



Exploring experiences of quality intrapartum care in a public hospital in Gauteng

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Dissertation submitted in fulfilment of the requirements for the degree
MAGISTER CURATIONIS
in
NURSING SCIENCE
at the North-West University (Potchefstroom Campus)

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November 2013

DECLARATION

I, Pauline Magugudi Mathebula, student number 22018050, declare that:

- The dissertation with the title: **Exploring experiences of quality intrapartum care in a public hospital in Gauteng** is my own work and that all the sources quoted have been indicated in the text and acknowledged by means of complete references;
- The study has been approved by the Ethics Committee of the North-West University (Potchefstroom Campus) in Potchefstroom and the Gauteng Department of Health
- The ethical standards of the North-West University (Potchefstroom Campus) have been considered during the conduct of the study.

PM Mathebula

November 2013

ACKNOWLEDGEMENTS

***“I give you thanks, O Lord, with my whole heart;
before the gods I sing your praise”***

-Psalm 138:1

As I reflect on my journey, it was indeed a collaborative effort and I would have not been to accomplish this research study on my own. ***My sincere gratitude and appreciation as I wish to thank the following:***

- Dr Antoinette du Preez, my research supervisor, for her continued guidance, encouragement and commitment for completion of this study. Her coaching and selfless mentoring will forever be valued.
- The Gauteng Department of Health for giving me the permission and opportunity to conduct the study, and secondly for the financial assistance in the form of a bursary.
- Special thanks to the CEO of the selected hospital Dr.G. Motlatla and the executive management for granting me permission to conduct the study in their hospital.
- Sincere gratitude to the mothers who willingly participated in the study, for their openness and cooperation without them and their information the study would not have been a success.
- Mrs. Louise Vos for her friendly assistance and support in the library in finding the relevant articles.
- Dr Belinda Scrooby, for her assistance in co-coding during data analysis.
- To my beloved son Lesego for the support and assistance with computer skills, including my nephews Tebogo and Kgomotso for being there when I needed their help. My aunts for words of encouragement and the motherly love they gave me, my sister and brother for the support, its greatly appreciated. Finally, I thank all my

family and friends and colleagues for their support, prayers and encouragement they gave me through this journey.

- Prof. AL Combrink for the language and technical editing of my dissertation.
- Prof. Casper Lessing for checking the bibliographical references.
- Susan van Biljon for assisting with the technical layout of my dissertation.
- I would like to **dedicate** this study to my late parents Phineas and Elizabeth Mathebula for their upbringing, encouragement and support. They taught me to believe in myself.

ABSTRACT

All mothers and newborns deserve competent care and continuous support during the intrapartum period (Tinker *et al.*, 2006:269). According to the *Saving Mothers: Fifth Report on Confidential Enquiries into Maternal Deaths in South Africa, 2008-2010* (SA, 2011:4), the maternal mortality rate (MMR) is 176.22/100 000 live births (SA, 2011:4). The majority of maternal deaths are preventable and have many common preventable factors which are mostly related to the knowledge and skills of the healthcare providers and the challenges within the health care system (SA, 2011:5).

The research was conducted in an attempt to make a meaningful contribution to the body of knowledge, specifically knowledge related to the experiences of women regarding the quality intrapartum care in a public hospital in Gauteng Province, and to make recommendations to enhance the quality of intrapartum care.

A qualitative study design was used and data collected with the use of individual in-depth interviews. Purposive sampling was used to select participants who represent the target population. The sample used for the study included all women who had given birth within 24 hours before the interviews by normal vaginal delivery. A pilot study was conducted and the interview schedule was finalised. Sixteen individual in-depth interviews were done until data saturation had been achieved. Trustworthiness was ensured according to the principles of credibility, transferability, dependability and confirmability. A digital voice recorder was used to capture data and the data were transcribed verbatim. Field notes were written down for each interview.

Data analysis was done by means of content analysis by the researcher and an independent co-coder. Themes and sub-themes were identified. The findings indicated that most of the women's experiences were positive regarding the quality of intrapartum care while a lesser percentage had had negative experiences. Identified areas of concern are staff attitudes, communication and staff shortages.

Conclusions drawn are that women's experiences of quality of intrapartum care were that it is not of the highest standard. There is a need for provision of continuous emotional support during labour, improvement of staff attitudes and promotion of rooming-in, and a need not to be separated from their babies for long periods of time

The research concluded with the researcher's recommendations for policy, nursing practice, nursing research and nursing education, for the enhancement and adherence of midwives to recommendations in improving the quality of intrapartum care in public hospitals.

Keywords: quality of care, intrapartum care, experiences

OPSOMMING

Alle moeders en pasgebore babas verdien goeie sorg en deurlopende ondersteuning tydens die intrapartum-tydperk (Tinker *et al.*, 2006:269). Volgens die *Saving Mothers: Fifth Report on Confidential Enquiries into Maternal Deaths in South Africa, 2008-2010* (SA, 2011:4), is die sterftesyfer onder moeders (Maternal Mortality Rate, MMR) 176.22/100 000 lewende geboortes (SA, 2011:4). Die meeste sterftes onder moeders is voorkombaar en daar is heelwat voorkombare faktore gemeen wat meesal gekoppel word aan die kennis en vaardighede van die gesondheidsorgverskaffers en die uitdagings wat bestaan in die gesondheidsorgstelsel in Suid-Afrika (SA, 2011:5).

Die navorsing is gedoen om 'n betekenisvolle bydrae te kan maak tot die kennis (spesifiek kennis te doen met die ondervindinge van vroue van die kwaliteit van intrapartum-sorg in 'n openbare hospitaal in Gauteng Provinsie), en om aanbevelings te maak om die kwaliteit van intrapartum-sorg te verbeter.

'n Kwalitatiewe studie-ontwerp is gebruik en data versamel deur middel van diepte-onderhoude. Doelgerigte steekproeftrekking is gebruik om deelnemers uit te soek wat die teiken populasie verteenwoordig. Die steekproef wat in hierdie studie gebruik is sluit in al die vroue wat geboorte geskenk het in die 24 uur voorafgaande aan die onderhoude, almal normale vaginale geboortes. 'n Loodsstudie is gedoen en die onderhoud-skedule is gefinaliseer. Sestien individuele diepte-onderhoude is gedoen totdat data-versadiging bereik is. Vertrouenswaardigheid is verseker volgende die beginsels van geloofwaardigheid, betroubaarheid en bevestigbaarheid. 'n Digitale stemopnemer is gebruik om data vas te lê en die data is verbatim neergeskryf. Onderhoudsnotas is geskryf vir elke onderhoud.

Data-ontleding is gedoen deur middel van inhoudsanalise deur die navorser en 'n onafhanklike kodeerder. Temas en subtemas is geïdentifiseer. Die bevindinge dui daarop dat meeste van die vroue se ervaring ten opsigte van die kwaliteit van intrapartum-sorg positief was, terwyl 'n kleiner persentasie negatiewe ervaringe gehad het. Sekere areas wat kommer wek is personeelhoudings, kommunikasie en personeeltekorte.

Gevolgtrekkings waartoe gekom kan word, is dat vroue se ervaring van die kwaliteit van intrapartum-sorg nie van die hoogste standaard is nie. Daar is 'n behoefte aan voorsiening van deurlopende emosionele ondersteuning tydens die kraamproses, verbetering van personeelhoudings en die voorsiening van gedeelde slaapfasiliteite, sodat moeders en babas nie so lank van mekaar af weggehou word nie.

Die studie het afgesluit met die navorser se aanbevelings vir beleid, verpleegpraktyk, verpleegnavorsing en verpleegopleiding gemik op die verbetering van en deelname deur vroedvroue aan die aanbevelings vir die verbetering van die kwaliteit van intrapartum-sorg in openbare hospitale.

Sleutelwoorde: kwaliteitsorg, intrapartum-sorg, ondervindinge

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
DENOSA	Democratic Nurses Organisation of South Africa
DoH	Department of Health
EAS	External Anal Sphincter
HCAI	Health-Care Associated Infections
HIV	Human Immunodeficiency Virus
IAS	Internal Anal Sphincter
ICM	International Council of Midwives
ICN	International Council of Nurses
ICU	Intensive Care Unit
GDP	Gross Development Product
LSB	Labour Support Behaviours
MDGs	Millennium Development Goals
MRC	Research Council
MMR	Maternal Mortality Rate
MOU	Midwife Obstetric Unit
MTCT	Mother-to-Child Transmission
NPRI	Non-Pregnancy Related Infections
NWU	North-West University
PCERA	Parent Child Early Relational Assessment
SA	South Africa
SANC	South African Nursing Council
SSC	Skin -to -skin contact
WHO	World Health Organization

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CHAPTER 1

OVERVIEW OF THE RESEARCH

1.1 INTRODUCTION

A woman's right to health includes her right to have a healthy baby. Pregnancy and childbirth should not be a source of fear or apprehension for a woman, but rather a celebration of life (Tinker *et al.*, 2006:269). It is estimated that between 359,000 and half a million women die during pregnancy – these are the women who die of pregnancy related causes worldwide and 99% of these deaths occur in the developing world (Hogan *et al.*, 2010:1619). Over 80% of these deaths are caused by haemorrhage and hypertensive disorders that could be prevented or avoided through actions that are proven to be effective and affordable (Khan *et al.*, 2006:1074). In addition an estimated two (2) million intrapartum related stillbirths and neonatal deaths occur each year (Lawn *et al.*, 2009:5).

In 2000 the Millennium Development Goals (MDGs) were accepted and targets were adopted for the Millennium Declaration, which was signed by 189 countries (WHO, 2005b). MDG 4 commits the international community to reducing mortality in children under (5) five years by two-thirds by 2015, with a target of 32 per 100 live births (Lawn *et al.*, 2005:891). MDG 5 aims to improve maternal health, and this goal was translated into two targets: to reduce the maternal mortality rate by 75%, and achieve universal access to reproductive health by 2015 (WHO, 2005a). Ensuring access to and availability of skilled birth attendance and essential obstetric care that is effective and of good quality are key strategies to help reduce maternal and newborn mortality and morbidity (WHO, 2005a). Although the intrapartum care a pregnant woman receives also has a direct influence on the outcome of the newborn baby, this study focuses on the MDG5 maternal health.

This chapter provides an overview of the study and starts with the background and rationale followed by the problem statement which explains the need for this study. The research aim and objectives flow from the problem statement. This is followed by the meta-theoretical, theoretical and methodological assumptions of the researcher. An outline of the research design and method as well as the context, rigour, ethical considerations and research report layout concludes chapter one.

1.2 BACKGROUND AND RATIONALE

All mothers and newborns deserve competent care during pregnancy and childbirth, as well as immediately afterwards when the greatest danger to the mother and child exists (Tinker *et al.*, 2006:269). According to the *Saving Mothers: Fifth Report on Confidential Enquiries into Maternal Deaths in South Africa, 2008-2010* (SA, 2011:4). the MMR is 176.22/100 000 live births which has increased from 151.77/100 000 live births reported in the 2005-2007 triennium, and the MMR has increased at all level of care (SA, 2011:4). The 2008-2010 *Saving Mothers: Fifth Report on Confidential Enquiries into Maternal Deaths in South Africa* clearly identified three conditions that contribute to the majority of preventable maternal deaths, namely non-pregnancy related infections (NPRI), obstetric haemorrhage and complications of hypertension in pregnancy. These conditions comprise 66.7% of the possibly and probable preventable maternal deaths, and have many common preventable factors which are mostly related to the knowledge and skills of the healthcare providers and the challenges within the health care system (SA, 2011:5).

According to Dubbelman (2010), South Africa is failing to reach the MDGs, and with only two years to go before the deadline these targets seem unlikely to be reached by both South Africa and the rest of the African continent. South Africa needs to reduce its MMR to 30 by 2015 clearly an unattainable goal at present. Therefore health professionals involved in maternity care are obliged to ensure that the quality improvement initiatives such as *Guidelines for Maternity Care in South Africa* (SA, 2007a) should be adhered to in order to improve the quality of intrapartum care and reduce maternal mortality.

The quality of intrapartum care depends on having adequate number of midwives available as well as their competencies. Fullerton *et al.* (2005:3) state that the knowledge and practice of birth attendants vary widely. Even though facilities and staff can be available, the services offered often fall short of acceptable standards. Substandard obstetric care is now known to be a significant contributor to maternal mortality and morbidity in poor countries (SA, 2011). In South Africa evidence is available in the *Saving Mothers: Report on Confidential Enquiries into Maternal Deaths in South Africa* for the 2008-2010 triennium, where the most common administrative avoidable factors was lack of appropriately trained doctors and midwives (6.2%). The most common health care provider avoidable factors were not following standard protocols and poor problem recognition. There was significant sub-optimal care in 764 (38.8%) cases where 592 (30.1%) possibly affected the outcome and 172 (8.7%) probably affected the outcome.

This represents the highest number of possible and probable avoidable maternal deaths in the triennium (SA, 2011:32).

Even though there are quality improvement initiatives like the *Guidelines for Maternity care in South Africa* (SA, 2007a) and *Saving Mothers: Essential Steps in the Management of Common Conditions Associated with Maternal Mortality*” and the *Saving Mothers: Report on Confidential Enquiries into Maternal Deaths in South Africa* (SA, 2007; SA, 2011) with key recommendations developed from the latest international evidence-based practice body of knowledge, and while in many cases training has been provided, the reality still seems to be that for a range of reasons these guidelines are not being implemented in many hospitals. Therefore these quality improvement initiatives that target reducing maternal mortality have not been met with a significant degree of success.

Access to the health care system is required to obtain care that maintains or improves health, but simple access is not enough; the system’s capacities must be applied skilfully (Graham, 2002:704). The World Bank (2013) confirms that maternal mortality and morbidity cannot be reduced without skilled midwives. Health-care workers with midwifery skills are the key to reducing the maternal mortality rate.

This raises the question of what is quality of care? Amongst the earliest and most prominent definition and processes in provision of quality care is the one by Donabedian (1988:1745), which indicates that information about quality of care can be drawn from three categories: structure, process and outcomes:

- *Structure* includes all factors that affect the context in which care is delivered. This includes the physical facility, equipment, human resources, as well as organizational characteristics such as staff training and payment methods. These factors control how providers and patients in a health-care system act and are measures of the average level of care within a facility or system.
- *Process* is the sum of all actions that make up healthcare. These commonly include diagnosis, treatment, preventive care and patient education but may be expanded to include actions taken by the patients or their families. Processes can be further classified as technical processes, how care is delivered, or interpersonal processes which all encompass the manner in which care is delivered.

- *Outcome* contains all the effects of healthcare on patients or populations, including changes to health status, behaviour or knowledge as well as patient satisfaction and health-related qualities of life, biologic changes in disease, complications of treatments, morbidity and mortality (Donabedian, 1988:1745).

Thus *quality* means optimizing material inputs and practitioner skills to produce health. The Institute of Medicine defines quality of care as “quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Institute of Medicine, 1990:4). Quality improvement concentrates on the concept of customer/ patient and defines quality in terms of meeting and exceeding customers’/patients’ needs and expectations. Organisational needs and objectives are met if customers/patients expectations are met. These customers (patients) can be either internal or external to the organisation. Internal customers/patients are the employees who render the service, while external customers/patients are not employed by the health service, for example the patients, referral physician, family and the community (De Geyndt, 1995:22).

The definition by Hulton *et al.* (2000) states that “quality of care is the degree to which maternal health services for individuals and populations increase the likelihood of timely and appropriate treatment for the purpose of achieving desired outcomes that are both consistent with current professional knowledge and uphold basic reproductive rights (Hulton *et al.*, 2000:9).

Historically, quality of care has been defined in clinical terms focusing on biomedical outcomes. Over time, definitions of quality of health care have become more inclusive and now address user and provider satisfaction, social, emotional, medical and financial outcomes as well as aspects of equity and performance according to standards and guidelines (Pittroff *et al.*, 2002:277). High quality of care in maternity services involves providing a minimum level/ standard of care to all pregnant women and their babies and a high level of care to those who need it. This should be done whilst striving for the best possible health outcome, and while providing care that satisfies women and their families and their care providers. Such care should maintain sound managerial and financial performance and develop existing services in order to raise the standard of care provided to all women (Pittrof *et al.*, 2002:278).

In First World countries researchers acknowledge that it is difficult to measure the quality of care rendered, but have established a framework to guide health care services in reviewing the quality of their care so as to improve their quality of care through critical evaluation of their activities (Hulton *et al.*, 2000:1). In the *Framework for the evaluation of quality of care in Maternity services*, Hulton *et al.* (2000:1) state that the institutions that fall short in rendering quality care can then implement this framework to bring the practice up to an acceptable standard. A strategy to improve the quality of (intrapartum) care is quality improvement and quality assurance.

The experience of labour and birth referred to is complex, multidimensional and subjective, relating to both the outcome (i.e. safe birth of the baby), and the processes (i.e. the physical and cognitive processes) of labour and birth experienced by individual women (Larkin *et al.*, 2009:49). In their study Tucker and Adams (2001:283) examined the relationship between two measures, namely the patients' satisfaction with their care, and their assessment of the quality of that care. The findings indicated that patients appear not to distinguish between satisfaction and quality when evaluating their care of experience. The feelings induced by the provider performance as well as issues associated with accessing care explain the two major issues that the patients report. The provider performance aspect of the experience of care includes patients' assessments of outcomes of the care experienced, reassurance and attention, technical skills and the ability to diagnose problems, explanation of procedures and tests, and outcomes. The access factor relates to patients' concerns regarding the expedience, convenience and availability of care (Tucker & Adams, 2001:283).

Although labour is a universal physiological process, the more tenuous interrelated psychological and emotional elements that women experience are often ignored in favour of more tangible components such as quality of care, interventions, mortality and morbidity measures (Baker *et al.*, 2005:315). In maternity care the client-centred approach has led to increased activity to measure women's satisfaction, preferences and experiences in the Netherlands (Borquez & Wiegers, 2006:346; Janssen & Wiegers, 2006:56) as well as in the United States as is shown by reports such as *Listening to Mothers I and II* (Declercq *et al.*, 2002; 2006), *What mothers say: The Canadian Maternity Experiences Survey* (Public Health Agency of Canada, 2009). These reports not only show how women evaluate the care they received, but they also underscore the complexity of maternity care and the different routes, or "care paths" women can take through the health care system in the different countries received (Wiegers, 2009:5). The

above-mentioned reports aim to understand and improve the quality of maternity services, by not only information on outcome indicators such as mortality, morbidity and satisfaction, but also information about women's views and experiences with structure and process indicators of care (Wiegers, 2009:5).

Client-perceived quality care is a subjective, dynamic perception of the extent to which expected health care is received. The advantages of perceived quality measurement have been pointed out by several authors, even though most studies have been conducted in developed countries, and only a few reports available for developing countries (Van Doungh *et al.*, 2004:447). Moreover, the client-provider interface, patient satisfaction and aspects of user's experience of care are particularly important in maternity care (D'Ambrusso *et al.*, 2009:530).

While the quality of the provision of care in facilities is fundamental to ensuring effective care, women's actual experience of care is a significant, but often neglected aspect of quality of care that contributes to maternity outcomes (Hulton *et al.*, 2007:2084). If women's cumulative care experienced in a facility is such that it deters some from returning for a subsequent delivery, or leads to rumours to the same effect in the wider community, the actual quality of the provision of care for these women is academic (Hulton *et al.*, 2007:2084).

