaire was used to obtain demographic data using closed ended questions after the focus groups. The tool obtained socio-demographic data of the women, including age, gender, and employment status, level of education, marital status, parity, place of delivery, and mode of delivery. Data was collected over a period of two weeks, from the first week to the second week of October 2017. Refreshments were served after the focus group discussions.

3.8 Data analysis
After data collection, the audio recorded interviews were transcribed verbatim to Setswana and then translated into English as the first step of preparing the data for analysis. Thematic data analysis was used to analyse data. In thematic analysis, the researcher identified, analysed, and reported patterns (themes) within the data. The researcher read a few transcripts several times to familiarise herself with the data to identify codes which reflect the women’s experiences of labour and childbirth. The initial codes emerging from the data were used to develop a codebook in consultation with the supervisor who throughout data analysis played the role of the independent coder. After the researcher and supervisor agreed on the definition of themes, all the transcripts were then imported into NVivo version 11, a qualitative analysis software package, which was used for application of codes. The last step in the analysis was to identify and finalise themes and sub-themes that were used to present the findings. Data analysis was undertaken in close collaboration with the supervisor who played the role of an independent coder. The socio-demographic data was then analysed and summarized as frequencies and percentages using NVivo 11 software.
3.9 Trustworthiness

Trustworthiness is established when the findings reflect as closely as possible the meanings as described by the participants (Lincoln and Guba, 1985). The strategies to attain trustworthiness include credibility, dependability and transferability.

Credibility refers to whether the researcher accurately represented what the participants think, feel and do. The study should be credible if it presents such accurate descriptions of human experience that people who also share the experience would recognise as well. Dependability parallels the criterion of reliability in quantitative research and refers to the stability of the findings over time. Transferability parallels the criterion of the external validity or generalizability in quantitative research (Patton, 2002). It refers to the extent to which the conclusions of the study can be applied in other contexts or have any larger import. It also refers to the ability of other researchers to apply the findings of the study to their own. Conformability parallels with the criterion of objectivity in quantitative research (Patton, 2002) and refers to the degree to which the findings are solely from the participant and the conditions of the research and not from other biases (Lincoln and Guba, 1985).

3.9.1 Methods which were used to attain trustworthiness

Triangulation refers to the application and combination of several research methodologies in the study of the same phenomenon. It facilitates validation of data through cross verification from two or more sources. In addition to the use of FGDs, the researcher collected socio-demographic data and took field notes to increase the credibility of the findings.

An audit trail refers to the careful documentation of the research process and sufficient evidence to make it possible for interested others to understand how researchers reached their conclusions. In the current study, the researcher carefully documented all the research processes and provided sufficient evidence to make it possible for other researchers to understand how they had reached their conclusions on the findings of the study and provide evidence to those who might want to do similar studies.

Peer debriefing refers to the process of presenting analysis to a peer to explore meanings, interpretations, bias and inconsistencies. The researcher held peer debriefing sessions with the research assistant and the supervisor after each focus group discussion to review the focus
group and identify gaps as well as emerging codes. In addition, the researcher frequently consulted with the supervisor to identify gaps and discuss issues of concern in the study such as inconsistencies and interpretations to improve data quality.

Prolonged engagement in the field allowed the researcher to spend an extended period with the participants. This allowed her to check perspectives and allowed the participants to become accustomed to the researcher. The researcher was responsible for all the focus group interviews and spent time with the data after the interviews to familiarize herself with the data. Familiarizing with the data was also ensured by transcribing the audio files verbatim and translating the transcripts into English.

The researcher and research assistant went through additional training on the FGD guide and objectives of the study to ensure that the FGDs yielded rich data to answer the research question. In addition, the researcher was trained on NVivo software for data analysis. Verbatim transcribing from the audio recordings ensured that the data was coded and analysed in a way that reflected the experiences of the women.

3.10 Ethical considerations
Ethical clearance was granted by the Sefako Makgatho Health Sciences University Ethics Committee (SMUREC) and permission to conduct the study was obtained from the Tshwane district health office and the management of the respective health facilities. The women provided a written informed consent prior to participating in the FGDs but only after the researcher explained the purpose of the study. They were also given a participant information leaflet, which further explained the reasons for conducting the study. The women were informed that participation in the study was voluntary and that they were allowed to make an informed decision of whether to participate or not participate in the study. They were also informed that they had the right to withdraw from the study without consequences or compromising the care they received from the clinic.

To ensure anonymity, the participants’ names were not used during the study and they were informed that their identity would not be linked to the study in anyway. They were given the option of using pseudonyms during the interviews, which they did. The FGDs were
conducted in privacy, away from other patients and the clinic staff, to ensure privacy. All the interviews took place in a private room that was reserved for the purpose of the study. All the information that was provided by the participants was kept strictly confidential. All generated data was kept secured in a safe place at the researcher’s residence and the audio files were locked in the researcher’s computer in a password locked file. There were no known risks of discomfort for taking part in the interviews.
Chapter Four: Presentation of data and results

4.1. Introduction
This chapter presents the findings derived from the data collected through focus group discussions with mothers who delivered in the primary health facilities about their experiences of care during labour and childbirth as well as their demographic characteristics. The first section of this chapter will represent demographic profiles of the participants followed by the themes that emerged during data analysis. The aim of the study was to explore the experiences and expectations of women during labour and childbirth in primary health care facilities.

4.2. Description of study sample
This study sample consisted of 36 mothers who participated in five focus groups. Most women - 12 out of 35 (34%) - had their third child, nine (26%) had their second child, seven (17%) had their first child, five (19.4%) had their fourth child and one each had their fifth and sixth children respectfully. The average gestation at birth for the mothers was 37.65 weeks and 27 out of 36 mothers initiated breastfeeding and eight did not initiate breastfeeding within the first hour of birth, the reason being that they were not informed about it and some babies were admitted. The age range of mothers was between 18 and 41 years, but most mothers were between the ages of 20 and 34 years with two mothers less than 20 years and one 40 years old. The average age for the mothers was 29.1 years.

4.2.1 Age category of post-natal women
Figure 4.1 below presents the age category of the post-natal women in the study. Most of the women were between the ages of 26 to 30 (n=9), 31 to 35 (n=8), 21 to 25 (n=7) and 36 to 40 (n=6) with four between ages of 18 and 20 and one above 40.
4.2.2 Educational status

Figure 4.2 presents the level of education of the women, where most women were literate though their education level was low. Three (n=3) never received formal education, seven (n=7) had primary education, 16 (n=16) received secondary education, eight (n=8) passed matric and only two (n=2) received tertiary education and one did not indicate.

Figure 4.1: Age distribution of the post-natal women

Figure 4.2: Level of education of the post-natal women
4.2.3 Marital status

Figure 4.3 shows that most of the women were single (n=25), ten were married and one woman did not specify her marital status.

![Marital status](image)

*Figure 4.3: Distribution of the marital status of the women*

4.2.4 Employment status

Figure 4.4 present the marital status of the women, and most 30 of 36 (83%) were unemployed with only five of 36 (13.8%) employed, and one woman was a student.

![Employment status](image)

*Figure 4.4: Distribution of the women’s employment status*
4.2.5 Antenatal attendance
Figure 4.5 shows that most of the women (17 of 36) booked antenatal care during their second trimester. This was followed by ten women who booked during their first trimester, and lastly eight women booked during their third trimester.

![ANC Attendance](image)

Figure 4.6: Reported time for antenatal booking

4.2.6 Birth companion
The women were asked several questions regarding birth companions and their responses are presented in the figure below:

![Birth companion](image)

Figure 4.7: Responses of the women regarding birth companion
Figure 4.7 shows that about 25 women were accompanied to the facility and 11 had no accompaniment. Concerning having a birth companion during labour and childbirth, 21 women wanted to have a birth companion and 14 did not want to have one. However, only eight of the women had a birth companion during the current birth.

