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EXPLORING PROVIDERS' PERSPECTIVES ON RESPECTFUL MATERNITY CARE IN A REGIONAL HOSPITAL IN GAUTENG

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A dissertation submitted to the Faculty of Health Sciences, University of Witwatersrand, Johannesburg in fulfilment of the requirements for the degree of Master of Science in Medicine (Obstetrics and Gynaecology)

Johannesburg, 2022

DECLARATION

I, Sthembile Promise Zwane declare that this Dissertation is my own, unaided work. It is being submitted for the Degree of Master of Science in Medicine (Obstetrics and Gynaecology) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



16th day of June 2022 in Johannesburg

In memory of my parents:

Mfaniseni Jabulani Zwane

1955 – 2012

And

Joubert Khathazile Zwane

1959 – 2019

ABSTRACT

Background

Women continue to die from preventable pregnancy-related conditions that can be managed using evidence-based care and delivery in healthcare facilities supervised by skilled birth attendants. However, women are not willing to deliver in maternity healthcare facilities because of the reported widespread disrespect and abuse. One of the proposed interventions has been the roll-out of respectful maternity care (RMC) in all healthcare facilities providing maternity services. While respecting women who seek maternity services has been studied, the focus has been on the perceptions of individual professional groups of healthcare providers such as midwives and nurses, this is despite the fact that maternity care is provided by multidisciplinary not individual professional teams. The purpose of the study was to explore the perspectives of RMC by a multidisciplinary team of healthcare providers working at a specialised mother and child academic regional hospital in Gauteng Province, South Africa.

Methodology

An explorative, descriptive, and contextual study design within a qualitative paradigm with the adoption of a phenomenological perspective as a measuring strategy, was used. Semi-structured interviews were conducted with 30 purposively selected healthcare providers supervising and rendering maternity care services at Rahima Moosa Mother and Child Hospital. All interviews were digitally recorded, transcribed, and analysed using Tech's Constant Comparison data analytical approach.

Results

Seven themes and twelve subthemes emerged. The themes and subthemes fall under two categories, (1) healthcare workers' perceptions and attitudes on RMC and (2) enabling conditions for the practice of RMC. In terms of perceptions and attitudes, overall healthcare providers had positive attitudes towards RMC perceived it to focus on three key areas: (1) women-centered care, (2) provision of high-quality care, and (3) preservation and promotion of women's rights. Furthermore, providers perceived the enabling conditions for the practice of RMC to include (1) creating an enabling

environment for healthcare providers to practice RMC, (2) in-service training, (3) accountability of healthcare providers for their actions as well as (4) community education and involvement.

Conclusion

Healthcare providers' perspective of RMC in this study is in line with global understanding. This study further highlights the importance of creating enabling conditions in order for RMC to be realised.

ACKNOWLEDGEMENT

Many thanks to Prof. Lawrence Chauke for everything he taught me and all the tireless sacrifices he made to enable me to complete this degree.

The CEO, clinical manager, HOD, nursing staff, doctors, and administrators of Rahima Moosa Mother and Child Hospital.

The maternity care providers from Rahima Moosa Mother and Child Hospital who participated in the study.

My siblings, Thandeka Zwane, Sibusiso Zwane, and Bongani Zwane for their continuous support and always believing in me.

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NOMENCLATURE

D&A:	Disrespect and abuse
LMIC:	Low- and middle-income countries
RMC:	Respectful Maternity Care
RMMCH:	Rahima Moosa Mother and Child Hospital
SANC:	South African Nursing Council
SDG(s)	Sustainable development goal(s)
SSA:	Sub-Saharan Africa
WHO:	World Health Organisation
WRA:	White Ribbon Alliance

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Background

Maternal health is concerned with the health status of women during pregnancy, parturition, including the period after giving birth. The field of maternal health focuses on ensuring that women enjoy positive experiences while pregnant and achieve positive pregnancy outcomes.[1] While considerable progress has been achieved especially in the last two decades, close to 295 000 women died in 2017 due to pregnancy-related complications globally.[1] A disproportionate number of maternal deaths (94%) could have been avoided and occurred in underdeveloped countries.[1] Sub-Saharan Africa(SSA) and Southern Asia contributed approximately 86% (254 000) of the global maternal deaths in 2017 and approximately two-thirds (196 000) of the deaths were from SSA.[1]