1.3 PROBLEM STATEMENT

The World Bank (2013) states that an estimated 287,000 maternal deaths occurred worldwide in 2010, all but 1,700 of them in developing countries. More than half of maternal deaths occur in Sub-Saharan Africa and a quarter in South Asia. This is a serious problem, largely because it points to the clear lack of progress towards achieving the MDG5, which aims to improve maternal health globally by reducing the maternal mortality rate by 75% in 2015. It is important that if this goal is to become a reality, the best health-care interventions and strategies should be identified on the basis of sound evidence and should be put into practice (Cross *et al.*, 2010:147).

It is important to acknowledge that availability of effective appropriate intrapartum care is one of the most important means to reduce maternal mortality and that the poor quality of care received in a normal uncomplicated delivery may impact negatively on the maternal and neonatal outcome if the timing of use of is delayed as a result of perceived sub-

standard care (Hulton *et al.*, 2000:5). In South Africa the *Saving Mothers Reports* over the past 10 years have shown evidence of avoidable factors, missed opportunities and sub-standard care that have contributed to the rise in the MMR (SA, 2002b; SA, 2006b; SA, 2009a, SA, 2009b, SA, 2011). Since the first *Saving Mothers* report of 1998 the 10 key recommendations have remained essentially the same. During the last decade the implementation of the recommendations has been uneven and incomplete and the MMR seems to be increasing (SA, 2011:43).

South Africa has nine provinces, one of which is Gauteng. While Gauteng is the smallest province in South Africa in geographical terms, it is the most densely populated. The 2011 census data have shown that the population of South Africa has increased by 11.2 million from the census 1996. The province with the largest population is Gauteng (12 272 263), which has overtaken KwaZulu-Natal that has a population of 10 267 300 (Stats SA, 2011:23). In most provinces there was an increase in MMR as well as in most conditions including Gauteng in the 2008-2010 report (SA, 2011:7). There has also been an increase in the institutional MMR at all levels of care (SA, 2011:18).

Women using maternity services of the South African public sector are very dissatisfied with the availability of the services and the treatment they receive during intrapartum care. According to a study performed by the MRC Maternal and Infant Health Care Strategies Research Unit, patients were least satisfied with the following elements of care:

- Care in midwife obstetric units (MOU) at primary level hospitals without caesarean section facilities.
- Midwives not empowered to refer patients to a higher level of care.
- Doctors in the hospital, but are not dedicated to maternity care. Practices at most of the MOUs in the country are appalling, with little or no adherence to standards.
- Patients are being abused emotionally, verbally and physically by medical personnel who are supposed to care for them during labour.
- Harmful practices have become routine practice in most of the public health institutions (Farell & Pattinson, 2005:11).

Safe intrapartum practices are important determinants in the reduction of maternal and perinatal deaths, considering the increasing MMR prevalent in the South African context. From this background it is necessary to contribute to the implementation of quality intrapartum care in public hospitals and therefore the following question needs exploration:

What are the experiences of women in a specific public hospital in Gauteng regarding quality intrapartum care?

1.4 AIM AND OBJECTIVES

1.4.1 The aim of the study is to explore women's experiences of the quality of intrapartum care they received in a public hospital in Gauteng.

1.4.2 Objectives of the study are:

- To explore and describe women's experiences of the quality of intrapartum care they received during the intrapartum period; and
- To make recommendations to enhance the quality of intrapartum care.

1.5 RESEARCHER'S ASSUMPTIONS

According to De Vos *et al.* (2005:40), all scientific research is conducted within a specific paradigm, or way of viewing one's research material. Therefore in order to keep communication with his reading public clear and unambiguous the researcher must decide within what paradigm he or she is working. The paradigmatic perspective of this study is based on meta-theoretical, theoretical and methodological assumptions that are discussed in the section that follows.

1.5.1 Meta-theoretical assumptions

The meta-theoretical assumptions determine the research paradigm used in this study, the researcher's Christian world view of the self and others (participants in this study) that are rooted in God and the Old and New Testament of the Bible as the truth. Though these statements guide the study, they are not necessarily empirically testable. Meta-theoretical

assumptions comprise man, environment, health and nursing illness as described in the paragraphs that follow.

1.5.1.1 *Man*

God created man in His own image (Genesis 1:27) and man is distinct from all other beings (Bible). Equally, the researcher's view of man is related to that of God. In this research, man refers to pregnant women. Man cannot live alone, but lives in constant interaction with other human beings in a community with the direct command to rule the world, together with the responsibility to be accountable for all actions. In this study, the pregnant woman as a human being has a free will and the ability to make informed choices about the safe birth of her baby. She looks to the midwife during labour to guide her through the process with her academic knowledge and clinical competency which involving supporting her and treating her with respect and dignity and rendering quality intrapartum care.

1.5.1.2 *Environment*

The researcher believes that the environment consists of an internal and external environment. For this study, the internal environment of the pregnant woman includes her thoughts, expectations and beliefs of her view of the quality of intrapartum care she receives in the labour ward. External environments include the social and physical structure of the labour ward, which can influence her view the quality of intrapartum care that she receives. The physical structure includes infrastructure (beds, linen, food and toilets), while the social includes the skilled and competent midwives, attending to the pregnant woman during the intrapartum period, giving her emotional support and adequate information to be able to participate in decision-making and her family. This will lead to a positive practice environment, and have a positive impact on the health and illness of the mother and her baby.

1.5.1.3 *Health*

The World Health Organisation (WHO) defines health as a state of total "physical, mental, and social wellbeing and not merely the absence of disease or infirmity" (Saracci, 1997:314). The health of a pregnant woman can be viewed as being on a continuum of health/ illness that ranges from minimum to maximum health. The different dimensions of health (physical, mental social and spiritual) are not necessarily on the same level. If one

of the dimensions is deficient, the other components are affected. The pregnant woman in labour can experience good health in one dimension and less health in another. Saracci (1997:314) stresses that health as defined by the WHO links it to the real world of health and disease, is measurable by means of appropriate indicators such as mortality, morbidity and quality of life. In this study, the focus is to improve the quality of intrapartum care the pregnant woman receives. The midwife can provide high quality intrapartum care to the pregnant woman that can reduce maternal and perinatal mortality while ensuring that the pregnant woman and newborn baby experience optimal care.

1.5.1.4 Nursing/ Midwifery care

Nursing is the professional conduct of the registered nurse and midwife to care for the patient with academic proficiency and clinical competency to achieve optimal health, through interaction and functional activities aimed at the maintenance, promotion and rehabilitation of health (adapted from Du Preez, 2011:10). The midwife plays an integral role in rendering quality intrapartum care to the pregnant woman. She needs to be well prepared with the optimal knowledge and skills to guide her in performing the intrapartum practices.

1.5.2 Theoretical Assumptions

Kerlinger, in De Vos *et al.* (2005:36) defines theory as a set of interrelated constructs (concepts), definitions, and propositions that present a systematic view of phenomena by specifying relations between variables, with the purpose of explaining and predicting the phenomena. For the purposes of this study, a framework is developed for the evaluation of quality of care in maternity services, with ten elements of care by Hulton *et al.* (2000:10) as baseline. The framework allows for quality of care to be separated into two constituent parts: the quality of the provision of care within the institution and the quality of the care as experienced by users (Hulton *et al.*, 2000:9). This study will focus on the quality of care as experienced by the users. The framework is illustrated below in figure1.1.

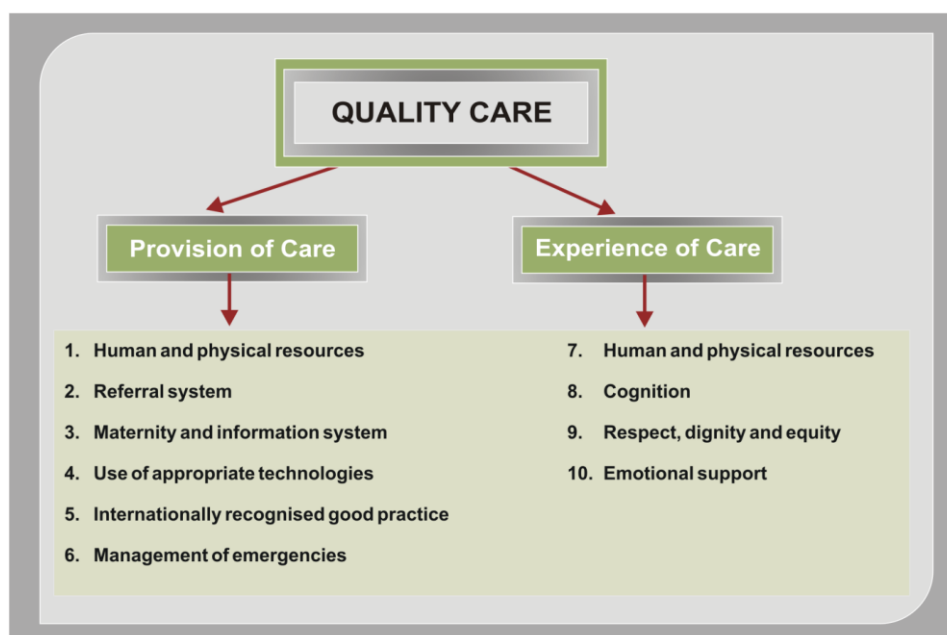


Figure1.1: Framework for assessing quality of institutional delivery services: ten elements of care (Hulton *et al.*, 2000:10)

1.5.2.1 Definitions of concepts

Because concepts tend to have different meanings and different interpretations, key concepts used in this study that are derived from literature are clarified and their meaning provided within the context of this study. The following concepts are therefore defined below (quality of care, quality of intrapartum care, intrapartum period, midwife and mother).

- **Quality of care**

Quality of care in health care can be described as “striving for and reaching excellent standards of care” (Feld, 2007; Wang, 2010). Quality of care involves not only evaluating the outcome, but reducing the risk. The use of appropriate tests and treatments continually improve personal health care in fields of medicine (Feld, 2007; Wang, 2010). Continuous improvement of patient care is the driving force behind standards and quality health care (Wang, 2010).

- **Quality Intrapartum Care**

The intrapartum care that a midwife provides is determined by the midwife's perception of the pregnant woman's physical condition (anatomy and physiology). This is combined with personal experience and the teaching by competent lecturers and mentors who provide a knowledge base to guide personal practice (Fullerton *et al.*, 2005:7). The intrapartum context addresses social, environmental, ethical and cultural issues that influence the intrapartum care of the pregnant woman (Fullerton *et al.*, 2005:7). Du Preez (2011) developed a new definition of quality intrapartum care which states that "quality intrapartum care must be based on the best possible evidence, given to provide an uplifting birth experience for both the mother and midwife in a safe and positive practice environment, in which the patient is treated with dignity and worth in the process of delivering a healthy neonate and reducing maternal mortality (Du Preez, 2011:17).

- **Intrapartum period**

The intrapartum period starts with the onset of labour and continues until the end of birth. This period consists of four stages: the first stage is labour which is divided into three phases namely, the latent phase (0-3cm cervical dilatation), the active phase (4-10cm cervical dilatation) and the transitional phase (8-10cm cervical dilatation). The second stage of labour lasts from full cervical dilatation until the birth of the baby. The third stage of labour lasts from the birth of the baby until the delivery of the placenta. The beginning of puerperium is called the fourth stage of labour. This is usually the first hour after delivery of the placenta and refers to the period in which homeostasis is re-established (Fraser *et al.*, 2010:649).

- **Midwife**

The International Confederation of Midwives' (ICM) definition of a midwife is as follows: "A midwife is a person who, have been regularly admitted to a midwifery educational programme, duly recognised in the country where it is located has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and who demonstrates competency in the practice of midwifery" (ICM, 2005). A midwife may practise in any setting including the home, community, hospitals, clinics or health units (ICM, 2005; Fraser *et al.*, 2010:5).

In South Africa and in the context of this research, a midwife is a clinically skilled and academically trained person who has achieved the academic requirements of an institution of education. After successful completion of the academic requirements, the midwife is registered with the South African Nursing Council (SANC, 1990) under regulation R2488, which outlines the scope for practice for South African midwives.

- **Mother**

For the purpose of this study mother, is a woman who had delivered a baby, and had had a normal vaginal birth within the last 24 hours in a public hospital.

1.5.3 Methodological assumptions

The researcher's methodological assumptions are grounded on the research model of Botes (1992:37-42) as adapted from Mouton and Marais (1994:22). The model can increase the validity and reliability of research since it is specifically developed for Nursing Science (Botes, 1992:36). The model advocates research that leads to new knowledge, which serves to improve the practice. The model consists of three levels. The first level represents nursing practices, where problems are identified that need solutions or improvements. Research is done to find solutions. Research activities are focused on the promotion, maintenance and restoration of health. In this study the first level represents the poor quality intrapartum care rendered to women in a public hospital. The second level represents the practice environment (labour unit), where nursing research and enhancement of the scientific body of knowledge occurs and adoption of the methodology. The third level represents the meta-theoretical assumptions that determine the research paradigm used in this study, the researcher's Christian world view of the self and others that are rooted in God and the Bible as the truth. Though these statements guide the study, they are not necessarily empirically testable.

1.5.4 Central theoretical statement

Midwives working in the public hospital labour wards are faced with women in labour who are seeking maternity care, interventions and emotional support on a daily basis. The experiences of women regarding the quality of intrapartum care received during labour will provide insight and understanding into this phenomenon and will assist and lead to the enhancement of successfully implementing recommendations for rendering quality

intrapartum care in the midwifery practice. The research design is briefly discussed below, and will be discussed in more detail in chapter two.

1.6 RESEARCH DESIGN

The study was conducted as an explorative, descriptive and contextual research design. The qualitative design has its roots in symbolic interactions, or phenomenology and concentrates on aspects such as meaning, experience and understanding (Brink *et al.*, 2008:10). The aim of the research was to understand the experiences of women of the quality of intrapartum care in a public hospital in Gauteng. The women who were asked to participate in the research study had delivered their babies within the last 24 hours and have had a normal vaginal birth. They were requested to participate in individual interviews (Brink *et al.*, 2006:73).

1.7 RESEARCH METHOD

The research method provides an overview in terms of the context, sampling, sample size, data collection and data analysis methods applied in this research. The aim is to achieve the objectives in a trustworthy and ethical manner. A detailed description of the method follows in chapter two.

The research is **contextual** in nature, because the data were collected within a certain environment or setting. In this study the experiences of the participants are described within the context of the specific setting which is a level 2 public hospital. Therefore the results of the study will only be valid for the situation under which the study was conducted and cannot be generalised (see chapter 2 for details).

1.7.1 Population

Brink *et al.* (2008:27) describe a population as “the entire group of persons or objects that is of interest to the researcher, which also meets the criteria which the researcher is interested in studying”. For the purpose of this research one population has been identified and comprised of all the women who had delivered their babies in the hospital. They had delivered by normal vaginal delivery within the last 24 hours at the time of data collection during June and July 2012 and were willing to participate in the research.

1.7.2 Sampling

According to Brink *et al.* (2008:124), a sample is a part or fraction of a whole or subset of a larger set selected by the researcher to participate in a research study. A non-probability, purposive sampling method was used. In purposive sampling, the researcher selects information-rich cases or those cases from which he/she can learn a great deal about the central focus or purpose of the study (Burns & Grove, 2009:355). The maternity register where all deliveries are recorded will be used as the sampling frame. Criteria for inclusion were women who:

- have delivered within the last 24 hours before discharge
- Who understand and speak English.
- Participation was voluntary and written consent was given.
- The birth was by normal vaginal delivery.

1.7.3 Sample size

The sample size depended on data saturation. Saturation of data occurs when additional sampling provides no new information, only redundancy of previously collected data. Interviews were conducted until no new findings were identified during the interviews (Burns & Grove, 2009:361).

1.7.4 Data collection

Polit and Beck (2006:36) defines data collection as pieces of information that the researcher gathers in that are relevant to the purpose of the study. The actual steps of collecting the data are specific to each study and are dependent on the research design (Burns & Grove, 2009: 508).

For the purposes of this qualitative research, the focus is on properly describing the experiences of the quality of intrapartum care of women who had delivered babies by normal vaginal birth. The method that was used in the collection of data was individual in-depth interviews. Brink *et al.* (2006:151) describe an interview as a method of data collection in which the interviewer obtains responses from a participant in a face-face

encounter, through a telephone call or by electronic means. In this study the individual interview (face-face encounter) was chosen as the appropriate method of data collection.

Field notes were written after data collection had been conducted. The field notes entailed the time and the interview procedure (methodology notes), the behaviour of the respondent (observational notes, e.g. facial expression, gestures and reactions) and the own thoughts of the researcher (Botma *et al.*, 2010:218). The individual interview was used for this study because the researcher is able to observe the non-verbal behaviour, mannerisms and misunderstood responses could be clarified.

1.7.5 The role of the researcher

Permission to conduct the research was obtained from the following structures: Ethics Committee of the North-West University, Potchefstroom Campus (see Addendum A); the Gauteng Health Department (see Addendum B) and the Chief Executive Officer of the Hospital (see Addendum C). The researcher with the help of the Operational Managers of the postnatal unit identified the counselling room as the appropriate setting to conduct the interviews. The room was comfortable and private. Permission of the participants was obtained by the researcher. The researcher first explained the research, got the informed consent (see Addendum D) from the participants before the onset of the individual interviews. The researcher asked for permission regarding the recording of everything said during the interview and the whole interview was electronically voice-recorded (Brink *et al.*, 2006:153; De Vos *et al.*, 2005: 298). All the ethical procedures were also explained to the participants for better understanding and assurance of confidentiality. Field notes were made to remind the researcher of events that occurred during the interview.

1.7.6 Data analysis

Data analysis in qualitative research is the process of imposing some order on a large body of information so as to reach a general conclusion (Polit & Beck, 2006:329). In this research, the records of data collection (verbatim transcriptions of the interviews) were analysed and encoded in accordance with the technique of content analysis by two independent analysts. A consensus discussion was held between the researcher and independent co-coder and a decision was reached on the main themes and the sub-themes that emerged from the written text (Brink *et al.*, 2006:119, De Vos *et al.*, 2005:335).

1.8 RIGOUR

The researcher used the framework of Lincoln and Guba (1985:290-311), which is supported by Morse *et al.*, (2002:1-19) and (Botes, 1995:143-147), to describe strategies to enhance the rigour in this study. According to Lincoln and Guba's framework (1985:290-311), the researcher questioned herself about the following basic standards and measures that are outlined in each chapter:

- Is the research well-defined to ensure theoretical validity?
- Can the research findings be trusted? Was credibility assured when the population was chosen and the data collected and analysed? What is the authority of the researcher?
- Can the research findings be applied elsewhere? Are the findings extrapolatable to another maternity ward in a public hospital?
- How consistent are the research findings? Can the researcher depend on the data being the same if repeated elsewhere in another maternity ward in another public hospital?
- Are the research findings neutral? Was the research done without prejudice and can it therefore be said that it has operational validity?