4.2.7 Mode of transport used to come to the clinic

The women were asked to indicate the type of transport that they used to come to the clinic when labour started.

Figure 4.8: Type of transport used

Figure 4.8 shows that most of the women (19 of 36) used a private car as a mode of transport to come to the health facility for delivery, 11 used public transport in the form of a taxi, only four women used an ambulance, and two women walked to the facility when labour started.
4.3 Themes identified

The qualitative data which was collected through five FGDs was analysed and themes and sub-themes emerged from this process. These are presented in table 4.1 below:

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
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<tbody>
<tr>
<td>Verbal abuse</td>
<td>Being shouted at</td>
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<tr>
<td></td>
<td>Rudeness</td>
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<tr>
<td></td>
<td>Name calling</td>
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<tr>
<td></td>
<td>Being judged</td>
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<tr>
<td>Being neglected and abandoned</td>
<td>Being left alone during labour and childbirth</td>
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<td></td>
<td>Not being assisted when in need</td>
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<td></td>
<td>Not being attended to upon arrival in the facilities</td>
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<td></td>
<td>Being turned away during early labour</td>
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<td></td>
<td>Asked to go home during the night</td>
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<tr>
<td>Discriminated against</td>
<td>Discriminated for being a foreigner</td>
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<td></td>
<td>Refusing to call an ambulance for them</td>
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<tr>
<td></td>
<td>Discriminated for having many children</td>
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<tr>
<td>Poor rapport between women and providers</td>
<td>Poor communication with mothers</td>
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<td></td>
<td>Lack of information sharing</td>
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<td></td>
<td>Non-consented care</td>
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<tr>
<td>Health system conditions</td>
<td>Not offered food and clothes during labour</td>
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<td></td>
<td>Not being offered beds</td>
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<td></td>
<td>Not offered hot water for bathing</td>
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<tr>
<td>Failure to meet professional standards of care</td>
<td>Not being provided with pain relief</td>
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<tr>
<td></td>
<td>Not being allowed a birth companion</td>
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<tr>
<td></td>
<td>Not treated with dignity and respect</td>
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</tbody>
</table>

4.3.1 Views about maternity care

The mothers were asked about their general views on the maternity care provided in the health facilities. Most of the women reported that they are not treated well when they go to
health facilities during labour and childbirth. Some of the reported incidences are outlined in the following excerpts:

“Women are being ill-treated; they are beaten, and are done scary things” Participant 1, FGD 2.
“They are not patient and they don’t care about our feelings” Participant 4, FGD 1.
“This other woman came in with her husband and they told them the water broke in the car, but they refused to help them, and she gave birth on the floor because they refused to show them were they were supposed to go” Participant 1, FGD 4.

The data also showed that even though most mothers were treated badly, there are some whose experience of the maternity care was good, suggesting that treatment can be both good and bad for a mother in the same health facilities:

“When I arrive they were nice, but...as time goes by they started their things” Participant 5, FGD 4.
“Some will tell you don’t come irritates us, some will talk to you as if you not mentally sound but some will talk to you nicely” Participant 1, FGD 3.
“It was not nice for me because I have two children and this is the third one, so I feel that they were not treating me well” Participant 3, FGD 3.

The data also reflected that most mothers were not happy with the fact that at times they were not given immediate attention when they arrived in health facilities during labour.

“They sit like in groups..., you can scream..., like if there is something happening..., in the ward that I was in..., there was a woman who came to say the baby’s head is here she wants to give birth, they did not come to attend to her. They only attended to her late when the baby’s head was out shouting” Participant 4, FGD 2.

4.3.2. Women’s birth experiences
Women were asked to reflect about their individual experiences of labour and childbirth. Most responded that their birth experiences were not good, and that midwives made their labour and birth period not memorable. Some women felt that the nurses were inpatient with them when they were feeling pain. This is reflected in the statement below:
“I was bending as I was bleeding, I called the sister and when she came, blood was dropping on the floor, she said let us go and take off your dress and follow me. By then I couldn’t, my feet were not functioning well, I could not do anything, she told me not to waste her time as we must go to labour ward, she called me again” Participant 4, FGD 1.

The women also reported that they felt that the nurses disrespected them by not wearing their nametags when they assisted them during labour.

“They speak to us the way they please because they know they don’t wear name-tags” Participant 4, FGD 2.

“There was this other lady I don’t know her by the name as she was not wearing a nametag, she is the one I was afraid to talk to because when you start talking she will say you are not special, we have to attend to others, these are the things that they tell us” Participant 2, FGD 2.

4.3.2. Verbal abuse

Women expressed that they were not respected, were shouted at, were judged, discriminated against, and that midwives were rude towards them. These sub-themes are further explained below.

4.3.2.1. Being shouted at

In addition, most of the women reported that they were being shouted at by the nurses. This happened mostly when nurses asked women something and they did not understand. This is articulated in the following statements:

“They were shouting at me because I did not understand what they were saying and they were laughing at me at the same time” Participant 5, FGD 4.

“When you ask them about things you don’t understand they shout” Participant 5, FGD 2.
“When she was talking to me in Setswana I could not respond because I didn’t understand what she was saying and if I did not respond she would shout at me or she would just leave me in pain even when the baby came” Participant 4, FGD 4.

“The way they shout at us it was not easy, even when you have issues you cannot share with them” Participant 2, FGD 2.

4.3.2.2. Rudeness

The women also experienced disrespect from the nurses when they attended to them during childbirth. The women reported that the nurses were rude towards them as shown in the statements below:

“The sister was so rude and impatient, she did not have patience with me and was hurting me” Participant 5, FGD 4.

“They were harsh and rude towards me” Participant 3, FGD 5.

“It was not easy to communicate with them, they were harsh and rude” Participant 2, FGD 5.

In retaliating to the rudeness, some women reported that there was an element of rudeness from some of the mothers towards nurses who were rude to them.

“The way they were so rude to me I also was rude to them” Participant 2, FGD 1.

Most of the women reported that in addition to the nurses’ rudeness, other staff members such as cleaners were rude to them. This is illustrated by the statements below:

“One woman said, when I went to the toilet the cleaner followed me telling I did this and that… every time you go to the toilet she will follow you even when you enter the labour ward, she’s a cleaner, and she does not treat women who come to deliver well” Participant 1, FGD 3.

“There was this other lady [cleaner] who was rude to me and making me to remove my dirty sheets” Participant 3, FGD 5.

“The cleaner was so rude to me telling me to shift my stuff on the floor in a bad way” Participant 2, FGD 5.
4.3.2.3. Being judged

Some of the women reported that they felt that they were being judged by the midwives because of the number of children they had. The following statements further explain this:

“They started saying things that I did not like, while busy checking my file, they said my child is the third and that the other two are not spaced enough, one child was born in 2013 and the other in 2014. They asked why I was in such a hurry. They said I was not supposed to be pregnant and my heart was sore because they said that I abuse these children as they are still young, I should be having two children not three” Participant 1, FGD 3.

“They will ask you as to how many children do you have and you tell them maybe that you have a two year six months child at home and they say, you are pregnant again? That’s why other women will hide their babies saying it is my first pregnancy so they can treat us well” Participant 2, FGD 3.

“She checked my file and said Jesus..., the third child...., you know you are making noise...., you know even our ears are painful” Participant 2, FGD 1.

4.3.2.4. Name-calling

Some women reported that when attending to them nurses were calling them names and felt belittled at the same time. Some of the statements are reflected below:

“Hey you little girl (hey wena ngwanyana) come here” Participant 4, FGD 1.
They were calling me “the girl with dreadlocks” Participant 2, FGD 2.
“One of them was addressing me as the woman with many children” Participant 2, FGD 2.