In response to these global figures, the world united behind the United Nations Sustainable Development Goals (SDGs) and committed to accelerate global efforts to achieve meaningful reduction in maternal mortality by the year 2030.[2] SDG 3.1 is directed at reducing global maternal mortality rate (MMR) to less than 70 per 100 000 births with no country continuing to register maternal mortality rate that is more than twice the global average by 2030.[2] Majority of the maternal deaths can be prevented by making sure that pregnant women are attended by skilled healthcare professionals working in an adequately resourced and supportive environment.[3] Prevention of preventable maternal death therefore remains top on the world's agenda. Reducing maternal deaths can be achieved by addressing all the disproportions and injustices that affect maternal health outcomes, promotion of sexual, reproductive health, and gender rights as well as ensuring that every woman has access to high-quality and respectful maternity care (RMC).[3]

Despite the emphasis on delivery in maternity healthcare facilities with skilled healthcare providers in attendance as an effort to combat adverse maternal and perinatal outcomes, many women still prefer to deliver at home because of reports of abuse and neglect that are reported to occur in maternity healthcare facilities.[4] Women's despondency concerning their experiences of care has raised awareness of the mistreatment of women during birth as a crucial public health matter.[5] A review by

Bradley et al[5] provides a better understanding of how health workers' conduct affects women's satisfaction with healthcare and their wellbeing. The review explicitly reports on the high level of neglect of the psycho-emotional and sociocultural elements of childbirth, ignorance regarding the interaction of the psycho-emotional and sociocultural elements with structural inconsistencies, and how these manifest as disrespectful conduct that disregard women's needs.[5] With increasing awareness and acknowledgment of these non-clinical factors, providers' conceptions and responses towards promoting RMC initiatives remain part of the day-to-day responsibilities and essence of their successes. It is therefore crucial to study providers' perspectives and experiences in promoting RMC.

1.2 Problem statement

Skilled birth attendance is regarded as one of the critical elements for achieving the United Nations 2030 SDG 3.1 which aims to reduce maternal mortality to less than 70 000 per 100 000 live births.[2] There is evidence of widespread abuse of women worldwide and this abuse, has a negative impact on women's willingness to deliver in maternity facilities[4,6,7,8] One of the suggested interventions has been the roll-out of RMC in all healthcare facilities providing maternity care.[9] However the perceptions and the practice of RMC are influenced by multiple factors, among those; cultural beliefs, societal norms and practices and therefore, likely to be perceived and viewed differently in different settings.[6] While respecting women who seek maternity services has been studied, the focus has been on the perceptions of individual professional groups of healthcare providers such as midwives.[5,8,10] There appears to be a paucity of studies on the views of a multidisciplinary team of health care providers involved in rendering maternity care services regarding their perspectives on RMC.

1.3 Purpose of the study

The purpose of this study was to explore the perspectives of a multidisciplinary team of healthcare providers involved in the delivery of maternity healthcare services in a specialised mother and child academic regional hospital in Gauteng Province, South Africa.

The objectives were:

- To describe the providers' understanding of what is and what constitutes respectful maternity care.
- Explore health workers' attitudes regarding the implementation of respectful maternity care in maternity practice.
- To explore healthcare workers' perceptions regarding barriers to the practice of respectful maternity care in clinical practice.

1.4 Research question

This study was informed by one research question:

"*What are maternity health care providers' perspectives regarding respectful maternity care and implementation barriers*?

1.5 Clarification of concepts

The concepts forming the core of the study are defined below:

1.5.1 Provider

A provider is a person who gives someone something they need.[11] In this study, a provider refers to a qualified health care professional rendering supervisory and direct facility-based maternity care services.

1.5.2 Perspective

A particular attitude towards or a way of regarding something; a point of view.[11] In this study, perspective refers to the provider's knowledge, understanding, and views on respectful maternity care.

1.5.3 Respectful

Feeling or showing deference and respect.[11] In this study, respectful refers to acceptable, safe, and harmless maternity care.

1.5.4 Maternity care

Maternity care is the field of healthcare that is concerned with the type and quality of health services provided to women, babies, and families throughout the pregnancy period.[12] In this study maternity care refers to supervisory and direct clinical and non-clinical antepartum, intrapartum, and postpartum care services provided to women.

1.6 Conclusion

In this chapter, the problem statement, the purpose, and the rationale for undertaking this research were presented. In the next chapter, preexistent literature about the subject of enquiry will be presented.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The problem statement, purpose, objectives, and research question were presented and highlighted in Chapter 1. This chapter reviews existing knowledge on respectful maternity care with a specific focus on the history, disrespect, and abuse (D&A), impact of D&A on maternal health, building up into the concept of RMC and related domains as well as factors that influence the realisation of RMC.