1.9 ETHICAL CONSIDERATIONS

Ethical issues could manifest in any study and the researcher should be sensitive to this and should be aware of what is right and wrong in any given situation (Babbie, 2007:65). Cognisance was taken of the different ethical issues that might occur in the interaction with mothers participating in the study. Generally accepted international ethical principles in health research were applied, as outlined in the Helsinki Declaration and described in DENOSA (1998:1-8), Burns and Grove (2009:184-217) and Brink *et al.* (2006:30-43).

1.9.1 Code of ethics

The researcher made a conscious and deliberate decision to adhere to local, national and international ethical standards. Constant awareness of the ethical considerations was maintained throughout the research process.

1.9.2 International ethical governance

International ethical guidelines of the International Council of Nurses (ICN) (2006:1-2), the Helsinki Ethical Declaration and the Nuremburg Code (Manual for postgraduate studies, North-West University, 2010:55-56) that stipulate the handling of human subjects in medical research were followed by the researcher.

1.9.3 National ethical governance

At national level, the researcher adhered to the code of ethics as stipulated by the Medical Research Council (MRC), the Department of Health (Ethics committee: North-West University, 2006:1) and the Democratic Nursing Association of South Africa (DENOSA, 1998).

1.9.4 The University's code of ethics

As a registered MCur candidate of North-West University (Potchefstroom campus) the researcher adhered to the ethical code of the University as stipulated by statute. A research proposal was submitted to the School of Nursing Science research committee, after which it was sent to the North-West University ethics committee, Potchefstroom campus. The University issued an ethics number **NWU-0015-08-S1** (Addendum A).

1.9.5 Gauteng Department of Health

Written permission was obtained from the Gauteng Department of Health, and two months after the researcher had requested ethical approval from the Gauteng Department of Health, it was granted (Addendum B).

1.9.6 Selected hospital in Gauteng Province

Having received ethical approval from the Gauteng Department of Health, the researcher made an appointment with the hospital management to obtain permission to conduct the research in the institution. The institution granted permission for the research to be done (Addendum C).

1.9.7 The responsibility of the researcher to protect the rights of the participants

The researcher did also adhere to the principles as stated below:

- **Informed consent:** Before any data collection was done, the participants were provided with information leaflets and consent forms requesting their consent to voluntarily participate in the study. Participants received appropriate and adequate information both verbally and in writing (Addendum D). Data were collected only once written consent had been obtained (Burns & Grove, 2009:204). Participants were assured that they could withdraw at any stage if they wished, without any prejudice (Brink *et al.*, 2006:37).
- **Anonymity and confidentiality:** Every research participant has a right to remain anonymous and was assured that there would be no clues as to the identity of the participants as numbers were allocated and the data were kept confidential (Brink *et al.*, 2008:34-35; Burns & Grove, 2009:196). There is no link between the interview and the participants' information as numbers were used. It was explained that the digital voice recording and scripts would be kept safe until data collection had been completed would be destroyed after being kept for the period determined by the NWU (Potchefstroom Campus) after completion of the research.
- **Privacy:** The participants right to privacy would be maintained by ensuring that the private information would not be shared (Burns & Grove, 2009:194; Brink *et al.*, 2006:33).
- **Benefits:** The benefits derived from participating in the study were communicated to the participants, hospital management and authorities (Gauteng Department of Health).

- **Protection from discomfort and harm:** The right to protect from discomfort and harm is based on the ethical principle of beneficence, which dictate that one do good and most non-maleficence (important not to do harm) (Burns & Grove, 2009:198). The researcher therefore tried to conduct the study without any harm or discomfort and to bring a positive balance of benefits in comparison to harm. As the information is not sensitive by nature, no known risks were foreseen during the study. However, the participants could withdraw at any time during the study.

- **Right to fair treatment**

The ethical principle of justice forms the basis for the right to fair treatment. This principle underlines the fact that each person or participant should be treated fairly and receive his or her due (Burns & Grove, 2009:198). In this research there was a fair selection of the population and the specifically the participants. As the participants were directly related to the research problem they were chosen to participate in the research (Brink *et al.*, 2006:33).

The researcher did not choose the participants because they would specifically benefit from the research (Brink *et al.*, 2006:33); however, benefits derived from participating in the study will be communicated to the participants, the hospital's management and the authorities of the Gauteng Department of Health.

1.9.8 The researcher's responsibility to do research of a high quality

- **High standards with regard to planning, implementing and reporting of research**

Planning, implementing and reporting on research were carefully conducted. The proposal for the research was approved by the research committee of the School of Nursing Science and the work was supervised by an experienced researcher.

- **Displaying integrity by stating supporting and opposing views**

Various points of view found in the literature and during data collection are spelt out.

- **Acting honestly regarding results**

No results have been disguised, fabricated or falsified, and all participants, co-workers and sponsors have been acknowledged. Policies regarding plagiarism and copyright as described in the Manual for Postgraduate Studies (North-West University, 2010:44-45) are acknowledged.

1.9.9 The researcher's responsibility to share the results

- **Giving feedback on the research**

After giving informed consent, each participant had the choice of whether they wanted to be informed individually about the results by the researcher. The results of the research would thus be shared in the form of a report with all the participants who submitted their addresses as well as with the management of the hospital and the Gauteng Department of Health. The research results will be distributed to other scientists and service providers (hospitals and midwives) through journal articles, workshops and congress papers.

1.10 OUTLINE OF CHAPTERS

The division of chapters is the generic structure used for the dissertation that entails empirical research (Bak, 2005:31). In this study the chapters are divided as follows:

CHAPTER 1: Overview of the research

CHAPTER 2: Methodology of the research

CHAPTER 3: Discussion of research findings and literature control

CHAPTER 4: Conclusions, evaluation of research, recommendations and limitations.

1.11 SUMMARY

In chapter 1 the researcher gave an overview of the research, discussed the background and rationale of the study, followed by the problem statement. The research question and the study, aim and objectives allowed the researcher to declare the meta-theoretical, theoretical and methodological assumptions. The research design and research methods, as well as the rigour and ethical considerations applicable to the research were outlined. A detailed description of the research design and methods applied to this study is provided in chapter two. This chapter was concluded by the responsibilities of the researcher and the outline of all the chapters.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

In chapter 1 an overview of the research was provided. The research problem was formulated followed by the problem statement, the aim and objectives, and the researcher's assumptions, as well as a brief orientation of the research methodology employed within this study were discussed. In this chapter a detailed description of the research methodology is given with special attention to the research design, the context, method and the ethical considerations applicable to this research as well as trustworthiness.

2.2 RESEARCH DESIGN

A qualitative research design has been chosen because it has its roots in symbolic interactions and concentrates on aspects such as meaning, experience and understanding (Brink *et al.*, 2006:10). This study is explorative, descriptive and contextual in nature.

Qualitative research is a systematic, interactive subjective approach used to describe life experiences and give them meaning (Burns & Grove, 2009:51). According to Brink *et al.* (2006:10), qualitative research is characterized by six principles which also manifest in this research:

1. Believing in multiple realities;
2. Being committed to identifying an approach in understanding that supports the phenomenon (intrapartum care) studied;
3. Being committed to the participants' viewpoint;
4. Conducting the enquiry in a way that limits disruption of the natural context of the phenomenon of interest;

5. Acknowledging the participants in the research process;
6. Reporting the data in a literary style rich with participants' commentaries (Brink *et al.*, 2006:10). A qualitative design was appropriate in this research in order to gain a better understanding of the experiences of women regarding the quality of intrapartum care they received in a public hospital in Gauteng.

Exploratory research is aimed at exploring the dimensions of the phenomena (intrapartum care) and the way in which they unfold. This research was explorative in nature and was conducted to gain insight and a deeper understanding (De Vos *et al.*, 2011:95) into the experiences of women regarding the quality of intrapartum care. The central question was asked and explored further according to the participants' responses.

The **descriptive** nature involved the (exploration and) description of the experiences within its practical context as it unfolded in real life (Burns & Grove, 2009:45). Describing findings explored from the world of the participants through qualitative data collection meant that communication and information-sharing took place between the participants and the researcher, who interpreted and reflected on the experiences of women about the quality of intrapartum care.

The **context** of the research referred to the site or environment where the phenomenon (intrapartum care) was explored (De Vos *et al.*, 2011:65). The exploration and description of women regarding quality of intrapartum care were conducted within the context of a Level 2 public hospital. The research was conducted in the Gauteng Province, one of the 9 provinces of South Africa (see figure 2.1). The Gauteng Province is the powerhouse of South Africa, providing 33.89% of the country's total Gross Domestic Product (GDP), (SA, 2012:15). Three of South Africa's eight metropolitan municipalities are situated in Gauteng, while it also has two district municipalities. Geographically it is the smallest province in South African province with 17.010sq km (1,4% of the country's) surface area, and has the largest population of 10 029 377 (2011), with 3.468 615 households. The principal languages are IsiZulu 21.5%, Afrikaans 14.4%, Sesotho 13.1% and English 12.5% (SA, 2012:15).



Figure 2.1 Map of South Africa (9 Provinces)(www.linkafrica)

The Gauteng Province is divided into 3 regions with six district health regions (see figure. 2.2) namely:

- **Region A:** Tshwane Metro and Metsweding
- **Region B:** Ekurhuleni Metro and Sedibeng
- **Region C:** Johannesburg Metro, and West Rand District.

The research was conducted in Ekurhuleni. Ekurhuleni is situated in the East Rand region of Gauteng, with a population of 3,178,480 (Stats SA, 2011:75). Migration into the area is high, and it is visible by the number of informal settlements and informal trading activity

(SA, 2012:15). It is highly urbanised with 99.4% of the population living in urban settlements ranging from informal settlements to elite urban residential suburbs. The different racial groups residing in the Ekurhuleni are Black (78,7%), Coloured (2.7%), Indian/Asian (2.1%) and White (15.8%) (Stats SA, 2011:75).

The hospital's catchment area is Kathorus, which is Katlehong, Thokoza and Vosloorus townships, including the surrounding informal settlements. It is a densely populated area with a lot of informal settlements in it. The hospital is a Level 2 and is a referral hospital for three Midwives' Obstetric units and two Level 1 hospitals.

In South Africa most of the population 82.4% (4 million) is dependent on the public health sector and only 17.6% belonged to a medical scheme in 2012 (SA, 2012:17). There has been an increase in the institutional MMR at all levels of care. A comparison between the institutional MMR for 2008-2010 is compared with the 2005-2007, and this was used as an approximation but was useful when looking at the quality of care at various levels of care (SA, 2011:18).

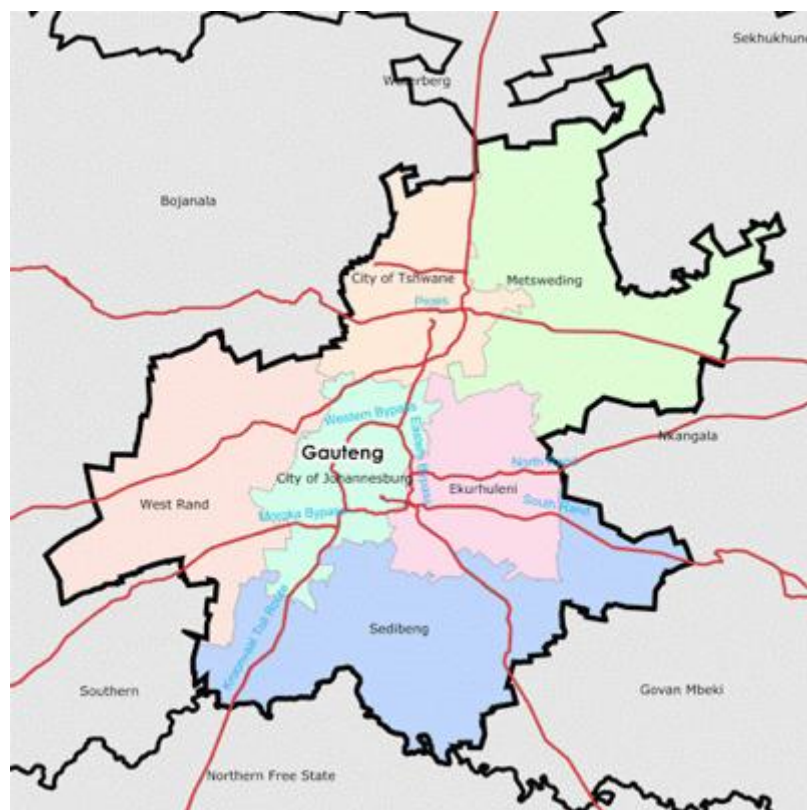


Figure 2.2 Gauteng Health Districts (Wikipedia, 2012)

2.3 RESEARCH METHOD

Polit and Beck (2006:765) describe the research method as the scientific method, procedures and techniques that are followed when a phenomenon is investigated. Detailed information of the research method is provided below with the emphasis on the population, sampling, data collection and data analysis.

2.3.1 Population

Brink *et al.* (2008:123) describe a population as “the entire group of persons or objects that is of interest to the researcher, which also meets the criteria which the researcher is interested in studying”. In this research the population comprised all the women who had delivered their babies in the hospital in a given time-frame. They had delivered by normal vaginal delivery within the last 24 hours at the time of data collection during June and July 2012. They were willing to participate in the research. The selected public hospital in Gauteng deals with ± 700 deliveries per month.

2.3.2 Sampling

A sample is a part or fraction of the whole, selected by the researcher to participate in the research study (Brink *et al.*, 2008:124). The researcher selected the sample from a population of all the women who had delivered in a level 2 hospital in the Gauteng Province to obtain information on a phenomenon (intrapartum care) that represents the population of interest (Brink *et al.*, 2008:124).

Purposive sampling was used in this research, using the research question as a guide. Experiences regarding quality intrapartum care needed to be explored therefore the participants were selected from among the women who had given birth. Purposive sampling allowed the researcher to select the information-rich participants, or participants from whom the researcher could learn a great deal about the central purpose of the study (quality of intrapartum care) (Burns & Grove, 2009:355). The inclusion criteria entailed that a prospective participant:

- Had given birth by normal vaginal delivery within 24 hours prior to the sampling;
- Should have provided informed consent to participate in the study voluntarily; and
- Should be able to understand and speak English.

The qualitative research sample size is determined by the depth of information that is needed to gain insight into a phenomenon (experience of intrapartum care) (Burns & Grove, 2009:361). In this study the sample size was determined by the purposive sampling used to select women who provided the depth of information needed to gain more insight into the experiences of women regarding the quality of intrapartum care in a public hospital and by data saturation that occurred when no new information was provided and by patterns of repetition of previously collected data (Burns & Grove, 2009:361).

2.3.3 Data collection

Data collection is the precise, systematic gathering of information relevant to the purpose of the research study (Burns & Grove, 2009:43). In this study sixteen (16) in-depth interviews were conducted for data collection. The data collection took place during the month of June and July 2012. The researcher compiled an interview schedule and conducted a pilot study prior to the actual data collection (Burns & Grove, 2009:404).

The **role of the researcher** in data collection constituted the following:

The researcher requested permission from different role players in order to conduct this research (see Addenda A, B, C and D). After the prospective participants had been informed about this research and responded positively to the invitation, the researcher explained the method of data collection and addressed any uncertainties raised by the prospective participants. The participants were then requested to give written consent (see Addendum E). The physical setting for data collection was identified beforehand.

The research setting is the location where a study is conducted (Burns & Grove, 2009:362). Polit and Beck (2006:16) state that a **physical setting** is the environment within which human behaviour unfolds and that it should not be constrained. This environment should foster psychological freedom and enhance participation. For this

reason the physical setting was a small counselling room in the post-natal ward free from distractions, by putting a “do not disturb” sign on the door to facilitate the process. The interviews were scheduled and conducted in a comfortable, well-lit and well-ventilated room, and promoted freedom of expression. The researcher had to ensure that the room provided privacy, and a non-threatening environment. Seating was arranged to encourage openness, involvement and participation.

2.3.4 Pilot study

A pilot study is a smaller version of a proposed study conducted prior to develop or refine the methodology, such as sampling, instruments or data-collection processes and analysis (Burns & Grove, 2009:44; De Vos *et al.*, 2005:207). Interviewing is a skill that is required of the researcher before initiating the interviewing in a study (Burns & Grove, 2009:510). Thus the researcher as a novice in undertaking qualitative research had to learn the skill of interviewing through a pilot study. Interview trials were conducted in order to identify how the researcher and the participants would experience the interview and data analysis processes. The following main research question was posed to the participant to elicit the desired details of the study phenomena (intrapartum care):

- **“What is your understanding of quality intrapartum care?** After the participant had given an account of her understanding of quality intrapartum care the following up question was posed
- “How was your experience regarding the quality of the intrapartum care you received?”

The question was adapted to easier language “How was your experience regarding the quality of intrapartum care you received in the labour ward?”

The interview was recorded to get a first-hand sample of the process for critiquing by the study supervisor as an expert in the field (De Vos *et al.*, 2005:208). Pitfalls that occurred during the participant- researcher interaction were identified and remedial measures instituted to ensure that the researcher gained the necessary competence before commencing with the more intensive and challenging data collection and data analysis exercise. It is through this mini-project that the important aspects such as designing interview questions and the actual handling of interview session were learned. The pilot

study was deemed to be important contributing greatly towards the integrity of the rest of the subsequent interviews and the data analysis procedures that followed.

2.3.5 Data-collection method

Before data collection, the purpose of the research was explained to the participants, including the data collection, recording of data using a voice recorder and the duration of the in-depth interviews.

Interviews involved verbal communication between the researcher and the participant, during which information was provided to the researcher (Burns & Grove, 2009:403). The unstructured one-to-one interviews, also sometimes referred to as the in-depth interview, were used for data collection. At the root of an unstructured interview is an interest in understanding the experience of other people and making meaning of that information. It is focused and discursive, and allows the researcher and participant to explore an issue (De Vos *et al.*, 2005:293). The in-depth interview was an appropriate method for a data collection because the events recounted and the experiences of quality of the intrapartum care, as described by the women, were made more substantial, more real, through being recorded and written down.

Preparation for the interviews

Participants were prepared for the interviews, and interviews were conducted at a time convenient for both the researcher and participants (Brink *et al.*, 2006:153). The researcher arranged the time and place ahead of time (De Vos *et al.*, 2005:295).

The researcher ensured that the room was clean and comfortable and that the interviews were conducted in privacy where interruptions were avoided as far as possible (Burns & Grove, 2009:405).

The preparation of the interviews entailed checking the electronic equipment (voice recorder) and the researcher had an additional voice recorder and extra batteries as a backup system.

The interviews were audio-taped (Brink *et al.*, 2006:153) and the voice recorder was placed unobtrusively, and a sensitive microphone was used to prevent faint or distorted

voices being recorded which would lead to difficulty in transcription (Burns & Grove, 2005:405).

The voice recorder allows a much fuller record than notes taken during an interview (De Vos *et al.*, 2005:298). The researcher gets an opportunity to listen to it as often as is necessary to ensure a good understanding of the meaning.

After the procedure had been explained to the participants who had voluntarily agreed to participate, were asked to sign the informed consent forms (see Addendum D) before the actual interview started.

The following aspects were highlighted:

The purpose of the research.

They were informed that they had a right to decide whether or not to participate in the study, or to withdraw from the study at any time, which they would be allowed to do without the risk of penalty or prejudicial treatment (Brink *et al.*, 2006:32).