4.3.3. Being neglected and abandoned

Data also revealed that some of the women felt neglected, abandoned and deprived of their dignity by the nurses during labour. Some women reported that they were left alone, not being attended to in time, not being assisted when in need, refused being allowed to sleep on the bed, being denied pain relief when they were in pain, not being provided with resources, and were asked to call their families to fetch them during the night.
4.3.3.1 Being left alone during labour and childbirth
Most women reported that they were left alone at some time during labour and childbirth. The data revealed that women would not be attended to even when they asked for help.

“I was alone during the night, the sister disappeared, and I didn’t know where she was” Participant 4, FGD 1.

“They checked me twice, from there I never saw them” Participant 4, FGD 1.

“After the baby came she was about to stitch me and I was afraid because she did not give me anything for pain, so I was refusing and she left me in bed with blood all over me for about two to three hours” Participant 5, FGD 4.

“I ended up giving birth without an assistant” Participant 7, FGD 5.

4.3.3.2. Not being assisted when in need
Besides being left alone, most women reported that nurses did not attend to them in time when they were in labour.

“When I scream for help they just told me they are still looking for gloves” Participant 4, FGD 4.

“There was another woman who came to say the baby’s head is here she wants to give birth, they did not come to assist her. They only attended to her late when the baby’s head was out” Participant 1, FGD 4.

“When I was about to deliver they said I must not push because they were still helping another lady” Participant 7, FGD 5.

4.3.3.3. Not being attended to upon arrival in the facility
Women reported that they were not attended to immediately upon arrival when they were in labour. There were delays in providing care when they arrived; this was despite the severity of the pain they were experiencing at that time.
“I arrived at four in the morning. Nurses told me to sit down and when I told them I was in pain they forced me to sit. They checked my file and without even checking me they said I must go and sleep” Participant 2, FGD 5.

“Okay, I arrived there in huge pains and they told me to sit down and wait for them because they are still busy. They only helped me after 15 to 20 minutes and they just told me to go pee and go back to my sit again” Participant 3, FGD 5.

4.3.3.4 Being turned away during early labour
Some women reported that they were turned away during labour and were told that they came early.

“Yes, they will rather check you and tell you to go back home, and that you are not ready to give birth, asking why did you come this early?” Participant 1, FGD 5.

“They said I must take my money, and go to the taxis because I cannot go by ambulance to the hospital, but there were other people whom they were transferring by ambulance, I stayed outside the clinic..., the pains started, the water broke..., and I came back” Participant 1, FGD 1.

4.3.3.5. Asked to go home during the night
The women were not happy that they were discharged after six hours because they were still feeling tired. Some were discharged and told to go home during the night with no transport. This was despite the fact that they still had pains and there were no other patients in labour, but they were told to go home in order to give others space.

“No, I was already tired, they said we must go so that we can give others space” Participant 4, FGD 1.

“At 10pm they said I should call home for them to fetch me. It was in the evening. I too would not have left” Participant 1, FGD 3.
4.3.4. Being discriminated against

4.3.4.1 Discriminated against for being a foreigner

Some women revealed that they felt discriminated against because they were foreign nationals. This was also observed by some South African women who were in labour with foreign women.

“When I arrived there it was very bad. I am a foreigner, the sister who attended to me was speaking Setswana. I told her I don’t understand her language and asked her to please speak English, she said Setswana is the only language she speaks, and she said she doesn’t understand English, but it was not true she was just trying to spite me” Participant 5, FGD 4.

“Those who are from outside they say you Zimbabweans you are burdensome, immigrants you are tiresome, you give birth a lot, they don’t treat us nice, they treat us bad” Participant 5, FGD 3.

“Some do not treat you well, they were saying Zimbabweans are annoying because they don’t understand Setswana” Participant 4, FGD 4.

4.3.4.2 Discriminated for having many children

Most of mothers reported that they felt that they were being discriminated against by the nurses for having many children in the way they talked to them as reflected in the statements below:

“I have four children and this is the fifth, they said why did you have the baby so quick? Magrigamba (foreigners) are irritating you are just making babies” Participant 5, FGD 3.

“One nurse said you people are annoying you do not finish to have babies, you have many children, see here you are competing with young girls, when are you going to stop?” Participant 1, FGD 2.
4.3.4.3. By refusing to call an ambulance for them
In addition to being discriminated against because of being non-South African, other women responded that they felt discriminated against as well when they refused to call an ambulance for them.

“They chased us here. They refused to call an ambulance for me, and there was another lady who did not have money as well, who wanted them to call an ambulance. They refused. They said I must go home and get money to go to the hospital”
Participant 6, FGD 5.

“But there were other people whom they were transferring by ambulance”
Participant 8, FGD 1.

4.3.5. Poor rapport between women and the midwives
Data revealed that some women were not happy with the way nurses communicated with them when they were giving birth. Consequently, mothers felt that it was not easy to communicate with the nurses when they were in facilities for childbirth. Most of the mothers reported that some nurses did not make it easy for communication to be good between them.

4.3.5.1. Poor communication between mothers and health providers
“For me it was difficult because I felt that they were going to scold me” Participant 1, FGD 5.
“Th ey were difficult and things were not easy for me. They made it difficult for me”
Participant 6, FGD 4.
“No, they did not explain. If there was something wrong, I was afraid to ask”
Participant 5, FGD 4.

4.3.5.2. Lack of information
Women were asked about the kind of information that nurses gave them when they were in labour. Most of them reported that they were not given any information to understand how they were progressing or explained to them what to expect during labour. The lack of information contributed to the shouting and feeling of being disrespected as nurses would not explain what they did. One mother said:
“But it will be nice that when you have pain they check you and tell you what is happening, other than you are being in the dark, and you become surprised when a person puts their fingers in, check you and leave you, and here you are feeling pain”
Participant 2, FGD 1.

The women were asked whether they were informed about having a birthing partner or companion during labour. The data reflected that most of the women were not given information about having a birth companion and were not aware that they could bring someone during labour.

“I wanted to bring him but I was afraid because I didn’t know anything or any information about it” Participant 3, FGD 4.
“I thought it was okay because I never knew if partners were allowed when we give birth” Participant 4, FGD 4.
“We did not know that it can happen in public hospitals” Participant 2, FGD 5.

Some of the mothers shared their experiences of labour and the feelings of being left in the dark as reflected in the statements that follow below:

“Another one came and said this lady is 9 and she is not yet at ten, the other did not see that. I did not understand what they meant when they said 9 or 10. So they must tell us why they say 9 or 10, is my child near or still far and how long will I wait, they said my child will come at 11 but came at 9 they must tell us that when we say 9 it means you are left with so many time or seven so and on” Participant 8, FGD 3.

“She told me you will finish but did not tell me how far I was” Participant 2 FGD 1.
“At times they don’t explain and we can’t read their language” Participant 5, FGD 4.

The data revealed that lack of communication continued even after delivery. This is what one mother said about her baby:

“After the baby was born I heard them saying the baby was not fine, you are the parent whom they are supposed to tell me that my your baby is not fine…, they don’t tell you that there is breathing problem. That thing did not sit well with me; they don’t tell you that the baby is not fine they will not discharge her” Participant 6, FGD.
4.3.5.3. Non-consented care

In addition, mothers reported that they did not like the fact that midwives will call each other to double check the mother with them without explaining what they are doing to the woman and not asking for their consent.

“Calling each other to come and check me without telling me what is happening” Participant 1, FGD 4.

“Sometimes they come with students and just check us without even telling us what they are doing or why they are doing it” Participant 4, FGD 5.