2.2. History of Respectful Maternity Care

The traction that resulted in the global recognition of RMC can be traced back to the Universal Declaration of Human Rights in 1940.[13] Evidence started to accumulate regarding the existence of widespread disrespect and abuse of women across the globe and this forced the United Nations General Assembly to issue a declaration on eradication of Violence against Women in 1993.[14] The Traction Project further provided evidence of the existence of abuse in maternity delivery facilities in 2010.[15] In response, the White Ribbon put together an RMC Charter which advanced RMC as a universal right for Women and Newborns.[13] Similarly, WHO also called for the worldwide implementation of RMC in all maternity facilities as a basic human right.[9]

2.3 Disrespect and abuse (D&A) during childbirth

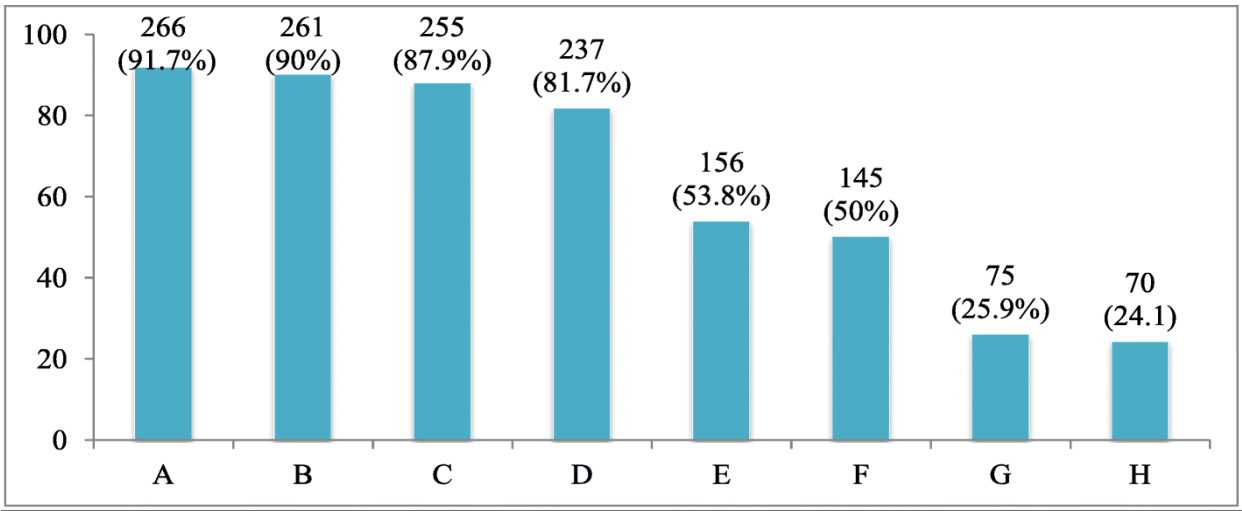
Approximately 295 000 women died due to conditions associated with pregnancy in 2017, of which 99% of those deaths occurred in underdeveloped and developing countries.[1] Although maternal mortality had declined globally by 45% between 1990 and 2013,[16] the progress towards MDG 5 has been stagnant. Some underdeveloped and developing countries failed to achieve a 75% reduction in the maternal mortality rate by 2015 as planned.[2,16] Accessibility to safe, sufficient, and efficient women's health services across the board, particularly prevention of unwanted pregnancies and maternal health through access to contraception and safe abortion services can drastically reduce the widespread burden of maternal morbidity and

mortality.[3] A dominant component among the known strategies to reduce maternal deaths has been on ensuring availability of adequate skilled birth attendants as well as access to facility-based childbirth services.[17] Furthermore, attempts to improve both the availability and efficiency of care provided to women in healthcare facilities, including the incorporation of women's rights to dignified and respectful care are required.[17,18]

Maltreatment of women seeking maternity services remains a challenge in developed, developing, and underdeveloped countries.[2] For decades, inhospitable and negative attitudes from maternity service providers have been described by women as hurdles to accessing maternity services.[2,17.18] Above that shaky healthcare systems contribute to this insufficient access and use of maternity health services by heightening the negative impact of disrespect and abuse during pregnancy and childbirth.[2] Furthermore existing quality of care strategies particularly in maternity care settings mainly focus on reducing adverse outcomes but do not emphasise caring for women with respect and dignity as a fundamental part of reducing maltreatment during childbirth and ultimately, improving maternal and perinatal outcomes.[2,18]