The participants were assured that anonymity would be maintained by using numbers instead of their names (Burns & Grove, 2009:196).

Confidentiality was assured to participants explaining that the data gathered during the study would not be divulged or made available to any other person and would be kept in a safe place (Burns & Grove, 2009:197).

It was indicated to participants that the proceedings would be digitally voice-recorded to ease the analysis process.

- Procedure

The researcher welcomed each participant and ushered her into the identified room, made her comfortable and exchanged introductory pleasantries. The researcher was respectful and made sure that the participant felt that she was an integral part of the research (Burns & Grove, 2009:512). The interviews were conducted more like a normal conversation, but with a purpose (De Vos *et al.*, 2005:292). The researcher initiated the interview by asking a broad question after the question had been adapted during the pilot study:

How was your experience regarding the quality of intrapartum care you received in the labour ward?

Active interviewing is not confined to asking questions and recording answers. The researcher used several communication techniques as adapted from De Vos *et al.* (2005:289):

- Open-ended question were formulated prior to the interviews in an interview schedule to allow room for participants to respond on their own terms.
- Probing was used by the researcher to obtain more information in a specific area of the interview in order to get more explanation from the participant (Burns & Grove, 2009:405), such as “will you please explain what you mean by saying they checked the babys’s heart beat.”;
- Participants were encouraged to continue talking by using techniques such as nodding the head or making sounds that indicated interest;
- Paraphrasing was used to enhance meaning (by the researcher repeating participants’ words in another form with the same meaning) and participants confirms
- Clarification was used to get clarity on unclear statements, for example “Could you tell me more about what happened after the delivery of the baby“;
- The researcher listened attentively to what the participants were telling her;
- Reflection was used by the researcher to indicate to participants that their concerns and perspective were understood by asking them to expand on ideas said;

At the end of the interview the researcher thanked the participant for their participation (Burns & Grove, 2009:512).

2.3.6 Field notes

Field notes are a written account of the things that the researcher hears, sees, experiences and thinks about in the course of interviewing (De Vos *et al.*, 2005:298), and they help the researcher to remember and explore the process of the interview. Field notes provide an opportunity of what the researcher observed and experienced outside the immediate context of the interview and this includes thoughts and ideas for consideration during data analysis (Polit & Beck, 2006:382-383).

The field notes were written by the researcher to serve as an analytical base for the collected data and as a written record for future publication of the research results (Polit & Beck, 2006:36). They were written and marked accordingly with a number to link them to the specific interview information relating to environmental factors. The following three types of field notes were written (Addendum E):

- **Descriptive notes:** reports on the portraits of description of participants, the physical setting, the interviewer's account of particular events that occurred and of activities that took place during the interview and reconstruction of dialogue (Botma *et al.*, 2010:218; Polit & Beck, 2006:307).
- **Reflective notes:** these involved the researcher's personal thoughts such as speculation about incidents, feelings, problems encountered during an interview, ideas generated during the process, as well as hunches, impressions and prejudices (Botma *et al.*, 2010:218).
- **Demographic notes:** information pertaining to the time, place and date to describe the physical setting where the interview took place (Botma *et al.*, 2010:218)

The field notes were typed, marked and attached to each transcript and made ready for data analysis.

2.3.4 Data analysis

Data analysis is the process of bringing order, structure and meaning to the mass of collected data (De Vos *et al.*, 2005:333). The data in qualitative research are non-numerical, usually in the form of written words (Brink *et al.*, 2006:184). Data were analysed by coding that was generally initiated as soon as data collection began (Brink *et*

al., 2006:105). The recorded interviews were transcribed verbatim. The researcher came to agreement with a second researcher with a known record as being experienced in qualitative data analysis to act as a co-coder. Data analysis was conducted and entailed the following steps (Niewenhuis, 2011:6):

- Transcripts were read, reflecting on the possible meaning and relationship of data and keeping the research question in mind;
- Words and themes were used as the units for analysis;
- The underlined words and themes were written on the right margin of the transcript;
- The identified themes were grouped into main and sub-themes; and
- Redundant information in the themes that did not specify, clarify or elaborate on the remaining themes was eliminated.

2.3.5 Literature integration:

After data analysis, the research findings were discussed and literature integrated. Literature integration was done to verify the research findings against the existing literature and to highlight the findings that came up from the research and those not found in the research that are unique findings (Burns & Grove, 2009: 564). Literature was also reviewed on the themes that emerged from the interviews to provide a scientific basis for the research and to highlight new insights gained from it. The literature integration necessitated a wide literature search. A computer search was conducted using databases such as CINAHL, PubMed, Medline, Premier Ebsco Host, Google Scholar, Science Direct, and SA Publications. In addition to the search engines indicated above textbooks, reports and other appropriate sources of literature were also accessed.

2.3.6 Rigour

In qualitative research rigour refers to trustworthiness (Klopper, 2008:69). Rigour is of scientific value because the research outcome is associated with it (Burns & Grove, 2009: 54). Guba and Lincoln (1989:218) proposed trustworthiness in qualitative research as an alternative for validity and reliability. Four standards of trustworthiness are: truth value, applicability, consistency and neutrality [See Table 2].

Table 2 Strategies to enhance trustworthiness of this research (Klopper, 2008:69-70; Krefting,1991: 215-221; Lincoln & Guba, 1985:290)

CRITERIA/-STANDARDS	THREATS	STRATEGIES TO ENSURE TRUSTWORTHINESS
TRUTH VALUE	STRATEGIES TO ENSURE CREDIBILITY	
This first criterion is reflected by the human experience of the participants	<ul style="list-style-type: none"> • If the practical engagement during data collection is too long • If participants were purposively invited to participate in the research • If the person conducting the interviews is not skilled in the interviewing procedure, it may lead to selective answers or misinterpretation of the data 	<ul style="list-style-type: none"> • Prolonged engagement <ul style="list-style-type: none"> • Months of preparations and thereafter data collection by the researcher (Brink <i>et al.</i>, 2006:118). • Selection of participants <ul style="list-style-type: none"> • All the women who had delivered their babies in the hospital, within the last 24 hours were invited to participate • The researcher tested the findings against the participants (women) who are familiar with the phenomenon studied (Poggenpoel, 2000:349). • Interview technique <ul style="list-style-type: none"> • A pilot study (Brink <i>et al.</i>, 2006:54) was conducted prior to the data collection by the researcher and took field notes during the interview. • Extensive literature control confirms findings of the research (De Vos, 2000:359). • Peer group discussion <ul style="list-style-type: none"> • Consensus discussions with the co-coder who also acted as the supervisor, and is skilled in data analysis, took place after the interviews when the coding took place.

CRITERIA/ STANDARDS	THREATS	STRATEGIES TO ENSURE TRUSTWORTHINESS
TRUTH VALUE		STRATEGIES TO ENSURE CREDIBILITY
		<ul style="list-style-type: none"> • Peer debriefing (Brink <i>et al.</i>, 2006:118) with supervisors and other MCur students took place as part of the peer group discussions.
APPLICABILITY		STRATEGIES TO ENSURE TRANSFERABILITY
To what degree can the findings of this study be applied to other populations and contexts or settings?	The researcher may become biased because of all the hours spent on the data collection and data analysis or does not provide rich enough contextual data for readers.	<ul style="list-style-type: none"> • Purposive sampling • Used purposive sampling because the participants are regarded as rich sources of information (Brink <i>et al.</i>, 2006:133) about their experiences of the quality of intrapartum care. • Dense description • A detailed description of the context, setting and methods of data collection used in this study. • Continue with data collection until data saturation occurs in the interviews. • A thorough literature control was conducted. • A detailed description of data realisation. • All the relevant data collection tools and analysis for audit purposes were kept.

CRITERIA/ STANDARDS	THREATS	STRATEGIES TO ENSURE TRUSTWORTHINESS
CONSISTENCY		STRATEGIES TO ENSURE DEPENDABILITY
<p>This third criterion refers to whether there would be consistency if the research was duplicated with the same participants over a period of time within a similar context.</p>	<p>The researcher works alone on the research study and might become biased.</p>	<ul style="list-style-type: none"> • Indirect • A dense description of the research setting and procedures of data collection and analysis. • Direct • Stepwise duplication of the research study through a dense description of the methodology. The pilot study resulted in adapting the question for the participants. • Inquiry audit – Searching of all possible literature available on the topic (Klopper, 2008:69). • Triangulation • Participants • The researcher and co-coder are participants in the triangulation process. Field notes and literature control were also used during triangulation. • Consensus meetings between researcher and co-coder enhanced dependability.

CRITERIA/STANDARDS	THREATS	STRATEGIES TO ENSURE TRUSTWORTHINESS
NEUTRALITY		STRATEGIES TO ENSURE CONFIRMABILITY
<p>This fourth criterion refers to the neutrality of this research study so that it is free from bias in procedures and results.</p>		<ul style="list-style-type: none"> • Confirmability audit • Consensus meetings with co-coder as well as peer group discussions (Klopper, 2008:70; Brink <i>et al.</i>, 2006:119). <p>Safekeeping of raw data on a personal computer as well as on CD back-ups; field notes and transcribed text are all kept in a safe place as required by the NWU guidelines for post-graduate studies (NWU, 2010:41).</p> <ul style="list-style-type: none"> • Dense description of the research process is given for possible auditing of other researchers to strengthen rigour. • Triangulation • Methods • All field notes were kept during the research study. Various methods were used during the study, namely individual interviews, content analysis through cognitive mapping and interpretative content analysis. • The researcher and co-coder are participants in the triangulation process.

2.4 ETHICAL CONSIDERATIONS

- Ethical permission from the School of Nursing Science, Potchefstroom campus was granted.
- Ethical approval was granted by the Ethics Committee of the North-West University Potchefstroom Campus (**NWU-0015-08-S1**), following the submission of the proposal (**Annexure A**).
- A letter requesting permission to undertake the research project was submitted to the Gauteng Department of Health and Social Development together with research proposal (**Annexure B**).
- Permission was also requested from the public hospital situated in the Ekurhuleni health district, where participants would be invited to participate in the research project (**Annexure C**).
- Informed consent would be obtained voluntarily from the participants before data collection commenced (**Annexure D**).

2.4.1 The responsibility of the researcher to protect the rights of the participants

- **Informed consent:** Before any data collection was done, the participants were provided with information leaflets and consent forms requesting their consent to voluntarily participate in the study. Participants received appropriate and adequate information both verbally and in writing (Annexure D). Data were collected only once written consent had been obtained (Burns & Grove, 2009:204). Participants were assured that they could withdraw at any stage if they wished, without any prejudice (Brink *et al.*, 2006:31).
- **Anonymity and confidentiality:** Assurance was given that there would be no clues as to the identity of the participants as codes were used (Burns & Grove, 2009:196). The participants had the opportunity to express their wish to be informed about the research findings in which case they had the opportunity to write their name and address on a form. There was, however, no link between the interview and the

participants' information. Audiotapes and scripts were kept safe until data collection and analysis had been completed and thereafter they were destroyed.

- **Privacy:** Participants had the right to determine the conditions under which private information would be shared and the extent to which this information would be shared.
- **Benefits:** The benefits derived from participating in the study would be communicated to the participants, hospital management and authorities (Gauteng Department of Health).
- **Protection from discomfort and harm:** The right to protection from discomfort and harm is based on the ethical principle of beneficence, which dictate that one do good and most important do no harm (Burns & Grove, 2009:198). The researcher therefore tried to conduct the research study without any harm or discomfort and bring a positive balance of benefits in comparison to harm. As the information was not sensitive by nature, no known risks were foreseen during the study. The participants could withdraw at any time during the research study.
- **Right to fair treatment:**

The ethical principle of justice forms the basis for the right to fair treatment. This principle underlines that each person or participant should be treated fairly and receives what he or she is due (Burns & Grove, 2009:198). In this research there was a fair selection of the population and specifically the participants. As the participants were directly related to the research problem they were chosen to participant in the research (Brink *et al.*, 2006:33).

The researcher did not choose the participants because they would specifically benefit from the research (Brink *et al.*, 2006:33); however, benefits derived from participating in the study would be communicated to participants, the hospital's management and authorities of the (Gauteng Department of Health).

2.4.2 The researcher's responsibility to do research of a high quality

- High standards with regard to planning, implementing and reporting of research

Planning, implementing and reporting on research were carefully conducted. The proposal for the research was approved by the research committee of the School of Nursing Science and the work was supervised by an experienced researcher.

- Displaying integrity by stating supporting and opposing views

Various points of view found in the literature and during data collection are spelt out, assessed and integrated.

- Acting honestly regarding results

No results have been disguised, fabricated or falsified, and all participants, co-workers and sponsors have been acknowledged. Policies on plagiarism and copyright as described in the Manual for Postgraduate Studies (North-West University, 2010:45-46) are acknowledged.

2.4.3 The researcher's responsibility to share the results

- Giving feedback on the research

After giving informed consent, each participant had the choice of whether they wanted to be informed individually about the results by the researcher. The results of the research would thus be shared in the form of a report with all the participants who had submitted their addresses as well as with the management of the hospital and the Gauteng Department of Health.

These research results will be distributed to other scientists and service providers (hospitals and midwives) through journal articles, workshops and congress papers.

2.5 SUMMARY

The chapter provided an overview of the research methodology applied in this study, as well as a detailed description of the research design and methods. The methods applied to ensure trustworthiness and ethical accountability concluded the chapter. In the next chapter the researcher reports on the realisation of data collection and analysis, the research findings and literature integration.

CHAPTER 3

DISCUSSION OF RESEARCH FINDINGS

3.1 INTRODUCTION

In this chapter results of the findings are discussed in terms of the experiences of quality intrapartum care by women in a public hospital in Gauteng. This is justified by the participants' comments and literature. In the following paragraph the realisation of data collection will be discussed, followed by a detailed discussion of data analysis. The discussion of the research findings is enriched by direct quotations from the transcripts of the interviews. In order to confirm these findings in terms of the existing literature pertaining to quality intrapartum care, references to current literature are also included. The process of data integration will add to the richness of the findings and crystallization of the conclusions on the experiences of quality intrapartum care by women.

3.2 REALISATION OF DATA COLLECTION AND DATA ANALYSIS

3.2.1 Realisation of data collection

The sample that qualified according to the set inclusion criteria was selected from the population for the identification of the participants. A purposive sampling method was used as described in chapter 2. The sample was drawn from all the women who had given birth at the public hospital in Gauteng Province. This study included women who had given birth by normal vaginal delivery within 24 hours and had consented to participate in the study. For orientation of the potential participants and in order to request them to participate in the study, the information sheet and consent form (see Addendum D) were hand delivered.

Some potential participants did not agree to take part, citing fear of intimidation after the interview, and exhaustion from the labour process. The participants who confirmed their willingness to participate were visited in the ward at the date and time agreed upon with the researcher. Before each interview, the researcher obtained the signed consent form

(see Addendum D). Data were collected using an in-depth interview, and were recorded using a battery operated digital voice recorder. Field notes (see Addendum E) were written immediately after each interview. Two questions were asked (refer chapter 2 3.4., paragraph 2), and data saturation was reached after 16 participants who participated. Digitally voice recorded interviews were transcribed verbatim for data analysis (Burns & Grove, 2009:405).

3.2.1.1 *Participants demographics*

Demographic data from the 16 women who participated in the in-depth interviews include the participant's age, parity, educational level, employment, and marital status. The illustration of the demographic data for the participants is provided in table 3.1

Table 3.1 Demographical information of the participants

Age	<p>3 were up to 19 years (18,75%)</p> <p>9 were between age 20-29 (56,25%)</p> <p>3 were between age 30 – 39 (18,75%)</p> <p>1 was 42 years (6,25%)</p>
Parity	<p>6 were primigravidas (37.5%)</p> <p>6 had 1 child (37,5%)</p> <p>2 had 2 children (12,5%)</p> <p>1 had 3 children (6.25%)</p> <p>1 had 4 children (6.25%)</p>
Educational level	<p>3 had not reached grade 8 (18.75%)</p> <p>6 had passed grade 8-10 (37.5%)</p> <p>5 had passed grade 11-12 (37.5%)</p> <p>2 had reached tertiary education (12.5%)</p>
Employment	Out of 16 only 1 was employed (6.25%)
Marital status	3 participants were married

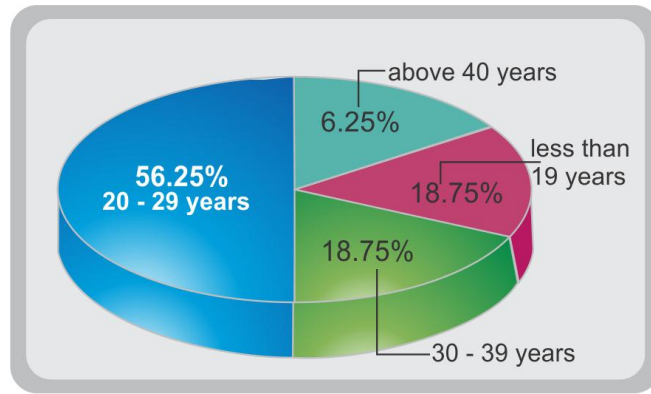


Figure 3.1 : Age of participants

- **Ages**

Of the 16 participants, 3 (three) of the participants (18,75%) were up to 19 years old; 9 (56,25%) were aged between 20-29 years; 3 (18.75%) were aged between 30-39 years; while 1 (one) participant (6,25%) was 42 years old, which indicates that most of them are in the child bearing age between 20-29 years.

- **Number of live children**

Six (6) participants were primigravidas; 6 (six) had one live child; 2 (two) had two live children; 1 (one) had three live children and 1 (one) had four live children.

- **Educational levels**

Two (2) had reached tertiary education, 5 (five) participants had passed grade 11-12; while 6 (six) had passed grade 8-10, and 3 (three) had not reached grade 8. Most of the participants had had formal education and were able to understand the explanations regarding the research study and made an informed choice to participate.

- **Employment and marital status**

Of the 16 participants 10 (ten) were unemployed, only 1(one) had formal employment and 5 (five) were still attending school or a tertiary institution. Only three participants were married; the rest were single; but 3 (three) of them had stable partners and were living

with them. The largest number in the group are not in a stable relationship and do not have the support of a partner financially or emotionally.

3.2.2 Realisation of data analysis

A verbatim transcription of data was read and re-read. The audio recordings were played and replayed in order for the researcher to become immersed in the data (Burns & Grove, 2009:521). The data were reduced to small, manageable parts closely examined and compared for similarities and differences (Burns & Grove, 2009:521). Words and themes were used as the units of analysis. The descriptive codes that characterised the data incident they presented were written down, and the underlined words and themes were written on the right margin of the transcript. The identified themes were grouped into main and sub-themes. The redundant information in the themes that do not specify, clarify or elaborate on the remaining themes by relating them to each other as a whole were eliminated. Themes and sub-themes that emerged were written on the margin of the page.

Data analysis was done according to the principles of content analysis for qualitative research as described by Botma *et al.* (2010:4-5). The data were analysed by the researcher for themes and sub-themes. A co-coder was requested to analyse the data and code the transcripts independently from the researcher. A meeting was then scheduled between the researcher and co-coder. After a lengthy discussion, they reached consensus on the themes and sub-themes that emerged from the data and they completed the data analysis. Five main themes emerged from the analysed data. Table 3.2 presents the main and sub-themes that emerged from the data analysis.