4.3.6 Failure to meet professional standards of care

4.3.6.1. Being denied a birth companion

The data revealed that women who knew about having a birth companion and wanted a birth companion were not allowed to have one either during labour or during childbirth as reflected in the excerpts below:

“My mother was there sitting on the chair so she came and helped me from her chair. They told my mother she should not help me; that she’s not meant to help me with every single thing. They did not chase my mother, she came with me, but in the delivery room she did not enter” Participant 1, FGD 2.

“He wanted to be with me, he wanted to hold me, I refused because I was in pain, I could not walk, he helped me to walk, and they said leave that lady alone and go back home” Participant 5, FGD 2.

“After I changed my clothes the nurse ordered my sister to go home and I was left alone” Participant 6, FGD 4.

Only two women were allowed to have the mother present during labour and delivery. When asked whether they believed that having a companion affected the treatment they got, here is what one said:
“Yes, they treated me well because my mother was there, because other women who were in labour at the same time were not treated well” Participant 7, FGD 1.

Similar views were held by some of the mothers who believed that “the nurse will see that there is someone with you and will talk to you like a human being.”

“It is something I am thinking about, even the harsh words they speak to us will become fewer” Participant 2, FGD 1.

“I think having someone with you will make things good for you, and the way they speak to us they won’t even speak that way if someone is there close to you” Participant 2, FGD 3.

The data revealed that most of the mothers wanted to have someone to be present during labour and delivery for support.

“It was very hard because when you are in pain you need someone to comfort you and tell you that it is going to be okay” Participant 2, FGD 1.

“Yes indeed, I would have loved to have my sister next to me when I give birth I would love to have the support through the whole process” Participant 2, FGD 4.

However, data also revealed that some of the mothers felt that they preferred to be alone during labour for various reasons.

“I don’t want anyone because I don’t think my partner can come because I think if my partner can see what is happening here he will think I cannot go in there again” Participant 4, FGD 4.

“No, I did not want to see anyone … other people talk too much and they will gossip about you saying that you were doing this and that” Participant 6, FGD 4.

Furthermore, the data showed that most of the women understood the role played by the companion during labour and childbirth.
“When the sister is busy at the other side when they are few the partner helps you” Participant 2, FGD 1.

“It will make things easy because someone will feel for you and their support will give you courage” Participant 3, FGD 3.

4.3.6.2. Not offered pain relief
Concerning pain medication, only one woman (1 out of 35 women) received pain medication during labour. No other women received any pain medication as expressed in the following quotes:

“They will leave you in pain saying once the baby is out the pain will go away” Participant 8, FGD 3.

“When I was in pain I was crying but they did not give me anything” Participant 5, FGD 4.

The data further revealed that women were denied pain relief during labour despite them reporting to have severe pain and asking for pain medication.

“For me it was difficult because I was feeling pain, I was begging that so they help me with pain medication so that they can reduce the pain, but they kept on saying there is no way that they can reduce the pain, pain is when you deliver the baby it will become better” Participant 8, FGD 3.

The woman who received pain medication during labour said:

“Yes they gave me an injection and said I must sleep” Participant 7, FGD 1.

4.3.6.3 Not treated with dignity and respect
Most of the mothers reported that they felt that they were being disrespected by the nurses in the way they talked to them as reflected in the statements below:

“She checked my file and said Jesus..., the third child....., you know you are making noise..., you know even our ears are painful” Participant 2, FGD 1.
“I was bending as I was bleeding, I called the sister and when she came, blood was dropping on the floor, she said let us go and take off your dress and follow me. By then I couldn’t, my feet were not functioning well, I could not do anything, she told me not to waste her time as we must go to labour ward, she called me again” Participant 4, FGD 1.

4.3.7. Not being offered resources

4.3.7.1. Not offered a bed
Some women reported that they were not offered a bed during and after childbirth, and some were told to sit on the benches holding their babies.

“When I finish giving birth they let me sit on the chair. Imagine the pain when they just stitched you and they tell you to sit on the chair” Participant 2, FGD 1.

“I was sitting on the bench the whole time when I was in labour” Participant 4, FGD.

“When they know that you are going home, as they say they discharge you after six hours after giving birth, after six hours they discharge you, they do not give you a bed, they let you sit on the chair, waiting for that six hours” Participant 8, FGD 4.

4.3.7.2. Not offered food
Others were not happy about not being offered food and were told to go and buy with their own money.

“They asked me to go and buy food for myself” Participant 6, FGD 4.

4.3.7.3 Not offered hot water for bathing
One woman reported that she was not happy because she bathed with cold water after delivery because they said there is no hot water.

“They need to change because we wash with cold water” Participant 5, FGD 1.

4.3.8. Future utilization of facilities
Some women when asked about future utilization of health facilities reported that they would come back to the facility to give birth because of the care that they received.
“They treated me well” Participant 2, FGD 4.
“Because they know how to treat people right” Participant 3, FGD 4.
“I delivered here and I will come back here” Participant 2, FGD 5.
“I can go back if I ever decide to have another child” Participant 8, FGD 1.

However, some would prefer to go back to the facility where they gave birth because it was closer to their homes, not necessarily because they had a positive birthing experience there. The data revealed that they preferred these facilities because they would have constant contact with their families for support because of the close proximity to the health facility. This is reflected in the statements below:

“I saw it was near when I had pains, I understood I didn’t have a choice” Participant 5, FGD 2.
“Because it is closer to my home” Participant 7, FGD 1.
“Here, because it is closer to my home” Participant 4, FGD 1.
“It’s closer to my home” Participant 6, FGD 4.

In contrast, most women would not go to the same facility again if they had another child:

“I will rather die than go back there” Participant 2, FGD 2.
“Because of their treatment I will not come back” Participant 5, FGD 4.

One woman indicated that she would not return to the health facility for delivery and said, “I want those [nurses] to teach me how to deliver my baby by myself at home so that I can bring the baby here after birth” Participant 1, FGD 3.

4.3.8. Fear of safety for their children
Some mothers reported that they feared for their children’s lives because of the bad treatment they received from the midwives. This fear arises from the fact that nurses did not make it easy for women to trust them, meaning the trusting relationship between the mothers and the nurses was not built. This is shown in the statements below:
“I thought maybe she might hurt my baby because I have many children, she told me that because you have many children things might happen in another way, I said God help me for the way she speaks, she must not have another mind to say let me do something or how” Participant 1, FGD 2.

“I had no problem with that, but this thing that they say you must not sleep on the bed when your baby is near is not right because you may give birth to your baby on the floor” Participant 5, FGD 4.

“I had a horrible experience when I went to deliver my baby. It was very hard. They didn’t even explain to me how to keep my baby safe” Participant 1, FGD 5.

4.3.4. What women expect from the nurses during labour

In response to what they expected from the nurses during labour and delivery, most of the women responded that they need to be treated with respect and care by both nurses and other workers within the health facilities, regardless of whether they are foreigners or not. These are some of the quotations highlighting their expectations:

“They must treat us with respect, they shouldn’t call us names” Participant 2, FGD 2.
“They must be gentle with us, they must not be aggressive” Participant 1, FGD 4.
“Attend to me nicely even if I am a foreigner or not” Participant 5, FGD 3.

Most of the women also needed to be given adequate information about what is happening with them and their babies during labour, delivery and post-delivery.

“I was expecting them to explain to me how the process of giving birth and everything that I should know.” Participant 1, FGD 5

They say come this side so that we can check you, as to what they are checking you for I don’t know. Participant 6, FGD 1.

Some of the women expected to be allowed to have a birth companion.

“They must allow us to bring them, it is important so that we can help each other, and they also need to see how difficult it is to give birth” Participant 1, FGD 4.
“Yes, they must allow it, because when our parents are there they are friendly and start smiling but when they leave they start again” Participant 4, FGD 1.

Concerning pain relief, the women responded that they expected to be given pain relief during labour.