Recently there has been growing interest in the ill-treatment of women during childbirth. The concept of "obstetric violence" stemmed way back in 2007 from South America and is often used to describe this particular kind of maltreatment.[19] Lapperman and Swartz explicitly defined the concept of obstetric violence as the discourteous, violent, and degrading treatment of women during labour and childbirth.[20] Morales, Chaves and Delgado,[21] further argue that violence is an expression of aggression towards women by healthcare providers while receiving care in maternity care facilities, that occurs in an environment favoring the development of power disproportions between women and health care practitioners. In its entirety obstetric violence encompasses problematic practices such as abandonment, physical, verbal, sexual, and emotional abuse, lack of confidentiality, non-consensual care, and improper use of medical intervention, such as induction and augmentation of labour, episiotomies, and unnecessary caesarean sections.[20.]

Qualitative studies conducted globally on abuse and mistreatment of women during childbirth in healthcare institutions provide valuable insight into the existence of disrespect and abuse by describing the problem, especially in underdeveloped settings.[22] Quantitative studies have sought to measure the extent of the problem including the extent of the various types of abuse. Recent studies conducted in Kenya and Ethopia,[23,24] analysing experiences of women during childbirth, estimated the prevalence of disrespect and abuse to be between 20 to 98%.[23] Furthermore, the Ethiopian study on the prevalence of disrespect and abuse during deliveries in maternity healthcare settings conducted in 2019 to quantified the prevalence of D&A as well as factors that influence it.[24] The results of this study summarised in Fig 2.1 below, looked at the prevalence of the different types of D&A in the study population.



A	The woman had at least one type of disrespect and abuse
B	The woman's right to information, informed consent, and choice/preference was not protected
C	The woman was not protected from physical harm or ill treatment
D	The woman's confidentiality and privacy was not protected
E	The woman was left without care/attention
F	The woman was not treated with dignity and respect
G	The woman was detained or confined against her will
H	The woman did not receive equitable care, free of discrimination

Figure 2.1 Generic and category-specific prevalence of disrespect and abuse in Ethiopia (Source: Siraj, Teka, and Hebo[24])

It is evident from the graph that about 9 out of 10 women experienced some form of abuse or disrespect during facility-based delivery. Unfortunately, mistreatment during childbirth leaves unpleasant, unforgettable memories in women's lives and has far-

reaching negative consequences in their future utilisation of health care services.[24] A key implication of these findings is that as a means of improving access and utilisation of facility-based maternity services, disrespect and abuse must be addressed through women-centered approaches such as RMC.

South Africa, a more developed country (middle-income) in comparison with Ethiopia, also encounters multiple challenges in the health care sector.[25] With close to about a million deliveries per annum,[26] maternity healthcare professionals are faced with a high number of patients seeking maternity healthcare services and a lack of resources.[25] The healthcare system is further overstretched with demands from escalating numbers of illegal immigrant population that migrating into South Africa to seek healthcare and also due to the high numbers of local residents seeking care in the already overburdened and under-resourced public healthcare facilities.[25] Such deficits have led to multiple reports of disrespectful and substandard maternity care, evidenced by increased patient complaints regarding the poor quality of maternity care.[25]

Though ill-treatment and impertinent care have been recognised as a burden in South Africa, there is limited research that has been conducted on the quality of maternity care.[25] Moreover, there is a great scarcity of research studies investigating the experiences of women during childbirth in different settings such (i.e. public and private maternity facilities) and by different maternity service healthcare providers (i.e., obstetricians, midwives).[25] Considering the enormous challenges of the healthcare system as well as the need for professional support during childbirth, a study exploring women's experiences while receiving care in different maternity delivery settings in South Africa was conducted in 2018.[25] The aim of the study was to contribute and add to the evidence on the need for change in the provision of maternity healthcare in order to improve the care of women during a critical period in a woman's life - that is, the childbearing experience.[25] Mistreatment of women during childbirth across all healthcare settings by different healthcare workers (more especially in the public settings but more subtle in the private maternity healthcare settings) emerged from the

study[25]. This discovery is not unique to this study but features prominently in the global literature.[4,8,18,25] This creates an urgent need to raise awareness on and strategies to curb disrespect and abuse of childbearing women through the implementation of RMC globally and in South Africa. Knowledge of healthcare workers' perceptions and attitudes on RMC is therefore critical.