3.3 RESEARCH RESULTS AND LITERATURE INTEGRATION

The consensus reached between the researcher and the co-coder resulted in the identification of the five main themes related to the women's experiences of quality intrapartum care in a public hospital. These main themes are subsequently discussed. A detailed discussion of the study findings (main and sub-themes) enriched with relevant quotations from the participants expressions during the interviews. The numbering of quotes indicates the number of the specific participants, e.g. P1.3. As the literature review was conducted after the interviews had taken place, there was no preconceived framework for departure (Klopper, 2008:67). The literature was conducted to confirm the

findings of this research, to indicate findings that are unique to this study, as well as to indicate findings that are found in the literature but not confirmed by this study.

Table 3.2: Themes and sub-themes related to the experience of intrapartum care received

Theme	Sub-theme
1. Overall experience regarding the quality of care received in the labour ward	1.1 Positive 1.2 Negative
2. Experience of care received in the labour ward	2.1 Time-frame 2.2 Contact with staff 2.3 Privacy 2.4 Information given to patient by staff 2.5 Pain relief 2.6 Cuts/tears 2.47 Care after delivery
3. Experience of cleanliness	3.1 Positive 3.2 Negative
4. Experience of attitude of Staff	4.1 Positive 4.2 Negative
5. Recommendation to family / friends based on the experience	5.1 Positive 5.2 Negative

1. EXPERIENCE REGARDING THE QUALITY OF CARE RECEIVED IN LABOUR WARD

Experience is an event or circumstances undergone or lived through (Oxford English Dictionary, 1999:299). It is directly related to a person's internalisation of an event, which he/she has personally lived through. In this study experiences include emotions, thoughts, preferences perceptions and values within 24 hours of delivery regarding the quality of intrapartum care. The sub-themes of experience are divided into positive and negative.

Table 3.3: Theme1: Overall experience regarding intrapartum care

1. Experience regarding the quality of care received in the labour ward	1.1 Positive
	1.2 Negative

1.1 Positive

Giving birth is an important life experience for women. The child bearing woman undergoes one of the most daunting life experiences, and there is always a potential for psychological benefits or damage (Bryanton *et al.*, 2008:24). Women have reported gaining a sense of mastery, personal strength, and competency as they faced the challenges of labour and birth, and many have described a sense of elation and accomplishment (Callister, 2004:510). The participants were asked about the overall experience during labour, and delivery in the labour ward. Their responses were influenced by the quality of care they received, the interpersonal relations, privacy, and attitudes of the staff. Some mentioned that they had a positive experience, while others reported a negative experience. The following quotes express a positive experience:

“Uhm, it was so nice. Because they looked after me, when I was there until I delivered my baby” (Prt.1).

“... the care that I received was fine, it is just that I had unusual labour pains, but the nurse who was attending to me treated me well’ (Prt.6).

“My experience in the labour ward was a positive one” (Prt.7).

“My experience was positive. I was here with my last delivery and the experience that I had was negative.” I came here not by own choice, but I was transferred here by the hospital that I initially went to” (Prt.12).

“My experience was best considering the stories that people outside tell you about the hospital. I was expecting to deliver my baby at the clinic, when they told me about the transfer I got worried. I am indeed satisfied by the care that I have been given by the labour ward staff” (Prt.13).

The factors influencing a positive experience were similar to Hodnett (2002:160) who, in her systematic review of 137 research studies exploring women’s experiences of birth, identified four key factors that were so important in women’s evaluation of their birth experiences. The four factors are:

- personal expectations;
- the amount of support from caregivers;
- the quality of caregiver-patient relationship;
- and the involvement in decision-making, that it outweighed the effects of all other variables.

Of these four key factors, two relate directly to relationships: the quality of the woman/caregiver relationship and the amount of support received from caregivers (Hodnett, 2002:160). The following research supports this finding as Hardin and Buckner (2004:13), found that women in their study who had received physical and emotional support from their labour-and-birth nurse were grateful for the support and felt it contributed for their birth being a positive experience (Hardin & Buckner, 2004:13). Also when women felt supported, informed and part of the decision-making process, they were more likely to perceive their experience as positive regardless of previously held expectations (Hauck *et al.*, 2007:12).

In the *Canadian Maternity Experience Survey* more than 71% of women attended by midwives reported their experience of labour and birth as “very positive” compared to those by other health-care providers (Chalmers & Royle, 2009:165). They were “very

satisfied” with the respect shown to them, perceived competence of health care providers, concern shown for their privacy and dignity and with their personal involvement in decision making (Chalmers & Royle, 2009:165). These findings are supported by Lumadi and Buch (2011:26) who conducted research in the Limpopo Province of South Africa where mothers were mostly satisfied with the way respect was shown to them during examinations; the general cleanliness of the ward; information provided on how to care for themselves and their babies; and the manner in which midwives and doctors performed thorough examinations, thus making their experience a positive one (Lumadi & Buch, 2011:26). In their study, Nystedt *et al.* (2005: 582) found that 34% of the participants rated their birth experience as a negative experience (Nystedt *et al.*, 2005:582) while the rest of the participants rated theirs as a positive experience.

1.2 Negative

Mthethwa (2006:88) in her study conducted in an MOU in Gauteng found that 32% of the respondents were satisfied with the service delivery at the clinic which included the attitude of nurses, and that they were addressed in a way that they understood, while 68% reported that they were dissatisfied with the level of service regarding rudeness, lack of respect, unapproachable and hostile behaviour of the nurses (Mthethwa, 2006: 88).

In contrast a negative birth experience can be very disempowering (Fenwick *et al.*, 2003:11) and can have negative effects on a woman’s self-esteem, self-efficacy and mental health (Peterson *et al.*, 2005:679). In this research some participants also expressed negative experiences.

The following quotes reveal why the participants experience the birth as negative:

“No they don’t treat you well in there, because when you arrive they only attend to you when the nurse or sister brings you in there (labour ward)” (Prt.2).

“My experience was negative, because even though the other staff members were friendly and treated us with respect, the sister who delivered my baby hurt my feelings, she was insensitive in the manner in which she spoke to me” (Prt.10).

“My experience was negative because there was an incident that happened in the delivery room that I am not happy about” (Prt.11).

These findings are supported by El-Nemer *et al.* (2006:5) where many women reported negative experiences. The interpersonal relationship with professional staff was expressed via hostility or absence, and communication was usually limited to commands or criticism (El-Nemer *et al.*, 2006:9). Mthethwa (2008:6) supports these findings and stated that 68% of participants reported that they were dissatisfied with the level of service regarding rudeness, lack of respect, unapproachable and hostile behaviour of the nurses (Mthethwa, 2006: 88).

Women who felt they could not control the situation during labour and birth were at the highest risk of a negative experience (Waldenstrom *et al.*, 2004:22). According to Waldenstrom *et al.* (2004:23) how a woman was treated, for example, attentiveness to her and her partner's needs, encouragement and competency reduced a woman's risk of having a negative birth experience (Waldenstrom *et al.*, 2004:32). Negative birth experiences can increase the risk for post-partum depression and post-traumatic stress disorder (Beck, 2004a:34 ; Beck, 2004b:223).

The next theme that emerged was about specific care received in the labour ward. Table 3.4 illustrates theme two and sub-themes.

Table 3.4 Theme 2: Care received in the labour ward

2. Care received in the labour ward	2.1 Time frame
	2.2 Contact with staff
	2.3 Privacy
	2.4 Information given to patient by staff
	2.5 Pain relief
	2.6 Cuts / tears
	2.7 Care after delivery

2 CARE RECEIVED IN LABOUR WARD

The quality of care, together with the pregnant women's perception of the infrastructure (beds, linen, food and toilets) and the contact time spent with midwives determine her experience of the quality of care she receives (Hulton *et al.*, 2000:39). Vera (1993:40) and Budd *et al.* (2004:157) echo these findings, and add promptness and availability of services together with consultation as "good quality care". The following relates to the time spent in the labour ward:

2.1 Time-frame

Labour is described as the process by which the foetus, placenta and membranes are expelled through the birth canal (Fraser *et al.*, 2010:437). Labour is diagnosed if there are persistent painful uterine contractions accompanied by at least one of the following: 1, Cervical effacement and dilatation, 2, rupture of membranes and 3, show (SA, 2007a:34). The **latent phase** of labour is when the woman is in labour and the cervix is less than 4cm dilated and more than 1cm long, the **active phase** is when the cervix is 4cm or more and less than 1cm long (SA, 2007a:34). In the United States, the Friedman criteria for labour have been widely utilized for decades. Labour progress was used by separate sigmoid curves for nulliparous and multiparous in the active phase. Labour progressing slower than 1,2cm/hour in nulliparous or 1,5cm/hr in multiparous were identified as the outer fifth percentile for time in labour (Albers, 2007:209). The British physicians Philpott and Castle developed the partogram while working in Africa. The partogram illustrated labour progress as a straight line, changing at 1cm/hour in the active phase of the first stage of labour (Albers, 2007:209). It is utilized in Europe, Australia and in a number of developing countries, under the auspices of the WHO (Albers, 2007:209).

South Africa utilizes the partogram to monitor the progress of labour. According to the *Guidelines for Maternity Care in South Africa*, the cervical dilatation in the active phase should be 1cm/hour in primigravidas and 1,5cm in multiparous. The latent phase is prolonged when it exceeds 8 hours and the active phase of labour is prolonged if the cervix dilates at a rate less than 1cm/ hour (SA, 2007a:44).

All the participants had spontaneous onset of labour. The time spent in the labour ward by the participants ranged between two hours to eleven hours in the labour ward. Whether when they arrived in the labour ward, they were in the active phase of labour or not is not known. They did not have continuous one-to-one labour support during labour and

delivery. The participants felt that the shorter hours in labour and good midwifery gave them a positive experience of quality intrapartum care. Longer hours in labour and lack of support during care lead to anxiety and a negative experience in some of the participants. The following statements confirm the time spent in the labour ward.

“I arrived there at 10h00 in the morning, and at 15h00 they put the drip with an injection like the doctor said’. (Prt.1)

“I arrived, I actually was brought around 8 am by the sister from the antenatal ward, and delivered the baby the baby at 10h00 in the morning” (Prt.2).

“I arrived in the labour ward at one o’ clock in the early hours of the morning. I had the baby at half past twelve during the day” (Prt.6).

“I arrived in the labour ward at around ten in the evening,... I then delivered my baby yesterday morning, that is at six in the morning” (Prt.10).

“I arrived in the early hours of the morning around past one, ... I think it was 01h15. On my arrival the paramedics took me straight to the high care..., the sister that was in there immediately attended to me” (Prt.12).

“I arrived here at eight (20h00) in the evening, and I delivered my baby around five (05h00) in the morning. On arrival I was taken to the high care area of the labour ward. The sister in the room greeted and welcomed me well, gave me a bed and hospital night dress. She did a vaginal examination, checked the baby’s heart rate and put me on the machine to monitor it” (Prt.13).

Albers (1996:118) results indicated that the normal labour of a healthy woman lasted longer than many clinicians expect – they found that the mean length of the active, first stage was 7.7 hours for nulliparous and 5.6 labour for multiparous. The mean length of the second stage was 54 minutes for nulliparous and 18 minutes for multiparous patients (Albers, 1996:118).

Gross *et al.* (2005:31) found that among the factors influencing the duration of labour, only parity had a strong effect on the duration of the first stage of labour. Cervical dilatation at first assessment and time-varying factors, such as the timing of spontaneous rupture of

membranes and midwifery care, each had a strong influence on labour duration; however, the sequence in which they occurred exerted an even stronger influence. First stage labours were much shorter if the membranes ruptured before rather than after the start of care (Gross *et al.*, 2005:31).

In their study Adams *et al.* (2012:1243) also found that women with fear of childbirth spent 1.54 hours (1 hour and 32 minutes) longer in labour than women with no such fear. After adjustments for other factors associated with labour duration, the difference was attenuated to 0.78 of an hour (47 minutes), but the duration of labour remained significantly longer in women with fear of childbirth (Adams *et al.*, 2012:1243). Hodnett *et al.* (2007:2) in the systematic review, more specifically, conclude that continuous support leads to slightly shorter duration of labour, greater likelihood of spontaneous vaginal birth and reduced need of analgesia (Hodnett *et al.*, 2007:2)

- **Contact with staff (labour support)**

Fear, pain and anxiety may induce stress of pregnant women in the maternity unit. This together with the clinical environment and unknown birth attendance may cause adverse effects on the labour process (Hulton *et al.*, 2000:44). The care that women receive during the intrapartum period should help them cope with the stress, pain and effort, and minimise any hidden danger (Fraser *et al.*, 2010: 483; Sandall *et al.*, 2010:56). Labour support is a term used to describe the work of caring or social support that is provided to the mothers during labour and birth (Payant *et al.*, 2008:405). Sauls (2006:37) defined labour support as the “intentional human interaction between the intrapartum nurse and the labouring woman that assists the client to cope in a positive manner during the process of giving birth” (Sauls, 2006:37). Adams and Bianchi (2008:106) agree that the quality nursing care for labouring women combines a variety of skills and behaviours to ensure a positive birth experience.

The participants were asked about the contact time spent with the staff. In this study the contact with staff means the labour support. Most of the participants’ responses indicated that they did not have continuous contact with staff, they had contact with them when they came to check them which in most participants’ cases meant that they were only checked twice.

“I was checked twice, the first time.....” (Prt.7).

“They did come check me twice while I was in there” (Prt.10).

“I was checked twice while I was in the labour ward (Prt.11).

Women who receive constant support during the intrapartum period from a doula had a more positive birth experience (Hodnett *et al.*, 2007:2) This will speed up recovery, lead to early bonding between mother and the neonate and decrease anxiety and depression during the puerperium (Hulton *et al.*, 2000:45).

A woman’s experience of care not only relates to the quality and appropriateness of the maternity care she receives and her perception of the quality of that care, it also refers to her actual contact time spent with qualified staff (Hulton *et al.*, 2007:2087). Although labour support can be provided by a variety of individuals (e.g. family member or friend, trained doula, a labour nurse/midwife is always supposed to be present during labour and birth (Adams & Bianchi, 2008:107).

In the United States intrapartum nurses/midwives are present 99% at of births. These nurses/midwives have a unique opportunity to positively affect a labouring woman’s comfort and labour through the use of Labour Support Behaviours (SLB) (Adams & Bianchi, 2008:107). However in South Africa especially in public hospitals, midwives are not always present during labour to offer the women support due to high number of patients and fewer number of midwives on duty. This is supported in the study of Payant *et al.* (2008:405), that because the midwives spend more time with women in labour than do other health-care providers, midwives are in a unique position to have a powerful influence on the physiologic and psychosocial outcomes of the childbirth experience through their actions and words (Payant *et al.*, 2008:405).

The LSB includes four categories namely: physical, emotional, instructional / informational and advocacy (Adam & Bianchi, 2008:106). Physical LSB and comfort enhance labour progress and increase satisfaction with the birth experience (Adam & Bianchi, 2008:107). Emotional support is directed towards activities such as continuous presence, positive reassurance, and praise (Mitner, 2000:493, Payant *et al.*, 2008:408). Instructional/ informational LSB include instruction for relaxation, breathing and pushing and information about patient care (Adams & Bianchi, 2008:110). Advocacy includes protecting the client,

attending to needs, assisting in making choices related to health care; this requires the establishment of a therapeutic relationship (Foley *et al.*, 2002:183). When advocating for the labouring women includes, the nurse must convey respect, acknowledge the mothers' expectations, and resolve conflict (Adam & Bianchi, 2008:112). Advocacy may require being the client's voice when she is vulnerable or unable to speak for herself, and by being an advocate for the client, the nurse empowers the client to give birth with dignity (Adam & Bianchi, 2008:112).

In Matthews and Callister's (2004:500) research, participants reported that midwives played a pivotal role in preserving dignity during childbirth by their role in supporting them. The nurse's presence, encouragement, continuity of care, and the knowledge maintained women's dignity (Matthews & Callister, 2004:500).

In this study participants stated that the midwives did not give them support during labour, but only came into contact when they came to check (do observations and procedures) on them only. Other participants mentioned that the checking on them was every now and then but no support given, and one felt that even though the hospital was short-staffed they tried to stay in contact checking on them. These are their quotes:

"they put the drip and after 30 minutes they came and checked me" (Prt.1).

"She would every now and then come back to check on us" (Prt.6).

"There were two sisters working in that high care room with four beds (patients), they took turns on checking us" (Prt.12).

"They kept on checking on me from time to time. The doctor also came to check on my labour progress" (Prt.13).

The findings are supported by Hodnett *et al.* (2007:11), also reported that labour support does not always occur because nurses tend to have coexisting responsibilities for more than one labouring woman, spend large amounts of time managing technology or keeping records, begin or end shifts in the middle of the women's labour (Hodnett *et al.*, 2007:11). Some of the women in Hardin and Buckner's research (2004:13) also stated that their nurse merely completed her paperwork and monitoring duties and provided no further support during the labour, and they were not pleased with this type of care (Hardin &

Buckner, 2004:13). Also in Hulton *et al.* (2007: 2090), found that many of the women were left for longer periods unsupported by staff, because they were not permitted to be supported in labour by a person of their choice (Hulton *et al.*, 2007: 2090).

The reality may be that shortage of staff makes it impossible for nursing staff to always be present, even during the later stages of labour. In such circumstances it seems likely that nurses will have to make a conscious decision as to who will receive care (Gibson, 2004: 2017).

One participant was not satisfied with the contact time spent with staff members:

“They only check you once, when you are having pains they tell you that they cannot check you many times because there are lot of patients in there” (Prt.2).

In Larkin *et al.* (2012:7), study support of these findings, it is reported that shortcomings in the care were attributed to lack of staff by most women. The participants in their study discussed their feelings after labour and birth and the rationale of being left alone in situations where they felt vulnerable. They were reluctant to blame individuals and actually empathised with the staff (Larkin *et al.*, 2012:7). Hassan-Bitar and Wick (2007:107) in their study confirmed that there was understaffing of midwives given their responsibilities and workload. Observation and women’s reports revealed that the mother frequently went through labour alone, with little caregiver support (Hassan-Bitar & Wick, 2007:107).

Kruger and Schoombee (2010:90) in a study conducted in South Africa reported that 14 of the 93 participants had support from someone other than medical personnel during labour. This means if nursing staff was not present, most of the women were totally without support (Kruger & Schoombee, 2010:90). They reported feeling forgotten, lost and lonely in their pacing of corridors and that, without the nursing’s staff attention, they experienced a sense of isolation and loneliness (Kruger & Schoombee, 2010:89). The same was found by El- Nemer *et al.* (2006:5) where more than half of the women in their study conducted in Egypt described experiencing loneliness during their labour and delivery. This was despite the fact that nurses were usually with the women in the same room (El- Nemer *et al.*, 2006:5).

Hodnett *et al.* (2007:2) in the systematic review reinforces the benefits of continuous one-to-one support for women during childbirth. More specifically, the review concludes that

continuous support leads to slightly shorter labour, greater likelihood of spontaneous vaginal birth and reduced need of analgesia. In addition women who receive continuous support are less likely to report dissatisfaction with their childbirth experience (Hodnett *et al.*, 2007:2).