“I will expect them to give me some injection for pain when I go to deliver because the pain was strong” Participant 8, FGD 3.
“I expected something because I heard others talking about pain injection and even the doctor said they will they will give me pain medication” Participant 1, FGD 4.

From the data, it was revealed that most of the women wanted to be attended to within a reasonable time of their arrival or when there was a need.

“We must be helped immediately when we get there” Participant 5, FGD 2.
“We are asking that when we enter there they must treat us well and help us when we ask for help immediately” Participant 5, FGD 2.

The women felt strongly about the need to be offered resources such as beds, food, ambulance services, hot water and clothes when they are in labour in health facilities.

“I feel they can change the issue of ambulance, they must not say this person must go by ambulance, this one must arrange a car and not go by ambulance” Participant 1, FGD 1.

“They must not let us sit on the chairs after giving birth” Participant 8, FGD 3.
“I expect that at the clinics there must be clothes, like in hospitals like Odi, where the hospital clothes for patients, there must be hospital clothes and food because we are not the same as people” Participant 1, FGD 3.

When asked about how they need to be addressed most women wanted to be addressed in a proper manner by the nurses.

“They should change referring to us as “magrigamba” Participant 5, FGD 3.
“They must address us nice, not to point us or call us with their hands” Participant 2, FGD 1.

In addition, some women reflected that they would like to be discharged when they are ready and not discharged during the night.

“They should discharge people when there’s still light outside” Participant 1, FGD 3.

One woman, in addition, expected to be taught how to breastfeed her baby.

“With me I expected that I made a mistake as I was still young, I expected that I don’t know how to breastfeed the baby, I expected that they will come to the ward and tell me how to hold and feed the baby” Participant 1, FGD 2.
Chapter Five: Discussions, conclusions and recommendations

5.1 Introduction
This chapter provides a summary of the discussions of postnatal women’s experiences of care during childbirth in health facilities. Firstly, the chapter addresses the socio-demographic characteristics of the mothers and links them with their experiences of care. Secondly, the discussion is arranged into the themes aimed at addressing the study question such as the type of care women experienced during labour and childbirth, and the women’s expectations of care. Lastly, the conclusions and recommendations are presented.

5.2 Socio-demographic characteristics of participants.
A total of 36 women who delivered six weeks prior to the study participated in five focus group discussions. The women were recruited from community health care centres where they were attending their postnatal care. The age range of the mothers was between the ages of 18 and 41 years with most mothers falling between 20 and 34 years. Most of the mothers were literate although their education levels were low. Most of the mothers who participated in the study were single. The mothers’ employment status was very low as well at 11.5%.

Regarding their first antenatal visit, most mothers booked antenatal care in their second trimester (17 of 36), ten during their first trimester, and eight during their third trimester. Almost all the mothers used transport to get to the facility when labour commenced, most (18 of 36) used private car, and 11 used public transport, four used an ambulance, while two walked to the facility. This shows that for most of the mother access to the health facility during labour was dependent on the availability of transport. Where mothers do not have a private vehicle or do not have money for public transport, they will delay in getting to the facility on time for proper monitoring during labour. This may contribute to an increase in maternal mortality where there was a delay in seeking help during obstetric emergency where the mother does not have transport available. This is in line with other studies conducted in sub-Saharan Africa, which found that availability of transport for a woman during labour has been identified as a barrier to equitable, accessible, quality maternal and child health services (Ganle et al., 2014; Bohren et al., 2014).
5.3 Birth experiences

The study explored the birthing experiences of women, and the data showed that women had negative experiences during labour and childbirth. The study found that women were treated with disrespect and received undignified care from midwives throughout the birthing process. The findings are in line with the previous findings from studies conducted in Ghana, South Africa and other African countries. These studies also found that women were treated with disrespect and received undignified care in public health facilities when they present for labour and childbirth (Kruk et al., 2014; Asefa & Bekele, 2015; Oosthuizen et al., 2017; Chadwick & Foster, 2014; WHO, 2015a).

Disrespect of women during labour and undignified care occurred despite midwives being guided by the code of conduct for midwives. The codes stipulates that midwives must treat women with dignity and respect during labour and childbirth (SANC, 2013). In addition, respect for human dignity is drawn from the declaration of human rights, which is stipulated in in chapter 3 of the Bill of Rights, summarised in the patients’ rights charter and Batho Pele principles (Constitution, 1997). The disrespect and undignified care further showed that nurses did not adhere to the WHO quality of care framework for maternal and new-born care which identifies respect and dignity as one key domain to quality maternal and new-born health care (Tunçalp et al., 2015).

This study also revealed that women were shouted at during labour and childbirth. The data further revealed that shouting was triggered by trivial things such as when the woman did not understand what the midwife wanted. In one such case, the woman did not understand the local language, and that triggered the shouting from the nurse. Shouting was common in the findings from previous studies conducted in South Africa, which reported that women were scolded and shouted at by the nurses during labour and childbirth (Jewkes et al., 1998; Silal et al., 2012; Chadwick & Foster, 2014; Oosthuizen et al., 2017). The shouting affected the communication between the women and the midwives in the study. The communication between the midwives and the women was also compounded by the rudeness that women experienced from the midwives. The women reported that the midwives were rude towards them and described them as very harsh and rude. This made it difficult to communicate with them about issues related to their care as well as that of their babies. A study conducted in rural Tanzania also reported on the abusive language that is used by midwives during labour.
and childbirth. The study further suggested that abusive language was one of the many barriers to facility-based care (Mrisho et al., 2007). Similar observations of abusing language and rudeness experienced by women during labour and childbirth has been documented in previous studies conducted in South Africa (Chadwick & Foster, 2014; Silal et al., 2012). Literature suggests that health workers ignore the abuse of women during labour by midwives and often treat it as normal. The lack of sanctions to nurses leads to them seeing their practice as normal (Jewkes et al., 1998).

The data revealed that rudeness towards women during childbirth has resulted in the women retaliating by being rude towards the midwives. However, this is in contrast with the study by McMahon et al. (2014), which found that in response to the abuse from midwives women most often use non-confrontational strategies such as resigning oneself to abuse, returning home, or bypassing certain professionals or facilities. This supports the general belief that women generally expect to be shouted at, beaten, or neglected when attending public health facilities during childbirth. On the contrary, the male partners may use assertive strategies such as requesting better care, lodging a complaint or assaulting the midwife in response to the abuse of their partners.

Discrimination has been identified as one of the forms of disrespect women are subjected to by midwives during childbirth. Asefa and Bekele (2015) maintain that there are many forms of discrimination that women are subjected to during childbirth. In the current study, women were discriminated against because they were foreign nationals. The study revealed that women were called names and referred to as “magrigamba”. They were also labelled as having many children. This has also been identified in other Southern African studies (Oosthuizen et al., 2017; Okafor et al., 2015; Kruk et al., 2014).

5.3.3 Being neglected during labour and childbirth

Global data suggests that women generally expect to be shouted or neglected in primary health facilities during childbirth. Similarly, this study revealed that women were neglected by midwives in the health facilities during childbirth. The women recounted incidences of being left alone during labour for hours or told to sleep and never saw their midwives throughout the night while others gave birth without an assistant. It is concerning that the women would not be attended to even when they asked for help, which, as mentioned, resulted in giving birth unattended. The study findings are similar to those of other studies
conducted in African countries. These studies showed that neglect was most prevalent during labour and delivery by midwives. Similarly women reported incidences of giving birth without assistance (Asefa & Bekele, 2015; WHO, 2015a; Abuya et al., 2015; Bohren et al., 2014; Bohren et al., 2015; Ganle et al., 2014; Okafor et al., 2015; Kruk et al., 2014; Mirkuzie, 2014; Chadwick & Foster, 2014; Silal et al., 2012; Honikman et al., 2015).