2.3.1 Patient-related factors

Several studies reported on the correlation between disrespect and abuse and a wide range of patient-related factors during pregnancy; however, the results yielded inconsistent results. Abuya et al,[23] found no relation between obstetric mistreatment and maternal age, marital status, academic ranking, and the presence of birth companions, but did find a link between parity and socioeconomic status as well as between detention for failure to pay for services and the aggressive manner of payment requests. Jewkes and Penn-Kekana[27] could not find any relation between dehumanising treatment and academic level but found positive correlation between disrespect and extremes of age (adolescents and older women). Some studies also revealed a correlation between non-consensual care with informational or academic ranking and the childbirth type.[4,7,27,28] Kruk et al,[29] found an association between disrespect and abuse with higher parity, poverty, and higher educational level however, these authors could not find an association with age, marital status, and factors related to healthcare facilities. It can be concluded from the above studies that all women are prone to D&A regardless of their age, educational status, social standing, etc.

2.3.1 Provider related factors

Jolivet et al[30] identified four provider-related factors that influence ill-treatment and abusive care in institution-based childbirth: (1) injustice and prejudicial behavior subjected to certain sub-population groups of women by providers; (2) withdrawal of providers from patients due to the training that normalises social distancing as well as disrespectful care; (3) providers' discouragement and lack of motivation as a result of weak health systems, staff shortages and scarce professional growth opportunities; and (4) a climate of disharmony and persecution among maternity healthcare providers which translate into abuse and mistreatment of women seeking maternity services.

Intervening at the level of providers to infuse positive changes in the behaviour of healthcare providers and creation of healthy clinical working environments would make it possible for women to access and experience respectful care from skilled maternity care providers.[30]

2.3.3 Health system-related factors

Various health system-related factors are part of the D&A drivers. These factors include lack of or inadequate provider supervision, inadequate training, limited resources, poorly communicated policies and guidelines and, poor obstetric, nursing, and midwifery management. These are some of the factors that make women avoid and/or delay seeking help in maternity care facilities.[18,30,31] In addition, these factors have a negative impact on women's reproductive health such as a lack of desire to bear children, fear of pregnancy and childbirth including the woman's choice regarding the mode of childbirth.[30]

2.4 Impact of disrespect and abuse on maternal health

Maternal mortality is a determinant of women's health status, hence limited or lack of access to healthcare reflects the insufficiency of the healthcare system to cater for their needs.[32] It is therefore indispensable to have information on the prevalence of maternal mortality not only for prediction of risks of pregnancy and childbirth, but for implications posed by maternal mortality to women's health in general including their social and economic standing.[32]

Obstetric violence has implications on maternal mortality. In addition to the risk associated with adverse events of management of vaginal delivery, there is a possibility of damage associated with the use of improper and excessive meddlesome interventions in vaginal births such as the unregulated use of oxytocic agents to augment labour, assisted delivery, episiotomy, among others.[33] These interventions are carried out without any justifiable clinical indications as widely reported in national studies.[32]

Aggressive management of childbirth is also linked to oppressive enforcement and women opting for cesarean section, which increases its occurrence and associated risks.[33] Furthermore, women experience other forms of violence in maternity units, such as the ill-treatment of women who scream during labour. These women often receive unpleasant treatment especially those considered to be “uncooperative” or maladjusted, or those expressing any dissatisfaction with lack of support, delays when they need help or insist on urgent assistance.[32,33] The delay in attending to these needs can be some of the factors that increase the woman’s risk of experiencing adverse events as well as dying during pregnancy and childbirth.

Women are also subjected to verbal abuse and delays when they require transfer from home birth to maternity healthcare facilities and between healthcare facilities themselves.[34] Such occurrences are examples of what has been called “professional hostility” in studies conducted in other countries and can pose a major threat to the safety of women.[33,34] Professional hostility also manifest in the form of neglect and sometimes delay in caring for women who present with incomplete abortions whereby healthcare providers assume that the abortions were intentional.[31] Denying women companions during labour is also a major threat to women’s health. Not allowing companions during delivery is one of the known risk factors for maternal death. In one study, denying women access to labour companions resulted in 38 maternal deaths in one public hospital.[31] Disregarding the importance of companions during labour poses a threat to women’s safety because labour companions could warn healthcare providers when there is change in women’s conditions during labour. [31,32]