A hospital environment where separation of family members and rigid protocol are enforced is one of the factors believed to cause the high intervention rates during labour that are seen in many industrialized societies (Hulton *et al.*, 2007:2090). Women in this study were also not permitted to be supported by persons of their choice in labour, due to the constraints of the physical structure of the labour ward. Labour support by a female relative is a cost-effective and beneficial practice to apply to intrapartum care in developing countries with limited resources (Khresheh, 2010). Yuenyong *et al.* (2008) support the finding that having a female relative to support in labour can reduce maternal stress and anxiety and improve childbirth outcomes (Yuenyong *et al.*, 2008:256). Martis (2007:3) commentary, also states that in research is generally interpreted as continuous support and birthing women needing to be provided in single rooms. However, continuous support can be provided by one female lay person for each woman labouring in a large room with other women (Martis, 2007:3).

2.3 Privacy

The privacy of all women in the birth setting should be respected. The participants were asked whether any privacy had been maintained during examinations and during the delivery. The infra structure of the labour ward does not have single rooms and the patients are either two, three or four in one room during the labour process. There are two delivery rooms, where patients give birth, with each room having four delivery beds. Most of the participants reported that they were given privacy, by closing the screens/curtains around the beds. The following quotes relate to privacy:

“Yes, privacy was given to me, .they closed the screens around my bed to give me the privacy” (Prt.7).

“Yes, during the delivery the curtains around the bed were closed, so there was privacy” (Prt.11).

“Yes, privacy was given to us. The sister would close the curtains around the bed (Prt.12).

“Yes, I got privacy, the screens around the bed were closed every time they checked me” (Prt.13).

Conveying respect to the labouring woman means ensuring privacy, protecting modesty, providing non-judgemental care and protecting clients’ rights. Nurses ensure privacy and protect modesty by keeping unnecessary people from the room, securing the door during procedures, providing gowns that adequately cover the woman while ambulating and covering her with drapes when appropriate (Adams & Bianchi, 2008:112).

In the typical hospital environment, women are disturbed at every turn; with machines, intrusions, strangers and a pervasive lack of privacy (Lothian, 2004:5). She further states that the best labour support will protect a woman’s privacy and ensure that she is not disturbed so that she can tap into her inner wisdom and dig deep to find the strength she needs to give birth (Lothian, 2004:6).

Malcolm (2005:109) found that the use of curtains to screen areas of shared rooms is to grant an element of privacy for patients who may be undergoing a particular procedure. In reality, curtains provide only a visual barrier, preventing others from seeing patient in their exposed state but they do not provide auditory privacy. Participants regarded overhearing another person’s details as breaching privacy (Malcolm, 2005:109).

In contrast one of the participants felt that privacy was not always maintained. During an examination the door of the room was not closed, and the curtains were not closed just because at that time she was alone in the room. This is what she said:

“Not all the time. When the sister who was examining me in that waiting room, the door of the room was opened and people were going up and down the passage. There are curtains around the bed, they too were not closed, so I had no privacy” (Prt.11).

Hulton *et al.* (2007:2089) found that women were examined in crowded areas, where curtains or blinds were not used regularly to shield women being examined (Hulton *et al.*, 2007:2089). They further found that there are many circumstances during labour and childbirth where staff can fail to treat women with the respect they have the right to expect. These include the maintenance of her privacy and dignity during physical examinations, late-stage labour and childbirth (Hulton *et al.*, 2007 2089).

Lothian (2004:5) noted that lack of privacy could induce a catecholamine surge that would terminate early labour, make contractions ineffective and cause severe pains (Lothian, 2004:5). Lack of privacy was conditionally accepted by participants, where privacy can be less than the participants preferred. Aspects such as architecture, economic considerations and a busy workforce were acknowledged as constraints to providing privacy (Malcolm, 2005:159).

2.4 Information given to patient by staff

Hulton *et al.* (2000:45) state that women who receive adequate information and encouragement reported a greater sense of control which leads to a feeling of satisfaction about the birth process (Hulton *et al.*, 2000:45).

Participants were asked if any information was given to them during labour regarding procedures that were carried out and the findings of the examinations done. Some participants responded that they were given information. The following are quotes of participants on information given to them by staff:

“Yes she did tell me, because after she checked me she told me that the baby is still far, but told me to walk up and down in the ward to allow the baby’s head to descend” (Prt.6).

“She checked using her two fingers”. “She then told me that the baby was still far” (Prt.7).

“The communication was good, because they checked us and they informed us about the findings. The one who delivered me when she had to cut me she told me and the reason why she had to do it” (Prt.7).

“The communication was good, there was no shouting or screaming at us” (Prt.13).

Halliday and Hogarth-Scott (2000:63) and Gibbins and Thomson (2001:302) state that there are many expressions of the need for information, reassurance and confidence building. They further point out that information given during childbirth enables the mother to take decisions and empowers her to make informed choices. These findings are supported by Adams and Bianchi (2008:110), to the effect that instruction and information on all aspects of labour and birth provide the clients with an opportunity to be part of the decision-making process, which fosters a positive experience for all.

When women were having an influence on decisions and interventions they felt being in control. Individual differences and communication and information from care providers affected women's experiences of control (Matthews & Callister, 2004:502). Department of Health (SA, 1997b:4) states that informing patients and involving them in decision-making leads to active participation of patients in their care which can improve the effectiveness of care as well as their satisfaction with care. Patients who are treated with dignity and are well informed and able to participate in treatment decisions are more likely to comply with their treatment plans (SA, 1997b:4).

About two of the participants mentioned that no information or explanation was given to them.

"No they did not explain to me' (Prt.10).

"No she did not inform me about the laceration, I just found it here in the ward" (Prt.12).

This was supported by Rudman *et al.* (2007: 485) who reported that women are dissatisfied with interpersonal care. The feelings of being not informed and not being given the opportunity to be involved in decision-making were associated with dissatisfaction with the intrapartum care, and that with holding information could contribute to a disempowering birth experience (Rudman *et al.*, 2007:485). Lumadi and Buch (2011:14) found that mothers were most dissatisfied with aspects concerning inadequate explanations of procedures and the lack of their involvement in decision related to their care and pain control during labour.

Just as women felt, if they received information during the course of labour, that it helped them feel in control; those who were "left in the dark" felt that information was being withheld for no particular reason and they were annoyed (Larkin *et al.*, 2012:6). In circumstances where women cannot effectively communicate with the midwives, they are unable to fully participate in the decisions about the care they receive. It is therefore vital that women are provided with relevant and appropriate information so that they can actively participate in the decisions about the care they receive (Fraser *et al.*, 2010:25).

2.5 Pain relief

Participants were asked if they were given any pain medication to relieve pain during labour. The majority of the participants did not ask and were not given any analgesia for

the pain relief. Non-pharmacological methods for pain relief like deep breathing and massage were used. These are some of the responses from the participants:

“No they did not give me anything to relieve the pains” (Prt.2).

“No they did not give us anything for the relief of pain”. “No I did not ask for something for pain” (Prt.6).

“No I was not given anything for pain and I did not ask for any pain medication” (Prt.7).

“No I did not get anything for pain relief, and I also did not ask for any pain relief” (Prt.11).

“I was not given anything and did not ask. No one rubbed my back, the nurses were few and they tried their best to satisfy us. I did deep breathing exercises during the contractions, rubbed my back like we were informed by the clinic” (Prt12).

The non-pharmacological approach to pain includes a wide variety of techniques to address not only the physical sensation of pain but to also to prevent suffering by enhancing psycho-emotional and spiritual components of care. Pain is perceived as a side effect of a normal process, not a sign of damage, injury or abnormality (Simkin & Bolding, 2004:5). Massage during labour is most commonly used for its stress reduction and relaxation. Massaging muscles and tissues not only relaxes the muscles, it can also alleviate pain, through distraction (Huntley *et al.*, 2004:38).

Chang *et al.* (2002:71) in their Randomised Controlled Trials (RCT) reported significantly lower pain intensity scores at each phase of labour and anxiety levels were significantly lower during the latent phase in the massage group. Eighty seven percent (87%) of the women in the massage group reported that the massage was helpful in providing pain relief and psychological support (Chang *et al.*, 2002:71). However in this hospital there is no support person/ doula during labour to support or encourage or assist the participants. Patients have to massage their own backs and do breathing exercises without any support.

According to *Listening to Mothers Report II*, conducted in the United States by Declercq *et al.* (2006:32) it was found that while 14% of mothers reported using no pain medication, women who experienced labour used a variety of non-pharmacological methods to

increase comfort and relieve pain. Fully 69% used at least one non-pharmacological method of pain relief. Almost half (49%) used breathing techniques, and 42% used position changes and/or movement to relieve discomfort. The women rated the effectiveness of the breathing techniques highly at 77% (Declercq *et al.*, 2006:32). This was supported by O'Brien *et al.* (2009:150), in *The Canadian Maternity Experiences Survey*, which found that among women with a vaginal birth, breathing exercises 74,1% and changing positions 69,5%, were the non-pharmacological techniques most frequently reported for pain management in labour (O'Brien *et al.*, 2009:150).

Relaxation and breathing may contribute more to a woman's ability to cope with labour pain than to actual reduce that pain (Simkin & Bolding, 2004:35).

Only two of the participants were given some pain medication. The pain medication administered was Pethidine and Aterax (Hydroxine) injections. In this hospital Pethidine is the preferred choice of pain relief injection used in the labour ward. This is what they meant by pain medication given:

"No I did not but when the sister came to put up the drip, she gave me an injection here (she points to her right buttock)" (Prt.10).

"No, I did not but the sister gave me an injection when she saw I was in so much pain, told me that the injection will reduce the pain. Yes, it got much better because I managed to sleep for a while" (Prt.13).

In their study Keskin *et al.* (2003:1) found that Pethidine seems to be a better alternative than Tramadol in obstetric analgesia because of its superiority in efficacy and low incidence of maternal side effects (Keskin *et al.*, 2003:1). Tsui *et al.* (2004:13) support the continued use of Pethidine as a simple and cheap therapeutic option in the management of labour pain, particularly in the units where access to epidurals is limited. The results of their double blinded randomised placebo-controlled study of intramuscular pethidine for pain relief in the first stage of found that systematic Pethidine was more effective in relieving labour pain than placebos. Its analgesic effect, however, was modest and moreover it was associated with maternal sedation, nausea and vomiting (Tsui *et al.*, 2004:13).

2.6 Cuts/Tears

Williams (2001:156) defines an episiotomy as an incision of the perineum to increase the vaginal opening. Some of the benefits of the use of episiotomies include a decrease in third- degree tear, a decrease in the risk of incontinence and shoulder distortion and fewer disabilities (Williams, 2001:156). Spontaneous perineal tears are defined as follows:

- first degree tear (injury to the perineal skin only),
- second degree (injury to the perineum, involving perineal muscles but not involving the anal sphincter),
- third degree tear (injury to the perineum involving anal sphincter complex: 3a less than 50% of the external anal sphincter (EAS) thickness torn; 3b more than 50% of EAS thickness torn; 3c injury to external and internal anal sphincter (IAS)
- and fourth degree tears (injury to the perineum involving the anal sphincter complex (EAS) and anorectal epithelium (Fernando *et al.*, 2006:4).

In this study, because the women had a vaginal birth, were asked whether, just before the birth, they had had an episiotomy or cut to enlarge the vaginal opening, and whether they had stitches near the opening of the vagina to repair a tear or cut. The majority of the participants received stitches to repair a tear, and three had an episiotomy performed. The participants experience of cuts and tears and an episiotmy were perceived as a good experience, because the felt that it is part of giving birth. Here are the responses:

“...she then explained to me that she is going to cut me because the passage was too small for the baby to come out” (Prt.10).

“Yes they did give me stitches, but it was not the same sister who delivered my baby, because that one had to go off on duty and another shift came in” (Prt.7).

“Yes, I got stitches after delivery, I got a tear because the sister was not there next to me when I was pushing the baby out, she only came when the head of the baby was out” (Prt.11).

“No they did not cut me, but I got a tear, because the sister informed after she delivered the placenta. She cleaned me and checked me and said she is going to give me stitches” (Prt.13).

Perineal trauma whether by episiotomy or from naturally occurring tears is common during childbirth. In *Listening to Mothers Report II* more than half of the mothers (61%) in vaginal births also reported receiving stitches near the vagina to repair a tear or cut (Declercq *et al.*, 2006:39), and in a survey conducted in Canada, women with a vaginal birth or attempted a vaginal birth, 64,1% reported having stitches (O'Brien & Kaczorowski, 2009:141). Episiotomy rates range from 9% to 97% in developing countries such as Zambia and Brazil (Kropp *et al.*, 2005:158).

Graham *et al.* (2005:220) in their update on episiotomy rates around the world, for the years 1995 to 2003, that included both primiparous and multiparous range from as low as 9.7 percent (Sweden) to 100 percent (Taiwan). Rates for solely primiparous range between 63.3 percent (South Africa) to 100 percent (Guatemala), demonstrating the overall greater likelihood that primiparous women will undergo episiotomies (Graham *et al.*, 2005:220). Episiotomy rates tend to be the lowest in English-speaking countries and some European countries. In many parts of the world (e.g. Central and South America, South Africa and Asia), episiotomy rates remain very high (Graham *et al.*, 2005: 220).

A recent systematic review found no beneficial maternal outcomes and a potential harm from routine versus restrictive use of episiotomy (Hartmann *et al.*, 2005:143). Another study supports the above statement, they found that the mother undergoing episiotomy is characterized by greater blood loss in conjunction with delivery, and there is a risk of improper wound healing and increased pain during the early post-partum period. Perineal trauma is strongly associated with post-partum pain and morbidity, including bleeding and infection (Mohammed & El-Nagger, 2012: 648), which can also increase the MMR.

The World Health Organization (WHO, 2003) recommends restrictive use of episiotomy, however the decision to perform an episiotomy is dependent on the clinical situation and the clinicians' preference. In South Africa episiotomy use persists despite clinical practice guidelines not recommending its use. The *Guidelines for Maternity Care in South Africa* recommends that episiotomies should be avoided, as should other invasive procedures in order to reduce MTCT (SA, 2007a:138). Mother-to-child transmission (MTCT) is the main cause of HIV infection in young children. In the absence of preventive measures, it is

possible that 25-35% of HIV positive mothers' babies will be infected (SA, 2007:130). HIV transmission may occur during the antenatal (5-10%) and intrapartum (10-20%) periods and through breastfeeding (10-20%) (SA, 2007:131). However, Roets *et al.* (2003:17) in their study conducted in the labour ward in Bloemfontein, in South Africa found that only 27% of the respondents stated that they would perform an episiotomy on an HIV positive mother in selected cases as it may be necessary to do so.

Only one participant did not sustain any perineal tears, or have an episiotomy performed.

"No, I was not cut or sustained any tear, I delivered my baby well (Prt.6).

This was also found in the Canadian survey, just over a third (53,9%) of women with a vaginal birth or who attempted vaginal birth reported that they did not have an episiotomy or perineal stitches, implying an intact perineum or tears not requiring stitches (O'Brien & Kaczorowski, 2009:145).

2.7 Care after delivery

The mothers were asked about what happened after the baby was born, and for how long they held their babies. The responses were that all the mothers held their baby for the first time immediately after giving birth or within five minutes. They reported holding their baby skin-to-skin at first contact, but lasting for only a few minutes. The babies were kept in the nursery and separated for long period up to two hours, leading to mothers not being able to initiate breastfeeding within half an hour which is recommended by the Baby Friendly Hospital Initiative, which specifies that breastfeeding must be initiated within a half an hour of birth in the *Ten Steps to Successful Breastfeeding* (WHO, 1998b).

"They cut the baby's cord and showed me the baby and put the baby on my chest, then he was taken away to the baby's room" (Prt.2).

'The baby was taken away for hours and was only brought back when I was being transferred to here in the postnatal ward" (Prt.7).

"The baby was born and she cried. She then wiped the baby, she showed me the baby..., she then cut the cord and put the baby on my chest. Identification belts were put on the baby's leg and arm. The baby was then taken away to the baby's room" (Prt.11).

“The baby was taken away immediately to the nursery, I did not put her on the breast because there was not enough time. He was taken away for about two hours “ (Prt.12).

“The sister wiped the baby..., put him on my chest and put identification belts on. I stayed for a while with the baby before they took him to the nursery. No, I did not breast feed the baby” (Prt.13).

These findings are supported by the “*Listening to Mothers Report II* “, which states that despite the importance of early contact for attachment and breastfeeding, most babies were not primarily in their mothers arms during the first hour after birth, with a (39%) with staff for routine care. Although 61% of the mothers wanted to breastfeed as they neared the end of their pregnancy, just 51% were doing so a week after, which was a troubling missed opportunity (Declercq *et al.*, 2006:42).

Healthy babies placed skin-to-skin (SSC) on their mothers adjust easily to life outside the womb. They stay warm more easily, cry less and have lower levels of stress hormones (Bystrova *et al.*, 2003:326). This was confirmed by Bergman *et al.* (2004) stating that newborn care provided by skin to skin care on the mother’s chest results in better physiological outcomes and stability than the same care provided in closed servo-controlled incubators and breastfeed sooner than newborns who are separated from their mothers (Bergman *et al.*, 2004:784). Babies who are cold, including premature babies, return to a normal temperature more quickly when held skin-to-skin by mothers (Charpak *et al.*, 2005:515).

Early SSC between mother and infant has been shown to be beneficial, in a study conducted in Poland by Mikiel-Kostyra *et al.* (2002:1306) which reported that early extensive SSC after delivery, practised routinely in usual delivery room care, increased the duration of exclusive breastfeeding. Short contact had a limited influence on the overall duration of breastfeeding, while extensive contact lasting for at least 20 minutes was more beneficial (Mikiel-Kostyra *et al.*, 2002:1306). This is supported by Anderson *et al.* (2003:10) who stated that early SSC has a positive effect on long term breastfeeding. In addition to improving breastfeeding outcomes and early attachment, Moore *et al.* (2007) systematic review, studies indicate that SSC may reduce infant crying and increase cardio-respiratory stability, and has no adverse effects (Moore *et al.*, 2007:6).

Bystrova *et al.* (2009) reported findings that SSC, for 25-120 minutes after birth, early suckling, or both positively influenced mother-infant interaction one year later compared to routines involving separation of mother and infant (Bystrova *et al.*, 2009:102). The practice of SSC, early suckling, or both during the first two hours after birth when compared with separation between the mothers and their infants positively affect Parent-Child Early Relational Assessment (PCERA) variables maternal sensitivity, infant's self-regulation, and dyadic mutuality and reciprocity at 1 year after birth. The negative effect of a two-hour separation after birth was not compensated by the practice of rooming-in (Bystrova *et al.*, 2009:99).

Table 3.5 Theme 3: Cleanliness

3	Cleanliness	3.1	Positive
		3.2	Negative

3. CLEANLINESS

3.1 Positive

The participants were asked about the general cleanliness of the labour ward, the floors and toilets, and the bed linen. Most mothers were satisfied with the general cleanliness of the ward. These are the positive quotes on the cleanliness:

“The ward was generally clean and the toilets too, the bed linen was also clean” (Prt.1).

“It was clean, the wards are always clean, even the antenatal ward was clean. The toilets were also clean” (Prt.2).