It is argued that abuse during childbirth is not only a quality care system but it is a violation of the human rights of women (Kruk et al., 2014; Okafor et al., 2015). In the current study, the women reported that, when they presented to the facility in labour, they were asked to sit on a bench for more than two hours before they were seen by the midwives. Similarly, the women were instructed to sit on a chair with their babies after delivery to wait for the six hours of discharge. The violation of the human rights of the women in the current study is worrisome; one woman who refused to be stitched without pain medication was left to lie in bed with blood all over her for about three hours.

Neglect by midwives during labour and childbirth occurs despite the regulations from the South African Nursing Council (SANC, 1984). The regulations state that a midwife must never leave a woman in labour alone without informing her of where she can be reached without delay, and it also states that if second stage of labour is imminent, a midwife may not leave a woman alone. As mentioned, the lack of sanctions to midwives who subject women to abuse and neglect leads to them seeing their practice as normal (Jewkes et al., 1998). The World Health Organization argues that policies to promote respectful non-abusive maternal care have not yet been adopted into meaningful action (WHO, 2015a). Therefore, there is a need for human rights stakeholders and policy makers around the world to develop interventions to adopt and implement these policies to promote respective non-abusive care during childbirth.

According to Freedman et al. (2014), for women to exercise their right to accessible, good quality care, they need to have access to infrastructure, equipment, and skilled personnel to provide both routine and emergency obstetric care for them. The current study revealed that some women were not offered resources during and after delivery. There were some women who reported that they were not offered a bed during and after childbirth, some who were not provided with warm water to bath, some were told to buy their own food and some were not provided with clothes during childbirth. Other studies reported similar observations. These
studies further showed that not being offered resources such as food and a bed may be barriers to accessing health care in time (Oyerinde et al., 2012; Wilunda et al., 2014; Karkee et al., 2014; McKinnon et al., 2014).

The study further found that women were denied access to ambulance services during childbirth. The women, particularly foreign nationals, were instructed to find transport to go to the hospital if the nurses referred them to the hospital for delivery. Not being able to arrange suitable transportation for a woman during labour has been identified as a barrier to equitable accessible quality maternal and child health services by Ganle et al., (2014) and Bohren et al., (2014). It should be noted that when a patient is referred to the hospital for delivery, it implies that there are complications that should be managed there, thus the refusal of access to safe transport during labour borders on neglect of the human rights of the woman. Availability of resources in public health facilities is one key element of measuring quality. Difficulties in arranging transportation during labour discourages women from accessing and utilizing the services.

5.4 Failure to provide medication during labour

This study revealed that women were not given pain relief during labour and childbirth. This is despite women screaming with pain and asking for it. This study further revealed that midwives were not supportive and did not make the pain any easier as they ignored women when they were screaming and asking for pain relief. A study by Farrell & Pattinson (2004) has revealed that not providing pain relief during labour may lead to psychological trauma (National Institute of Clinical Excellence (NICE), 2007) and is practised by midwives with a belief that women must endure the labour pains and get what they deserve. A recent South African study found that most health facilities do not have pain relief medication, which means that most women are not provided with it when in labour (Oosthuizen et al., 2017).

5.5 Being denied a birth companion

The data shows that, although people who accompanied women to facilities during labour wanted to support them throughout the birthing process, most of them were denied the chance to be a birth companion. This invariably denied women the opportunity to have a birth companion. The study findings concur with other studies conducted across the globe and in sub-Saharan Africa which found similar results of women being denied birth companions
even if those who accompanied them wanted to support them (Asefa & Bekele, 2015; Honikman et al., 2015; WHO., 2015; Silal et al., 2012; Abuya et al., 2015; Bohren et al., 2014; Bohren et al., 2016; Jewkes et al., 1998; Okafor et al., 2015; Kruk et al., 2014; Mirkuzie, 2014).

This happens despite the fact that the presence of a companion during labour has been identified as one of the practices that improves the health of the woman by improving maternal satisfaction, shortening labour and reducing the need for pain according to Better Birth Initiatives which has been adopted in South Africa (Smith et al., 2004; White Ribbon Alliance, 2011; Banda et al., 2010). Support during labour refers to the relationship with the midwife whereby the midwife advises and informs the woman about the labour progress, and also includes social support, which may be from the husband, a relative or a doula (Larkin et al., 2009).

There is enough evidence that shows that women value and benefit from having a birth companion or support person during labour (Bohren et al., 2016; Banda et al., 2010; Kaibe 2011; Hodnett et al., 2013; Van der Gucht & Lewis, 2015). Despite women being denied birth companions, this study has revealed that some women knew the benefits and roles of having a birth companion in labour. They reported that the companion may be able to assist when the midwife is busy with other patients, may provide for their immediate needs and may also report to the midwife if the woman is about to deliver. This reduces the incidences of women delivering alone. This is in line with a study by Kaibe (2011) who reported that the presence of a birth companion could help provide the support the midwife is unable to provide and may assist the woman in coping with pain and provide emotional support.

In addition, this study revealed that women felt that having a birth companion might help alert nurses to treat them with respect and dignity. A support person during labour is important and can ensure that midwives treat women in labour with dignity, compassion and respect when a support person is available (Okafor et al., 2015).

5.6 Lack of information

Most women indicated that the nurses did not give them any information regarding the progress of labour, what to expect during labour and childbirth. For instance, the women
indicated that the midwives would just put their fingers inside them without explanation as to why they are doing it and what they find. The study found that women felt disrespected when the midwives called another nurse to check the woman without any explanations. In other studies as well women reported that they were not given information about the aspects of the birth process (Chadwick & Foster, 2014; Mselle et al., 2011; Bohren et al., 2016; Oosthuizen et al., 2017). Lack of communication was observed in the current study despite the fact that effective communication has been identified as one of the three domains of the quality of care framework by WHO (Tunçalp et al., 2015).

Access to information is important to the women in the sense that it enables them to participate actively in decision making that involves their care, as they will be fully informed to make choices. Denying women access to information constitutes abuse of patient and human rights, as all patients according to the Patient Rights Charter have the right of access to information concerning their health (Crous., 1997; Constitution, 1997).

The women desired effective communication with midwives because they felt that communication would give them the chance to ask questions and get clarity as compared to being spoken to. The findings are in line with the findings from previous studies conducted in South Africa and other countries (Chadwick & Foster, 2014; Mselle et al., 2011; Diorgu et al., 2016). It is important that the midwife gives information that is adequate to the women in labour to help them make informed choices.

### 5.7 Future utilization of services

There is significant evidence that the women’s experience of care during childbirth influences their choice of childbirth setting for future pregnancies (Ganle et al., 2014; Moyer et al., 2014; McMahon et al., 2014; Kruk et al., 2014). Some of the women in the current study indicated that they would not use the health facilities in future because of the birthing experiences they had. The women felt strongly about the use of the health facilities for childbirth in the future. They indicated that they would not go back to the same facilities even if they were forced to do so. Some said they would rather die than go back to the same facilities. Other studies also reported that the consequences of abuse and disrespect during childbirth often result in women not utilizing health facilities in future (Ganle et al., 2014; Moyer et al., 2014; McMahon et al., 2014; Kruk et al., 2014).
The study further found that the negative experience of a woman during labour and childbirth may damage the trust between the woman and the health system which will have a negative impact on the woman in making a future delivery decision in the health facility (Moyer et al., 2014; Ganle et al., 2014; Mirkuzie, 2014; King et al., 2015; Jewkes et al., 1998; Odhiambo., 2011). Midwives play the important role of building relationships with women where mutual trust in each other’s competence is of much importance (Karlström et al., 2015). In the current study, there was lack of trust between the women and the nurses. The women reported that they did not trust the nurses and were afraid that something might happen to their new born babies. Some felt that they could have lost their babies in the midwives’ care. The code of conduct for midwives requires them to develop a trusting relationship with their patients and to always give honest and truthful information to the patients.