2.5 The concept of respectful maternity care

There is no universally accepted definition of RMC, however, Bulto, Demissie, and Tulu[28] define respectful maternity care as an individual-centered approach, based on ethical principles and human rights framework, both of which foster healthcare practices that acknowledge women’s unique choices and needs.[9, 34] RMC is not only a climacteric element of quality care, it is a universal human right that should be enjoyed by every woman visiting the healthcare system for pregnancy care.[9,36] The WHO

published the recommendations on Intrapartum care for a positive childbirth experience in 2018,[9] and one of the key recommendations that emerged, is "respectful maternity care." The underlying notion of RMC is that the provision of maternity care services should be based on principles of patient autonomy, respect, non-maleficence, and continuous support.[9]

As previously stated the White Ribbon Alliance developed a charter in 2011 which highlights the lawful place of maternal rights within the broader human rights contexture[37]. The charter outlines the seven rights of childbearing women (Figure: 2.2). These seven rights are anchored in human rights instruments globally.[37,38]



Figure 2.2: Respectful Maternity Care: The seven universal rights of childbearing women (Source: White Ribbon Alliance[37])

2.6 Domains of RMC

A qualitative systematic synthesis was conducted in 2017, to develop a conceptualisation of RMC.[39] This synthesis was conducted from RMC related research done in 67 countries and 6 of those countries were in sub-Saharan Africa. Twelve domains pertinent to providing a typology of RMC during childbirth in healthcare institutions emerged.[39] These are set down in Box 2.1 below:

Box 2.1: Twelve domains of respectful maternity care

- Being free from harm and mistreatment
- Maintaining privacy and confidentiality
- Preserving women's dignity
- Prospective provision of information and seeking informed consent
- Ensuring continuous access to family and community support
- Enhancing quality of physical environment and resources
- Providing equitable maternity care
- Engaging with effective communication
- Respecting women's choices that strengthen their capabilities to give birth
- Availability of competent and motivated human resources
- Provision of efficient and effective care
- Continuity of care

Looking in both Figure: 2.1 and Box: 2.1, it is evident that the domains are grounded within the universal rights of reproductive age women. This shows the significance and the urgency regarding the need to address disrespect and abuse (D&A) and infuse the practice of RMC in health systems worldwide.

2.7 Enablers and hindrances to RMC

A statement from the WHO calling on governments, healthcare institutions, and healthcare workers to avert and eradicate abusive treatment during facility-based childbirth has been endorsed by over 90 confederations.[36] These include the International Federation of Gynaecology and Obstetrics (FIGO) and the International Confederation of Midwives (ICM).[36] The vision is to ensure that every woman has the right to and able to access the highest attainable standard of healthcare, including the right to RMC.[37,38] Proposed measures to realise this noble vision are outlined in Box 2.2 below:

Box 2.2 Actions to prevent and eliminate disrespect and abuse during facility-based childbirth

- Greater support from governments and development partners for research and action on disrespect and abuse
- Initiation support and sustenance of programs designed to improve the quality of maternal health care, with a strong focus on respectful care as an essential component of quality care
- Emphasising the rights of women to dignified, respectful health care throughout pregnancy and childbirth
- Generating data related to respectful and disrespectful care practices, systems of accountability and meaningful professional support are required
- Involvement of all stakeholders, including women, in efforts to improve quality of care and eliminate disrespectful and abusive practices

In support of the above action measures, several studies investigating the enhancers and barriers to RMC have been conducted globally.[7,39] One of the studies, conducted in Liverpool in 2021 looked at barriers and enablers to RMC in underdeveloped as well as developing countries.[43] From the study, enablers to RMC included positive, mutual and supportive relationships between women and their caregivers i.e. welcoming attitude, provision of appropriate information, swiftness of care, treatment with dignity, psychological support and, privacy and confidential care. These are all grounded within

the endorsed actions (Box 2.2) to prevent and eliminate disrespect and abuse during facility-based childbirth.[41] The study further highlighted the barriers to the realisation of RMC which include, poor interpersonal relationships, lack of support (poor communication) non-consented care, stigmatisation, injustice, discrimination, physical abuse, lack of psychological support, breach of confidentiality and privacy.[43]

It is evident from the above literature that provision of quality maternity care requires more than just access to medicalised services. Respectful and inclusive care is a critical component of the provision of quality care – care that is clinically safe, emotionally, psychologically, and culturally acceptable to women and their families. This means that care must include respect, taking into consideration the public knowledge and values and be customised to meet women's needs and, most importantly, must be provided by health workers who can incorporate interpersonal and cultural competencies into their daily clinical duties in all health systems in every country.