“The labour ward was very clean, the linen on the beds was also clean” (Prt.6).

“The labour was clean, the floors were clean, the bed linen was also clean. The rooms were clean and neat, there are boxes in each room and toilets where we were told to throw in the dirty pads or linen savers” (Prt.7).

“The labour ward was clean. The floors were clean, the bed linen was also clean. They changed it if it was dirty, like with me, after the sister broke my waters, she changed my bed and put a clean sheet on and a linen saver” (Prt.10).

“The labour room was clean. ...they changed the sheets on the bed and put on clean ones. The delivery room was also clean, when there was blood spills on the floor the sister would call the cleaner to come and clean the floor, and she did come and clean” (Prt.11).

“It was clean, I must say, I was impressed..., floors were clean, the sheets on the beds were clean. Even the toilets were clean, there were boxes that we used for disposing dirty pads” (Prt.12).

“The labour ward was clean, the floors were clean there were no blood spills. The bed linen was also clean, and the toilets were clean” (Prt.13).

In Sofaer *et al.* (2005:2029) patients' view a clean and well-kept environment as a basic and essential element of a high quality hospital (Sofaer *et al.*, 2005:2029). According to Aziz (2012:152), a clean and tidy environment provides the right setting for good patient care. It is fundamental in preventing and/ or controlling the spread of Health-Care Associated Infections (HCAI). Cleanliness is an essential component for the comfort and dignity of patients (Aziz, 2012:152). The physical environment in which a woman undergoes labour and gives birth can have a great effect on the amount of fear and anxiety they experience (Pirdel & Pirdel, 2009:3). Therefore a physically more pleasant environment, which is very clean, welcoming and warm smelling nice and aesthetically pleasing, can help women relax especially when labour is long (Pirdel & Pirdel, 2009:3). On the other hand, positive aspects of the birth environment are associated with positive outcomes such as lower rates of analgesia, lower augmentation and operative delivery, as well as greater satisfaction with the care given (Lock & Gibb, 2003: 132-9).

- **Negative**

Two of the participants were not satisfied about the bed linen. One was left to lie on a wet bed from blood after birth, while the other one was made to sleep in a bed with dirty blood stained linen:

“I was left lying in the pool of blood for a long period of time. They left me lying in that wet bed from the delivery and was only cleaned around 13h00 hours and the baby was delivered at quarter to ten” (Prt.4).

“In the admission room the linen was dirty having blood stains. When I told the sister that the linen on the bed is dirty, she told me that I am complaining because it is the hospital, if it was at the clinic I would not be complaining. She told me to lie on the bed, and I did lie on that dirty linen because I was having pains” (Prt.4).

The findings were supported by Khoza and Du Toit (2011) where thirty percent (30%) of participant reported dirty wards, dirty beds and unhygienic bathrooms and toilets (Khoza & Du Toit, 2011:10). Sofaer *et al.* (2005:2028), in their survey on hospital quality, said that cleanliness was viewed by the participants as important both in terms of elimination of bacterial that could lead to infection, indicating poor quality intrapartum care and commitment of the hospital staff as a whole.

Table 3.6 Theme 4: Attitude of staff

4. Attitude of staff	4.1 Positive
	4.2 Negative

4 ATTITUDE OF THE STAFF

The participants were asked about the staff attitude in the labour ward, whether they were treated with respect and dignity. Some participants described the staff attitude as being positive. They used words like “friendly”, “kind” and “good communication. The following quotes relate to the positive attitude of staff:

4.1 Positive

“Aah, some were kind and treated us with respect” (Prt.1).

“I am satisfied and happy with the attitude of the sister who assisted me” (Prt.6).

“The communication was good, they talked in simple language that I understood, friendly and with respect. No screaming or use of abusive language “ (Prt.12).”

“The communication was good, there was no shouting or screaming at us” (Prt.13).

In Bowers’ (2002) review of 17 studies of perceived labour support, participants described a caring nurse as calm, warm and open. Supportive nurses bestowed praise and

encouragement upon the client, were respectful, and competent and provided a constant presence (Bowers, 2002:749), which is supported by Fraser *et al.* (2006:24), who maintained that the midwife should adopt a supportive attitude towards a pregnant woman. She must reduce anxiety by building trust and being reassuring. She must create a positive atmosphere and explain all procedures in understandable language and provide excellent obstetrical care by touching, making eye contact and speaking softly (Fraser *et al.*, 2006:24)

Hodnett (2002:161) reported that maternal satisfaction with the birth process was not related to relief of pain but more closely related to the attitudes and behaviours of caregivers. Communicating, caring, competence and advocacy in the nurse-client relationship foster the development of a trusting relationship through which emotional and physical needs can be met (Hodnett, 2002:161). Sofaer *et al.* (2005:2026) found that in participants' responses in their study regarding communication with the nurses, three items were mostly important: (1) that the nurses listening carefully to them (2) treating them with courtesy and respect and (3) explaining things carefully (Sofaer *et al.*, 2005:2026).

4.2 Negative

Most participants described the staff attitudes as negative. They felt that the some of the nurses were rude, disrespectful and insensitive towards them: These are quotes from participants about negative attitude of staff:

"... and one or two were rude" (Prt.1).

"They were not supportive and did not treat us with respect"(Prt.2).

"...she said stitching me was like stitching a shoe. I felt humiliated, because she was insensitive and disrespectful towards me. She was also rushing when she was putting the stitches because she was supposed to go off duty. So when I arrived here in the ward and they examined me, they found that my stitches were loose and had to be re-stitched again" (Prt.10).

"I was taken to the delivery room. When I was there I had the urge to push, I then told the sister because this is not my first delivery...The sister told me not to push, she just ignored

what I was telling her, she was standing far away from me, she did not even bother to come and check me, and I was not happy about the way she treated me. The urge was getting stronger and I could not hold myself, so I pushed the baby out, and the baby's head came out, it is only when she saw the head out, she then came next to me to assist me with the delivery" (Prt.11).

"I was treated with no respect and without the dignity that I deserved" (Prt.11).

A less noticed maternity care problem is how pregnant and labouring women are treated in the hospital setting. Although often not recognised as abuse, this behaviour towards women, especially in childbirth, is unacceptable and harmful; some forms of abuse, such as lack of informed consent, misrepresentation of medical situations, and threats likely contribute to the high rates of unnecessary interventions and to traumatic birth experience (Hodges, 2009:1). Verbal abuse includes behaviours such as threatening, scolding, ridiculing, shaming, coercing, yelling, belittling, lying, manipulating, mocking, dismissing and refusing to acknowledge behaviours that undermine the recipient's self-esteem while enhancing the abuser's sense of power, typical of bullying (Hodges, 2009:1; Mthethwa, 2006:78).

Kruger and Schoombee (2010) supported the findings where participants reported numerous accounts of verbal violence such as incidents of sarcasm, shouting, being ridiculed, being blamed and seemingly intentional humiliation. Participants reported being blamed for their behaviour during labour (being messy, for acting like savages, for being disobedient) (Kruger & Schoombee, 2010:93).

Khoza and Du Toit (2011:9) found that the respondents revealed violations as not to be treated with respect and human dignity. Thirty-seven percent (37%) of respondents reported that staff are not always friendly and the conduct of the staff was described as nasty, rude and short-tempered. Thirteen percent (13%) reported that doctors do not treat them with respect, some even shouting at them in front of other patients (Khoza & Du Toit, 2011:9).

The midwives and other professional health-care workers must demonstrate respect and dignity towards the patients. The Batho Pele principles, the principle on ensuring courtesy states that "citizens (patients) should be treated with courtesy and consideration" (SA, 1997). The Batho Pele principles seek to introduce a customer focused approach that

aims at putting pressure at systems, attitudes and behaviours within the childbirth units and re-orienting the attending midwives in the customers' favour, an approach which puts people first (Maputle & Nolte, 2008:56). This Batho Pele principle was also found in this study.

Table 3.7 Theme 5: Recommend to family / friends

5. Recommend to family/ friends	5.1 Positive 5.2 Negative
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5. RECOMMEND TO FAMILY/ FRIENDS

5.1 Positive

When asked if they would recommend the services, women considered the performance of attendants and the services they had received. Most of the participants expressed that they would recommend the hospital to friends and family. Recommendations were mainly due to positive attitudes of staff, and the care they received. The following quotes by participants on positive recommendation:

“Yes, because the care that I received was good...” (Prt.1)

“Yes, I would because I did not encounter any problems with the staff” (Prt.6)

“Yes, I would definitely recommend them, because as this was my first time to give birth , I was anxious about the labour process” (Prt.7)

“Yes, I would recommend to them, because there was a big difference, and I am very happy and impressed about the quality of the care” (Prt.12).

“Yes, I definitely will recommend anyone because I had the best experience, despite the negative talks that you will hear in the location” (Prt.13).

Jha *et al.* (2008:1927) support the findings. They found moderately high levels of satisfaction with care, of patients said that they would definitely recommend the hospital,

with a high degree of correlation among the measures of patients' experiences. Kutney-Lee *et al.* (2009:675) found that nurses' work environment was significantly associated with patients' satisfaction measures, and that patient-to-nurse workloads were significantly associated with patients' ratings and recommendation of the hospital to others. In this hospital the midwives working environment impact on the quality intrapartum care rendered and thus on the experience of the participant.

These findings are also supported by Aiken *et al.* (2012:4) in their study conducted in twelve European countries and in the United States, which also found that nurse staffing and the quality of the hospital work environment were significantly associated with patient satisfaction of care, and nurse workforce outcomes (Aiken *et al.*, 2012:4). Patients' and nurses' ratings were similar. Whether patients rated their hospital as excellent or would recommend their hospital to other patients was associated significantly with nurses' ratings of their hospital work environment and reports of nursing staff (Aiken *et al.*, 2012:40). In D'Ambruso *et al.* (2005:6), when asked if they would recommend the services, women considered the performance of attendants and the services they had received. Recommendations were mainly due to positive attitudes of one or more providers (D'Ambruso *et al.*, 2005:6; Mthethwa, 2006:110).

One of the participants stated that even though she was not satisfied with the care would still recommend the hospital. This is her quote:

"I will recommend one to come and deliver here despite the incident that occurred to me, because the nurses are not the same" (Prt.10)

Cheng *et al.* (2003:352) confirmed the finding that a certain proportion (20.8%) of the "not satisfied" patients still recommend the hospital. Which meant that a hospital with a high percentage of patient satisfaction does not necessarily receive similar levels of contribution.

5.2 Negative

"No the staff treat the patients badly. They just think we are just making noise when we are crying for help, they don't care" (Prt.2).

"Eish, that is a difficult one. I don't think I would recommend someone to come and have their baby here, but at the same time when someone wants to come and have her baby

here, I would not discourage her because maybe she may have a positive experience unlike me” (Prt.11).

D’Ambruoso *et al.* (2005:6) found that women showed clear abhorrence for those who were abusive and in general were determined to avoid any further contact with them, directly or indirectly and would not recommend their services (D’Ambruoso *et al.*, 2005:6). The same were findings of El-Nemer *et al.* (2006:7) who confirmed that the experiences of the women led them to claim that they would never come to the hospital again, despite the authoritative narrative of hospital safety (El-Nemer *et al.*, 2006:7). This is supported by Mthethwa (2006:110) who stated that the majority (78%) of respondents would not recommend their friends or sisters to utilise the MOU.

3.4 SUMMARY

The conclusions with regard to the findings will be discussed more extensively in chapter 4. The realisation of data and data analysis were described. The discussion of the study findings was done according to the main and sub-themes that emerged from the analysis obtained through individual interviews with the participants. The experiences of the women regarding quality of intrapartum care in a public hospital were integrated with the literature on the topic. In chapter 4 conclusions emanating from the research report, limitations of the study as well as the recommendations will be discussed.

CHAPTER 4

CONCLUSIONS, EVALUATION OF THE RESEARCH, RECOMMENDATIONS AND LIMITATIONS

4.1 INTRODUCTION

Chapter 3 offered a discussion of the study findings. The findings were supported by direct quotations from the interviews with the participants. A literature control was integrated into the discussion to verify the research findings against the existing literature and to highlight unique findings from the research. In this chapter the conclusions and limitations of the research will be discussed – this includes deductions made from the previous chapter about findings of this study. Recommendations will be made that will contribute to the improvement of the quality of intrapartum care given to women during childbirth.

4.2 EVALUATION OF THE STUDY

The study will consequently be evaluated as a means of reflection by looking at the background, the aim and objectives, the theoretical statement, the appropriateness of the research methodology and the research results.

In the background of this research, literature indicated that improving maternal health and reducing maternal mortality rates is one of the key factors in reducing mother and infant mortality. MMR rates are still very high in sub-Saharan Africa and South Africa, and achieving the MDG5 to reduce the MMR by 75% by 2015 seems impossible. Sub-standard care is now known to be a significant contributor to maternal mortality rates in developing countries (SA, 2011). The overall aim and objectives of the study were to explore and describe the experiences of women regarding the quality of intrapartum care they received in the labour ward, and to make recommendations to enhance the quality of intrapartum care.

The central theoretical statement was that the midwives working in the public hospital labour wards are faced with women in labour who are seeking quality maternity care,

interventions and emotional support on a daily basis. The quality of care is not only focused on the provision of care but also includes the patients' experience of intrapartum care. Exploring the experiences of women regarding the quality of intrapartum care received during labour did provide insight into and understanding of this phenomenon (intrapartum care) that would assist and lead to the enhancement of successfully implementing the recommendations for rendering quality intrapartum care in midwifery practice.

A qualitative research design was appropriate because of the personal and subjective nature of the participants' experiences. It enabled the researcher to get feedback from the women's accounts of their experiences in their own words. The in-depth interviews for data collection enabled the researcher to understand the experience of the women on quality of intrapartum care and the meaning they could make of the experience.

The in-depth interviews were held with the selected women and this enabled the realisation of rich results. Data saturation was reached with regard to experiences of quality intrapartum care in the public hospital. The literature integration indicated research results that were unique regarding the time-frame in the labour ward. In this research the participants stated that time-frame spent in the labour ward directly influenced their experience of the quality intrapartum care rendered.

4.3 CONCLUDING STATEMENTS

The experiences of women regarding quality intrapartum care received as described by the participants were classified according to the following main themes:

- Experience regarding the quality of care received in the labour ward
- Care received in the labour ward
- Cleanliness of the labour ward
- Attitude of the staff
- Recommendations to family and friends by the women

The following are the researcher's conclusions with regard to the experiences of women in terms of the quality of intrapartum care they received in the labour ward:

Experience regarding the quality of the care they received in the labour ward.

- Most of the participants described their experiences as being positive while a few of the participants described their experiences as being negative. The positive experience was influenced by the good interpersonal relations and attitudes of the midwives and staff, the manner in which they were treated and the delivery of a healthy baby. Similarly participants who had negative experiences were influenced also by the negative treatment from a few of the midwives, lack of respect and empathy by the nurses.

Care received in the labour ward

- Care received in the labour ward involved aspects such as the time frame that the participants spent in the labour ward from admission until the delivery of their babies. A unique finding in this research is that the time-frame spent in labour ward ranged between two and eleven hours. All participants had spontaneous labours, and came to the labour ward already in labour, even though the progress of their labour had not been established because most of them had to wait for hours before they were examined by the midwives or doctor in the labour ward.
- Regarding the contact time participants spent with midwives (labour experience), this was only received when they came to perform procedures and observations to monitor maternal and foetal well-being. There was no continuous emotional support given to the women during labour by the midwives. Participants were not afforded an opportunity to have at least female doulas to reassure, praise, encourage and give continuous one-to-one support to them during the labour process and delivery.
- Privacy was afforded to most of the participants during examinations, procedures and delivery by closing of curtains around the beds. There was one exception where a participant mentioned that on one occasion the midwife did not maintain privacy during an examination that she was doing, that even though she was alone in the room at that moment, the curtains and door were not closed and she felt exposed because some of the staff members were passing by in the ward's passage.

- Some participants were given information by the midwives on the observations and procedures that they were doing, and the importance of those observations, while some participants mentioned that they were not informed. They were also given instructions to do breathing exercises, and massage their backs during contractions to cope with the pain, and to mobilise during the first stage of labour. In terms of the communication with participants, some felt that the communication between them and the midwives was good and that they were friendly with them, while a few felt that the midwives were rude, disrespectful and were shouting at them. Even though the participants were informed about the progress of the labour, they were not involved in the decision-making process of the care they received, the midwives and doctors were the ones making decisions. Also information on self-care, for example of perineal sutures, was not given to patients in the labour ward, but was given in the post-natal ward.
- Of the sixteen participants only three were given medication to relieve the labour pains, the rest were not given any pain medication. Most of the patients were instructed to do breathing exercises and rub their own backs. Participants who did not receive pain medication did not even ask for it, because their perceptions are that pain was part of the labour process, so they had to endure the pain.
- Episiotomy is still performed routinely on participants despite clinical practice guidelines about its restricted use, especially in the primigravidas, because almost/most of them had an episiotomy performed. The Guidelines for Maternity Care in South Africa recommend that episiotomy should be avoided, as should other invasive procedures in order to reduce MTCT (SA, 2007a). Some participants sustained tears during delivery that required suturing, while some were not sutured. Only one participant did not sustain any tear.
- After delivery babies were immediately put on SSC with their mother; however, the period of the SSC was short because the babies were taken to the nursery for routine care. They were kept in the nursery after that, until the mothers were transferred from the labour ward to the post-natal ward. This led to mothers being separated from their babies for hours, and delayed the initiation of breastfeeding within half an hour of birth. Separation also made the mothers anxious about when they would have their babies back from the nursery.

Cleanliness of the labour ward

- Overall experience of participants regarding the cleanliness of the labour ward, beds and toilets was positive, except for two participants. One of them was left lying in the pool of blood after delivery before they cleaned and changed the bed linen, while the other participant was made to lie on a bed with a dirty sheet having bloodstains. It raises concern that the participant who was lying in a pool of blood may have been at risk of post-partum haemorrhage without being noticed, because the patient was left alone for a longer period, without being attended to. Infection control standards are not adhered to by some staff members.

Attitude of staff

- Some of the participants described the staff attitudes as being positive and reported that that they were kind and friendly, and there was good communication. On the other hand, some felt that the staff attitude was negative. They reported staff being rude and disrespectful.

Recommendations to family and friends

- Participants were asked if they would recommend the hospital to their friends or relatives, after their experiences. Some participants were satisfied about the care they had received, and had a positive experience, and would definitely recommend the hospital. One participant mentioned that she would not recommend the hospital, but would not discourage someone who wanted to come to the hospital. A few of the participants would not recommend the hospital based on the care and the negative incidents that occurred in the labour ward.

4.4 LIMITATIONS OF THE STUDY

This study was contextual as it was conducted at one public hospital, therefore the findings cannot be generalised to other hospitals (Burns & Grove, 2005:732), although some of the principles of the findings might be applicable in similar situations.

Even though all the participants were able and willing to speak English, they might have expressed themselves better had they used their home language.

4.5 RECOMMENDATIONS

From the above conclusions, recommendations are formulated in order to enhance the positive experiences of quality intrapartum care by women in a public hospital. These recommendations are divided into policy-making, nursing practice, nursing research and nursing education and are given below.