Consequently, women may choose home birth in preference to facility birth due to the support system and privacy they receive during home birth as opposed to the mistreatment they receive which will lead to an increase in home deliveries, and women may then choose facility birth only as a last resort (Ganle et al., 2014; Bohren et al., 2014). The choice of home birth may at times be problematic if the woman develops complications during childbirth because there are no skilled birth attendants, as this have been found to be one of the strategies to reduce maternal mortality.

However, some women in this study revealed that they would use the same facilities in future, mainly because they are closer to their homes and not necessarily because of good service. This shows how women view support during labour as an important element, so giving birth in facilities closer to home will give their families and support people the chance to be closer to watch over them rather than being far from home.

5.8 Expectations for women

Women indicated that they need to be attended to timeously when they present in the facilities for childbirth, and given information about their care in order to make informed choices. Similar findings were reported in studies conducted in other parts of the world and in South Africa (Ng’anjo Phiri et al., 2014; Diorou et al., 2016; Bohren et al., 2015). Women in
this study also reported that they need to be offered pain relief and support when they are in labour

5.9 Conclusions

The study found that women experienced the labour and childbirth negatively, they were treated with disrespect and received undignified care from midwives. They were left in blood-soiled linen after childbirth, ignored, and denied pain relief even if they were begging for pain medication. The findings showed that disrespect and abuse of women during labour occurred despite midwifery practice being guided by the code of conduct for midwives.

The findings further revealed that women were neglected by midwives during childbirth. They were left alone during labour, gave birth unattended, and were not attended to timeously, instructed to sit on a chair with their babies after delivery, and denied access to ambulance services. Lastly, the study found that this is in contrast with what women expected from midwives. Their expectations were in direct contrast with what they experienced. They expect to be treated with dignity and respect, to be attended to timeously, be offered pain relief and support and their voice to be heard.

Shouting, harshness, and abusive and rude language were common forms of disrespect by the midwives during labour and childbirth, which were triggered by trivial or unimportant things. The shouting and abusive language affected the communication between the women and the midwives which was characterized by shouting, rudeness, and abusive language. The women felt that the midwives were not approachable and they could not ask any questions in relation to their progress during labour.

Discrimination was also a common form of disrespect women were subjected to by midwives during childbirth particularly, women of foreign nationals who experienced discrimination and name calling more than the South African citizens.

The current study revealed that women were not offered resources during and after delivery. They reported that they they were not offered a bed during and after childbirth, they washed with cold water, were told to buy their own food, and were not provided with clothes during childbirth.
Despite adequate evidence that women value and benefit from having a birth companion or support person during labour, most of the women were denied a birth companion and lacked information about their rights to have birth companions.

The findings are in line with other studies, which found that disrespectful care influences the utilization of health facilities for childbirth. The study found that some of the women indicated that they would not use the health facilities in future because of their birthing experiences and would opt for home delivery.

Finally, there is great need to conduct quantitative studies with bigger sample sizes to investigate the magnitude of disrespectful care in primary health facilities to inform the development of interventions at provincial level.

### 5.10 Study limitations

In keeping with qualitative research design, the researcher used convenient sampling techniques to select post-natal mothers to participate in the study. Therefore, the sampling technique limits the ability to make broader generalisations to women in Tshwane. Nevertheless, the findings will serve as a basis for further studies and will inform the midwifery practice.

One other limitation of the study is that the researcher could recruit participants from only one facility because in the other community health centres there were not enough post-natal women to constitute a focus group discussion. However, the women who participated in the focus group discussions delivered in different facilities but opted to do their six week follow up in this facility.

### 5.11. Recommendations

Based on the findings of this study the researcher recommends the following to the district health service managers and facility managers in the sub-district:

An appropriate strategy should be developed to ensure compliance with legislation such as the SANC rules and regulations, scope of practice, and code of conduct for midwives. This
will ensure that midwives provide care by upholding the dignity and respect of women, including respect for human rights. One such strategy could be to conduct customer care, respectful care, and code of conduct workshops for nurses within the district and/or sub-district.

District managers need to conduct support visits and monitor compliance with regulations, and apply consequence management where compliance is found to be lacking. In addition, they must ensure that pain medication is available in all their facilities so that women in labour can be offered it if the need arises.

It is important that the Batho Pele principles and patient rights charter including the rights of women are incorporated in the job description of the midwives, and the right of access to information must be highlighted as an important principle that should be observed during the midwifery practice. Furthermore, the midwifery code of conduct and Batho Pele principles should form part of the orientation for new midwives in the district.

Both district and provincial health departments should revisit the provision of resources such as food, water, and linen as per the ideal clinic document. Availability of resources such as clothes, food and enough beds form part of the National Core Standards, and the office of health standard compliance must enforce compliance with quality standards by the Gauteng health department.

Exit interviews of women about their experiences of care during labour upon discharge should be incorporated into the quality assurance programme for facilities. This will allow the women a chance to voice their concerns and provide the health facilities with feedback on the care they received.
References


Appendices

Appendix 1: Focus group guide-English

My name is Refilwe Malatji. I am a student at Sefako Makgatho Health Sciences University. I am conducting a study with mothers at six weeks post-delivery; you have been selected because you are one of those mothers. You are invited to participate in a study that asks women about their experiences and types of care they received during labour and childbirth. The interview will take about an hour and will be audio-recorded if you agree so that we can get all the information you are sharing with us. You should know that participating in the interview is voluntarily and that the information you share with us will be kept confidential. You should also know that you could withdraw from participating in the interview at any time if you choose to with no consequences. I am prepared to answer any questions you might have regarding the interview.

1. What are your views about the care women receive during labour and childbirth in health facilities?
   
   **Probe**
   
   • What are your views about having a birth companion during labour?

2. Briefly explain how you were attended to when you came in labour for your childbirth?
   
   **Probe**
   
   • How were you addressed by the staff during labour?

3. What are some of the types of care you expected from the staff during labour and childbirth?
   
   **Probes**
   
   • What information were you given on admission regarding labour and childbirth?
   • What information was not provided regarding labour and childbirth?
   • How easy or difficult was it to talk to the staff about your birthing needs?
   • Were your expectation of care met?

4. What were your birthing experiences with regard to the care you received during labour and childbirth?
   
   **Probes**
   
   • What good things do you remember about your labour?
   • What things did you not like with regarding the treatment you received throughout your labour and childbirth?
   • What made you choose to give birth in this facility?
   • Would you choose to deliver in this facility again? Please explain.
5. What are the things that should be changed in caring for women during childbirth?

**Probes**
- What do you think are the rights of women during labour and childbirth?
- What kind of support and care should be provided to women during labour and childbirth?

**Socio-demographic information**

<table>
<thead>
<tr>
<th>What is your age?</th>
</tr>
</thead>
</table>
| What is your marital status? | Single  
|                             | Married  
| What is your employment status? | Employed  
|                             | Not employed  
| What is your level of education? | None  
|                             | Primary Level  
|                             | Secondary  
|                             | Completed grade 12  
|                             | Tertiary  
| How many pregnancies have you had? |  
| How many children do you have? |  

Appendix 2: Focus group guide-Setswana

Leina la me ke Refilwe Malatji, ke moithuti kwa Sefako Makgatho Unibesithi ya Saense ya tsa maphelo. Ke dira dipatlisiso go bomme ba belegeng mo dibekeng dile thataro tse di fetileng, mme wena o mongwe wa ba ba thlophiweng. O lalediwa go ithaopa go nna karolo dipatlisisong tse go batlisisa maitemogelo le thlokomelo ee o e boneng ka nako ya ga o ne o le mo dithlabing le go belega. Fa o dumela, puisano e tlile go nna nako ya ura, mme e gatisiwa ga o dumela, gore re kgone go bona tshedimosetso eotla re e neelang.