2.8 Conclusion

This chapter provided a focused review of the literature on abuse and disrespect in maternity units, their impact on maternal health, and the importance of RMC in improving women's health and reducing maternal mortality. The next chapter focuses on the methodology used in this research.

CHAPTER 3: METHODOLOGY

3.1 Introduction

The previous chapters discussed the problem statement, the purpose as well as the literature supporting the primary enquiry of this research. This chapter presents a comprehensive account of the steps and procedures taken in the collection and analysis of data including the underlying philosophical assumptions. The chapter begins with a discussion on the research paradigm followed by research design. The focus of the remaining sections is on the study sample, sampling procedures, methods of data collection and analysis, trustworthiness, strengths, and limitations, culminating to a conclusion.

3.2. Research paradigm

Research paradigm can be regarded as the researcher's beliefs and assumptions about the nature of reality and ways of studying it.[44] Research paradigm provides a philosophical framework that guides researchers in choosing research topics, formulation of research questions, selection of research design, choice of data and data sources, data collection, and, data analysis tools.[44] A research paradigm is made up of three principal components, namely, ontology, epistemology, and methodology.[44,45] Ontology refers to the nature of reality and epistemology is all about ways of acquiring knowledge, including the relationship between the method and the researcher.[46] Methodology refers to the method that researchers use to conduct research.[46,47]

There are many research paradigms but four (positivism, interpretivism, transformative and pragmatism) seem to dominate research papers. These are summarised in Table 3.1

Table 3.1 Summary of the four research paradigms or worldviews (Creswell[44])

Research paradigm	***Postpositivism***	***Interpretivism/ Constructivism***	***Transformative***	***Pragmatism***
Ontology	There is a single objective reality that is independent of social construction	There is no single reality. reality is multiple, subjective, and socially constructed.	Reality is political and social oriented	Reality is both external and constructed
Epistemology	Knowledge is derived only from observable data which can be used to establish cause and effect as well as generalisation.	Knowledge is co-constructed from multiple realities that are embedded in human existence	No uniform body of literature. It focuses on lives and experiences of marginalized groups	Knowledge is generated through objective and subjective means.
Research methodology	Quantitative	Qualitative	Mixed	Mixed

This study sought to explore subjective views perspectives of a multidisciplinary team of healthcare providers on RMC and as a result the study is informed by the interpretivist/ constructivist research paradigm.

3.3 Research design

The study aimed at exploring the perspective of a multidisciplinary team of healthcare providers working in a specialised mother and child academic regional hospital on RMC. An explorative, descriptive, contextual qualitative study design with the adoption of the phenomenological perspective as a measuring strategy proved to be the most appropriate study design.

3.3.1 Explorative studies

Explorative studies are conducted on research problems where there are limited or no earlier studies to rely upon or to refer to.[47] The explorative methodology was chosen because it employs an open, amenable, and inductive approach to research as it seeks to look for new insight into phenomena,[47] in the case of this study, RMC. This study aimed at gaining insight into healthcare providers' perspectives on RMC through exploration (few studies on RMC have been done in South Africa and furthermore, none were done at this specific or similar study setting).

3.3.2. Descriptive studies

Descriptive studies aim to describe a phenomenon without providing a causal explanation.[48] Descriptive studies use variables to answer the research question and they are mostly concerned with the collection of information from a representative sample of the population. Data collection in descriptive studies is carried out using interviews, structured observations, and/or questionnaires.[48] This study is descriptive because it sought to obtain un-interpreted descriptions of health care providers' perspectives on respectful maternity care only through the analysis of their viewpoints.

3.3.3 Contextual design

A Contextual design refers to research conducted in the natural setting. It involves physically going to the participants to conduct the interviews, making observations, and recording behavior in the natural setting where the phenomenon under study unfolds.[41] One of the canons of qualitative research is to understand the context within which participants act and behave and by so doing attempts to capture and understand the phenomenon in its entirety. The study was contextual because it was conducted in specialised mother and child academic regional hospital where the study participants were supervising and directly rendering maternity healthcare services.