4.5.1 Recommendations for policy making

- Hospitals should evaluate their own quality of intrapartum care given to women during childbirth, e.g. Quality Improvement Intervention Programme (QIIP™) for intrapartum care to set a golden standard for quality intrapartum care.
- Management should ensure adherence to policy implementation, by conducting in-service training and workshops to midwives on policy adherence and implementation in their practice environments in order to improve the quality of intrapartum care.
- Hospitals should develop a policy that would ensure that women should have female doulas during labour and delivery to ensure one-to-one continuous labour support.
- They should encourage midwives to take active participation in the development of hospital policies and become actively involved in decision-making.
- They should reinforce the accreditation of all hospitals to having maternity units to apply for Baby Friendly status and implement the “Ten Steps to Successful Breastfeeding”, as recommended by the WHO.

4.5.2 Recommendations for nursing practice

- Do immediate baseline observations of the woman on admission as soon as possible.

- Teach and encourage breathing and massage techniques as a way of natural pain relief.
- Establish an effective and sustainable workforce, recruiting the best midwives to render quality intrapartum care.
- Hospital management and midwives should be made aware of the influence of positive practice environments on the quality of intrapartum care.
- High standards of cleanliness will reduce infection rates.
- Implementation of the “Better Birth Initiatives” in the maternity units of all hospitals in order to improve the quality of intrapartum care.
- Avoiding invasive procedures such as episiotomy especially with high HIV infection statistics as this is a leading cause of MMR in South Africa.
- Continuous emotional support to be given to all labouring women throughout the intrapartum period to improve their experience regarding the intrapartum care they received.
- Enhance privacy to maintain dignity and respect as part of the implementations of the Batho Pele principles.
- Doula recruitment and retaining system should be encouraged in all hospitals to give LSB to women during labour and childbirth, especially because the midwives are not able to do that due to staff shortages
- Continuous communication with patients regarding procedures performed and findings on the progress of labour to provide informed consent.
- Pain relief medication should be prescribed and administered routinely as per patient need, because currently patients don’t get pain medication if they don’t ask.
- Recruit midwives who have a passion for intrapartum care to work in maternity units.
- Practice rooming-in to promote bonding between mother and baby which will promote breastfeeding. Skin to skin contact for the first hour-routine procedures to be done on the mothers chest or after 1 hour.

4.5.3 Nursing research

- Conduct a national survey on the experiences of the quality of intrapartum care women received during childbirth, to get clarity of what the quality of care is in maternity units in other contexts.
- The difference in practice environments between the different levels of hospitals should be determined as well as between private and public hospitals.
- Conduct research on midwives to determine their views and perceptions regarding the quality of intrapartum care.
- Further research the reasons why midwives still practise the use of routine episiotomy instead of restrictive use of episiotomy.

4.5.4 Nursing education

- Instruction in quality intrapartum care should form part of the midwives' curriculum both in the basic and advanced courses to set a standard to audit the quality of intrapartum care.
- Midwives should be trained in communication skills and necessary leadership skills in order to improve the way they communicate with their patients.
- In-service training programmes should be introduced to address the attitudes of the nursing staff. Clear messages should be portrayed to the nursing staff on the need of having empathetic caring attitudes toward women in labour.
- Short courses relevant to improving the quality of intrapartum care should be developed for midwives for continuous professional development.

4.6 SUMMARY

The study was aimed at exploring the experiences of quality intrapartum care in a public hospital in Gauteng. Various quality improvement strategies are in place in the public hospitals which should be implemented in order to render quality intrapartum care and improve the intrapartum experience while giving birth.

Management and midwives working in the public hospital should take pride in rendering quality intrapartum care while reducing the MMR. Quality intrapartum care rendered should not only reduce MMR and also have positive childbirth outcomes, but also provide positive experiences for the mothers. This word of mouth testimony by the mothers will soon reach the community, who will then recommend the services to their loved ones. The community can also feel safer using the facility because they will experience good quality intrapartum care while being treated with dignity and respect.

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ADDENDUM A

ETHICS CLEARANCE FROM THE ETHICS COMMITTEE OF THE NORTH-WEST UNIVERSITY



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
INSTITUTIONAL OFFICE

Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 018 299-4852
Web: <http://www.nwu.ac.za>

ETHICS APPROVAL OF PROJECT

This is to certify that the next project was approved by the NWU Ethics Committee:

Project title :

Exploring experiences of quality intrapartum care in a public hospital in
Gauteng.

Project leader : Prof HC Kloppe

Student: Pauline Mathebula 22018050

Ethics number: NWU-0015-08-A1

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project.

Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

The formal ethics approval certificate will follow shortly.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Halgryn'.

HM Halgryn
NWU Research Ethics Secretariate

ADDENDUM B

PERMISSION TO CONDUCT RESEARCH AT THE HOSPITAL



health and
social development
Department: Health and Social Development
GAUTENG PROVINCE

Natalspruit hospital

22 March 2012

Ms. PM Mathebula

APPROVAL TO CONDUCT RESEARCH STUDY

Since your research was approved by the Ethics Committee of the North-West University, Potchefstroom campus with the ethics numbers **NWU-001-08-S1** and the Gauteng Department of Health. The Natalspruit Hospital Management Team is pleased to grant you permission to conduct your study titled **"Exploring experiences of quality intrapartum care in a public hospital in Gauteng"**. Your data collection will be done by conducting individual interviews

The following conditions must be adhered to otherwise permission will be withdrawn:

- Only the research and /or research methods outlined in the protocol presented to the Research Committee should be conducted and /or followed otherwise the research will be cancelled.
- Research results are shared with the hospital

Trust you find the above in order.

Kind Regards



Dr. M.G. Motlatla

(Acting Chief Executive Officer)

Date 2012-03-22

ADDENDUM C

PERMISSION TO CONDUCT RESEARCH FROM THE GAUTENG DEPARTMENT OF HEALTH



**health and
social development**
Department: Health and Social Development
GAUTENG PROVINCE

Vision of the Department

"To be the best provider of quality health and social services to the people in Gauteng"

POLICY, PLANNING AND RESEARCH (PPR)

Enquiries: Dr B Ikalafeng

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CONTACT DETAILS OF THE RESEARCHER	
Date	31 January 2012
Contact number	n/a
Email	Pauline.Mathebula@gauteng.gov.za
Researcher /Principal investigator (PI)	Pauline Mathebula
Supervisor	Antoinette du Preez
Institution	North West University
Research title	Exploring experiences of quality intrapartum care in a public hospital in Gauteng

This approval is granted only for a research proposal submitted to GDHSD by Pauline Mathebula entitled
".Exploring experiences of quality intrapartum care in a public hospital in Gauteng"

METHODS

A qualitative, descriptive, explorative, phenomenological design will be employed. Purposive sampling will be used to select women who have delivered within the last 24 hours before discharge. In – depth interviews will be conducted in a private room to the selected participants in the post natal ward of the hospital on the day of discharge of the woman. Data will be analyzed using codes for themes and subthemes.

REVIEWER'S FINAL CONCLUSION

The proposed study is recommended, it will improve the quality intrapartum care in public hospitals and hence contribute towards strategies to reduce maternal mortality.

Reviewed and Recommended by


Dr Bridget Kalafeng

Date: 20/2/2017

Approved by


S. le Roux, Director PPR

Date: 31/01/2017

ADDENDUM D

INFORMATION LEAFLET AND CONSENT LETTER TO PROSPECTIVE PARTICIPANTS

INFORMATION LEAFLET AND CONSENT FORM TO PROSPECTIVE PARTICIPANTS

EXPLORING EXPERIENCES OF QUALITY INTRAPARTUM CARE IN A PUBLIC HOSPITAL IN GAUTENG

I am conducting this research as part of my masters degree at the School of Nursing science at the North-West University (Potchefstroom Campus). With this letter, you are invited to participate in the research study. Before you decide whether to or not to take part, it is important for you to understand why the research is being done and what will it involve.

The Nature and Purpose of the study

The aim of the study is to explore the experiences of women regarding the quality of intrapartum care. All pregnant women deserve competent and quality care during labour and delivery. You are requested to take part in the study because you have just delivered baby and you are a very important source of information. I will conduct an interview, asking you questions in order to understand how was the quality of care you received during the process of labour and delivery.

Approval to do the research

The research has been approved by Ethics committee of the Faculty of Health Sciences of the North- West University (Potchefstroom Campus) and the Gauteng Department. The Chief Executive Officer and Executive Management of the hospital also gave approval for the research to be done in this hospital.

Risk of discomfort involved

There are no risks for seen in this study, follow-up support will be available should your participation cause emotional discomfort. The interview will take some of your time. The interview will be conducted on the day of discharge, at the time that is most suited for you. It will be conducted in a private room, in the ward. Your permission is asked to record the interview.

Confidentiality

If you consent to participate in this research study, your identity and all information that you give will be kept strictly confidential. A number will be allocated instead of your name. The tapes of the interviews will kept in a safe place. Any personal information that may become known to the researcher will be kept strictly confidential. The results will be published or presented in such a manner that all participants will remain unidentifiable.

Voluntary Consent

Your participation in this research is voluntary, and you are under no obligation to participate. You have the right to refuse to participate or stop to participate at any time without stating any reason. There will be no discrimination against you if you prefer not to participate. If you decide to participate you will be given this information leaflet to keep and requested to sign a consent form.

Possible benefits of this research

Sharing your experience in this research study regarding quality intrapartum care will contribute to the formulation of guidelines to improve intrapartum care. These guidelines may be to the benefit of patients, health workers as well as the community as a whole.

Information

If you have any questions about the study or about participating in the study, you are welcome to contact the researcher, Ms. Pauline Magugudi Mathebula at this number 0732499068.

Thank you very much for taking time to read this information leaflet.

12/06/2012

CONSENT FORM

Name of the Researcher : Pauline Magugudi Mathebula

Contact numbers : 073 249 9068

I confirm that the person asking my consent to take part in the study has told me about the it. I also have received, read and understand the information leaflet for **Exploring the experiences of quality intrapartum care in a public hospital in Gauteng**. I had the opportunity to ask questions which were answered to my satisfaction. I understand that my participation is voluntary and that I am free to withdraw at anytime without giving reasons. I am aware that the results of the study, including my personal details will be anonymous.

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Participant's name	Date	Signature
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Name of Researcher	Date	Signature

ADDENDUM E

FIELD NOTES

Field notes

Interview conducted in June 2012 with one of the participants

Demographic

The participant is a 30 year old female, single but staying with the boyfriend. She has passed standard ten certificate employed, working in one of the leading super markets as a cashier. She is para1 gravid 2. She had delivered the first child by caesarean section. She had a normal vaginal delivery of an alive female infant. She sustained a first degree tear, and it was sutured.

Descriptive

The interview was conducted around eleven in the morning, in a private room used for counselling patients. It had 2 chairs and a table, adequate light and was warm since it was a winter season. There were no interruptions during the interviews. The room opposite the nurses' duty room, and we could hear nurses voices, talking every now and then, and the telephone ringing but that was not disturbing us.

Reflective

The participant was at first a bit nervous, but she gradually started talking freely as the interview progressed. She was satisfied about the care that she received in the labour ward.. She was grateful to the nurses because she felt that if it wasn't for their help she was not going to be able to make it through. She was worried that she might have another caesarean section delivery. She mentioned that as the labour progressed she felt exhausted but the nurses assisted her and encouraged her. I felt that the participant could have expressed herself better if the interview was conducted in her mother tongue.

ADDENDUM F

TRANSCRIPTION OF INTERVIEW

Transcript

Example of one of the in-depth interview with a participant

R: Good morning.

P: Good morning

R: How are you today?

P: I am fine, thanks

R: Congratulations on your baby girl.

P: Thank you.

R: How was your experience regarding the quality of care that you received in the labour ward?

P: My experience was just fine, it was not bad at all yet it was not excellent also. My first experience was better than this one, maybe it is because I was in the rural areas and there isn't a lot of deliveries. The sister there is able to care for you and give you the attention you need. Here it is different because we are so many and the sisters are few to care for all of us. So I can't blame them for not being able to be there for us all the time.

R: When did you arrive at the hospital, and what happened on your arrival.

P: I arrived day before yesterday, around five (05H00) in the morning. I was not having contractions, but my membranes ruptured around four (04H00) in the morning at home. So I knew that I have to come immediately to the hospital because my previous delivery was by caesarean section so I did not want to delay and end up with complications like the last time. I arrived in the labour ward's admission room and there was a sister with other patients in the queue, so I had to wait for my turn to be examined.

R: Uhum.

P: I waited and when it was my turn, the sister checked my blood pressure, did the vaginal examination and there after the baby's heart beat using a machine that monitors the baby's heart rate. for about half an hour. I had to wait for the doctor to also examine me. After some time the doctor arrived and checked us again. He took me to the sonar room and did a sonar, and thereafter admitted me in the antenatal ward, because at that time I did not have contractions.

R: Did they inform you about the findings when they were examining you?

P: Not really, because the sister just told me about findings of the vaginal examination only, she said my cervix is closed. With the blood pressure readings, and the baby's heart rate, findings she didn't tell me whether they were fine or not. She just tore the paper strip from the heart rate machine and stapled it inside my bed letter. The doctor too did the sonar, I don't know the reason why he was doing it and he didn't even tell me about the findings. He just admitted me in the antenatal ward and said it for observations.

R: Did you ask what were the observations?

P: Yes, I asked the sister, she told me is to monitor me and the baby until I got go into labour. She told me that they are going to give a chance to try a normal vaginal birth. So I was admitted in the antenatal ward.

R: Hmmm, so when did you go back to the labour ward to give birth?

P: I went back to the labour ward yesterday morning ten minutes after eight (08h10) in the morning and gave birth just before six (17h40) in the evening. I started having mild contractions around four in the morning in the antenatal ward. Around past five I saw the mucus with blood (show) and I told the sister. She then did a vaginal examination and she told me that I was about two and a half centimetres dilated, and I did not even understand what she meant about that. Thereafter she told me that as soon as I was four or more centimetres dilated, they will transfer me back to the labour ward.

R: Did you ask her to explain what she meant about the centimetres?

P: I did ask her, she just said to me that I am still in latent phase of labour thus I am not ready to go back to the labour ward, and that as soon as I am in active phase, that is four or more they will then transfer me to the labour ward.

R: Ok, so when did you go back to the labour ward?

P: The contractions continued, and just before eight I told the sister who had arrived for day shift that the contractions are getting stronger now. She did a vaginal examination and inserted a urinary catheter and a drip. She put me on the machine to check the baby's heart for about twenty minutes. She was better than the night sister because she explained to me when she did procedures and about the findings.

R: Okay.

P: Yes, she told me that they are going to give some time to go into labour and monitor the progress of labour, and that if I don't progress as expected they may have to do a caesarean section again. But if the labour progresses well I will have a normal vaginal birth. She then accompanied me to the labour ward and handed over to the sister there and she left.

R: So what happened after she left you in the labour ward?

P: I was taken to the high care room of the labour ward, and was given a bed in there. The sister did a vaginal examination and wrote her findings in the file. I stayed there and the pains kept on getting stronger. We were left most of the time alone, and unattended. Around past ten a doctor came and examined us, and the contractions were now getting stronger and more painful.

R: Did you tell the doctor about the pains?

P: Yes, I did, and he told me that he is going to write me some pain medication to relief the pains. He wrote some pain medication in my file. The sister came back after maybe thirty minutes later and I was in so much pain, I told her that doctor has written something to relieve the pain. She looked in the file and went and brought back some injection and told me is to relief the pains and injected me.

R: Did the injection give you some relief of pain?

P: Yes, it did give me some from the pains, they got a bit better and it made me fall asleep. I slept for some time and rested a bit. I was woken up by the stronger contractions again. The sister came and put me on a machine that monitors the baby's heart rate to check on how the baby was doing.

R: How was the baby doing?

P: She examined me again and said I am progress well. I was happy to hear that because I really wished to have a normal vaginal delivery this time around and thanks God willing I did.

R: Please, explain to me about the delivery, what happened?

P: The contractions continued to get stronger and coming more frequent for some time, and eventually it was time for me to deliver. The sister examined me that I am almost fully dilated, put should not start pushing as yet until she tells me to. She then came and checked me again and confirmed that the baby is coming. She then told me to push harder each time I get a contraction to push the baby out. I did that and after a few pushes the baby was born.

R: Yes, thereafter what happened?

P: I heard her cry, the sister wiped the baby, she then showed me the baby, and asked me what the sex of the baby was, I told her it is a girl. She then cut the cord, placed the baby on my chest and put the identification belts on. The baby was then taken to the nursery, to keep her warm, I was told.

R: Did you manage to breast feed her, before being taken away to the nursery.

P: No, I did not get to spend enough time with her, to start breastfeeding. I was still looking and admiring her and the sister had to take her away soon. I was only able to start to breast feed here in the ward, after she had been brought back to me.

R: Ok, after the baby was taken to the nursery, and then?

P: The sister came back and gave me an injection on my thigh, and told it is to prevent me from bleeding too much. She then told me to push when I get a contraction to push the placenta out, rubbed my abdomen and I had contraction and pushed and the placenta was delivered.

R: Uhum.

P: When she was done she cleaned and checked me for any tears that I may have got. There after she cleaned me and changed the bed linen and informed me that she is going to suture me because I have a tear. She gave me an injection to numb the pain around the area of the tear.

R: did you feel any pain during the suturing.

P: No, I didn't feel any pains.

R: Oh, so what happened after you have been sutured?

P: After suturing, she cleaned again and gave me a clean night dress. She thereafter took me to a place where they keep the stretchers and I slept in the stretcher before being transferred here in the ward.

R: Did they provide you any privacy when they were examining or doing procedures on you?

P: Yes they gave us the privacy, because every time they checked us, they screened around the bed. In the delivery room there were four beds, but only two were occupied when I gave birth. The screens around the bed were closed during the delivery for privacy.

R: How was the communication between you, the labour ward staff and the other patients?

P: The communication was good, there was no shouting or screaming at us. They were polite and friendly most of the time. The only problem is that they at times did not inform you why and when they were doing things, and did not explain to us in simpler language that you can understand.

R: Ok, how was labour ward regarding cleanliness?

P: The labour ward generally was clean. The floor were clean, the bed linen was also clean. They changed it if it was dirty, like with me, after the delivery of the placenta, the sister she changed my bed and put clean sheet on and a linen save before she suturing me.

R: Will you recommend your friend to come and deliver her baby here.

P: Yes, I would recommend her to come deliver here. The care was not bad, it's just that the time that the nurses spent with us, or check us is not sufficient. They at times look like they are in a hurry to do their duties are just. Yet you can't blame them because they are overworked due to the shortage of staff. They tried their best, that I must mention, and may God bless them for their hard work.

R: Okay, is there anything else that you want to say, or ask me any question? Okay thank you very much for talking to me, and for your time. I really do appreciate.

P: Thanks.

R: Keep well and enjoy your baby. Good bye.

P: Thanks, and good bye.

ADDENDUM G
DECLARATION OF LANGUAGE EDITING

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Declaration

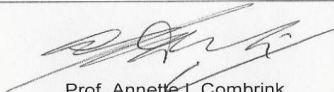
This is to declare that I, Annette L Combrink, accredited translator/language editor of
the South African Translators' Institute, have edited the study by

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With the title

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Date: 13 October 2013