Itse gore, go tsaa karolo mo puisanong ke ga boithaopo mme tshedimosetso eo oneelanang ka yona e tla boe filthilegile. Gape itse fa o na le toka yago ka ikgogela morago nako nngwe le nngwe ya puisano ya dipatlisiso kwa ntle ga ditlamorago dipe.

Ke ikemiseditse go araba dipotso dingwe le dinwe tseo ka tswang o nale tsona ka puisano.

1. Maitemogelo a gago ka tshwaro le thlokomelo ka nako ya dithlabi le pelegi a jang kwa maokelong?
   
   Probe/ batlisisa ka go tsenelela
   • Maikutlo a gago kago nna le mothusika nako ya pelegi a jang?

2. Thlalosa ka boripana thlokomelo e oe neilweng ka nako ya ditlhabi tsa go belega.
   
   Probe/ batlisisa ka go tsenelela
   • Badiri ba neba go buisa ka mokgwa o o ntseng jang?

3. Ke thlokomelo enngwe gape eo neng o e solofetse gotswa gobadiri ka nako ya dithlabi le pelegi?
   
   Probes/ batlisisa ka go tsenelela
   • Ke tshedimosetso efeng e o e neilweng ka nako ya ditlhabi le pelegi.
   • Ke tshedimosetso e feng eo esa neiwang ka ditlhabi le pelegi?
   • A go ne go le bonolo kgotsa boima go bua le badiri ka dikeletso tsa pelegi?
   • Ditsholofelo tsa gago tsa thlokomelo di diragetse?

4. Maitemogelo a gago ka pelegi e nnile eng kanako ya dithlabi le pelegi?
   
   Probes/ batlisisa ka go tsenelela
   • gopola eng se sesiameng ka nako dithlabi?
   • Ke eng se o sa se itumellang ka tlhokomelo ka nako ya dithlabi?
   • Ke eng se sedirieng gore o tlhophe kokelo e, go tla go belega?
   • Oka belegela mokokelong e gape? Re thlalosetse ka go tsenella
5. Ke eng se se ka fetolwang ka thlokomelo ya basadi ka nako ya pelegi?

Probes/batlisisa ka go tsenelela

- nagana gore ditokelo tsa bomme ka nako ya ditlhabi le pelegi ke dife?
- Tshegetso le thlokomelo e eka newang bomme ka nako ya ditlhabi le pelegi e tshwanetse go nna jang?
Appendix 3: Informed consent-English version

SMU: ENGLISH CONSENT FORM

Statement concerning participation in a research project

Name of study:
I have read the information/heard the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.
I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name and hospital number are not revealed.
I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition and neither will it influence the care that I receive from my regular doctor.
I know that this study has been approved by the Research Ethics Committee of the Sefako Makgatho Health Sciences University. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study.

____________________  __________________
Date                   Place

Statement by the Researcher

I provided verbal and/or written* information regarding this study
I agree to answer any future questions concerning the study as best as I am able.
I will adhere to the approved protocol.

_____________________________  ___________________  __________
Appendix 4: Informed consent-Setswana version

SMU- SETSWANA CONSENT FORM

Seteitemente se sekaga go tsayakarolomo tekopatlisisong.
Leina la Patlisiso:

Ke buisitse tshedimosetso mo ke utlwile maitlhamo le ma ikemisetso a patlisiso e e tshitshintsweng mme ke filwe tšhonoya go botsa dipotso le go fiwa nako e elekaneng yago a kanya gape kantlha e. Maitlhomo le maikemisetso a patlisiso e a tlhaloganyega sentle. Ga kea pateledi wa ka opekatselaape go tsaya karolo. Ketlhaloganya gore go tsaya karolo mo patlisiso ke boithaopo le gore nkaigkogela moragomo go yona kanako nngwe le nngwe kwantlega go neela mabaka. Se ga se kitla se nna le seabe sepe mo kalafongya me ya go le gale ya bolwetsi jo ke nang le jona e bile ga se kitla se nna le tlhotlheletso epe motihokomelong e ke e amogelang mo ngakengya me ya go le gale. Kea itse gore patlisiso e re botswe kaPatlisiso le Molaowa Maitsholotsa Sefako Makgatho Health Sciences University (SMUREC). Ke itse ka botlalo gore dipholo tsa patlisiso di tla dirisetswa mabaka asa entifiki e bide di kanna tsa phasaladiwa. Ke dumelana le seno, fafela go netefadiwa gore se e tlanna khupamarama.

Fano ke neela tumeleloya go tsaya karolo mopatlisiso e.

__________________  ______________   ______________
Leina la moithaopi    Tshaeno.     Letlha
________________________________________________________________________

SeteitementeakaMmatlisisi
Ke tlametse tshedimosetso ka molomo le/kgotsa e kwadilweng malebana le patlisiso e. Ke dumela go araba dipotso dingwe le dingwe monakong e tlang tse di amanang le patlisiso ka mo onkakgonang kateng. Ke tlatshegetsa porotokolo e re botsweng.

__________________  ______________   ______________
Appendix 5: Permission Tshwane Research Committee

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

MEETING: 05/2017
PROJECT NUMBER: 72/2017
NHRD REFERENCE NUMBER: GP_201708_005

TOPIC: Exploring the experiences of care for women during labour and childbirth in health care facilities in Tshwane district, Gauteng province

Name of the Researcher: Refillwe Malatji
Name of the Supervisor: Professor S. Madiba
Facility: PHC Facilities – sub-district 1
Name of the Department: Sefako Makgatho Health Science University

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

Dr. Lufuno Razewedani
Chairperson: Tshwane Research Committee
Date: 22/09/2017

Ms. M. Lerutla
Acting Chief Director: Tshwane District Health
Date: 28/9/2017
Appendix 7: Ethical clearance certificate

Sefako Makgatho Health Sciences University
Research & Postgraduate Studies Directorate
Sefako Makgatho University Research Ethics Committee
(SMUREC)

Molotlegi Street, Ga-Rankuwa 0208
Tel: (012) 521 5617/3698 | fax: (012) 521 3749
Email: lorato.phiri@smu.ac.za
P.O. Box 163 Medunsa 0204

APPROVAL NOTICE - NEW APPLICATION

01 June 2017

Ms P Malati
Department of Public Health
P.O Box 215
Medunsa, 0204

MEETING: 05/2017

SMUREC Ethics Reference Number: SMUREC/H/104/2017: PG

The New Application received on 18 May 2017, was reviewed by members of Sefako Makgatho University Research Ethics Committee 01 June 2017 and was approved on 01 June 2017.

Title: Exploring the experiences of care for women during labour and childbirth in health care facilities in Tshwane district, Gauteng Province

Researcher: Ms E Malati
Supervisor: Prof S Madiba
Department: Public Health
School: Health Care Sciences
Degree: MPH

Please note the following information about your approved research protocol:

Approval Period: 01 June 2017 – 01 June 2018

Please remember to use your protocol number (SMUREC/H/104/2017: PG) on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modification, or monitor the conduct of your research and the consent process.

After Ethical Review: Please note a template of the progress report is obtainable in the Research Office and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit. Translation of the consent document in the language applicable to the study participants should be submitted.

International Organisation (ORC00009381), Institutional Review Board (IRB000010388) Expiry date: 09 December 2018, Federal Wide Assurance (FWA000023943) Expiry date: 31 August 2017 and NHREC No: REC 210408-003

Sincerely,

PROF C BAKER
DEPUTY CHAIRPERSON SMUREC

Date: 01.06.2017