3.3.4. Phenomenological approach

A phenomenological approach aims at exploring the manner through which people perceive and interpret a phenomenon and the world.[48] Its critical aspect is that researchers need to shelve their personal views about a phenomenon of interest and seek to understand it through the perspectives of study participants. The aim is to demonstrate that there is an underlying unifying meaning of experience that is invariant and unites all people concerned despite the unique personal experiences that each has about the phenomenon.[48] A phenomenological perspective was adopted with the use of semi-structured interviews to seek an understanding of different health care providers' perspectives on respectful maternity care with the intent of eventually generating a unified understanding of these perspectives which are invariant and common among participating health care providers.

3.3.5 Qualitative research method

The qualitative research method involves a comprehensive and verbal description of cases, people, study settings, or systems obtained through the interactions, conducting interviews and/or, observing the study subjects. It uses research approaches that seek to gain insight into the phenomenon of interest using verbal data rather than calibrated instruments.[47] Qualitative research uses multiple methods that are interactive and humanistic.[48] Hickson further maintains that the strength of the qualitative method is in its way of acquiring knowledge that helps illuminate the object of enquiry.[48] Qualitative research generates more in-depth and more complete information.[47] This is achieved through the collection of subjective information generated from participants' subjective accounts of their personal experiences, researcher's observation of the phenomenon

and context which is used to generate deep and rich materials that aid in the understanding of the phenomenon and the entire situation.[47]

3.4. Study Setting

The study was conducted at Rahima Moosa Mother and Child Hospital (RMMCH), formerly known as the Coronation hospital. RMMCH is a specialised mother and child academic regional hospital located in Coronationville, Gauteng, South Africa. It was renamed after Rahima Moosa who was an anti-apartheid stalwart involved in the 1956 women's protest against passes for non-white women.[49] The hospital opened in October 1944 to serve local communities of Newclare, Noordgesig, and Coronationville. Its catchment area expanded to include Primville, Orlando, and Sophiatown in 1955.[49]

In 1995, all obstetrics and Gynaecology departments were moved from Helen Joseph hospital to RMMCH. It is one of the regional hospitals falling under the CMJAH cluster and the Cluster C in the School of Clinical Medicine at Wits (Family Medicine, Obstetrics and Gynaecology and Paediatrics. It is the only specialised mother and child hospital in Gauteng and one of the only two in South Africa.

This hospital was chosen as a study site because the hospital it proved to be an ideal study environment to study the healthcare providers' perceptions of RMC because of several reasons: (1) It is one of the only two dedicated mother and child hospitals in South Africa (the other one being Mowbray Maternity Hospital in Cape Town), (2) It is one of the busiest regional hospitals in Johannesburg, South Africa, delivering approximately 15 000 women per annum,[50] (3) Even though it is a regional hospital, RMMCH caters for low risk as well as high-risk women who could qualify to deliver in midwife obstetric units and tertiary hospitals respectively, mainly because of inadequate healthcare facilities

3.5 Data collection

3.5.1 Study population

The study population is the group of interest that has the characteristics set out in the inclusion criteria of the sample of interest.[51] The target population was health care providers supervising and rendering direct maternity services at RMMCH, some of which have worked in other hospitals as part of the registrar rotation.

3.5.2 Study sample

This is a subgroup of the population that is selected for the purpose of a study and the elements of a sample are called the participants.[51]

The sample comprised of health care providers supervising and rendering direct maternity services at the selected hospital (including those who have been rotating in other academic hospitals as part of registrar training), who have been providing maternity care for a minimum of two years. The chosen years of experience have been proven to be adequate for one to be a productive provider in terms of knowledge and skills required for rendering safe services.[52]

3.5.2.1. Inclusion criteria

Inclusion criteria refer to certain characteristics that are preselected and predefined by the researcher. These characteristics must be possessed by each participant in order to be included in the study.[51] The inclusion criteria for the study are summarised in table 3.2 below.

Table 3.2 Inclusion criteria

Element	Criterion
Participants	Managers/supervisors, Obstetricians, and Midwives providing maternity services at the study site.
Language	English
Work	Study site
Years of experience	Two or more years consistently in maternity units

3.5.2.2. Sample size

In qualitative research, Vasileiou[53] proposed that sample size determination must be determined using the criterion of informational redundancy. By informational redundancy the author meant that sampling should stop when further sampling no longer generates new information. Van Rensburg et al.[54] further emphasise that purposive sampling involves continuous sampling until the researcher obtains no new information. In this study the sample size was not predetermined instead the sample size was guided by saturation which was reached after interview engagements with 25 maternity care providers. Five more interviews were conducted to verify that indeed saturation was reached and to compensate for any recording-related mishaps.

3.5.2.3. Sampling technique

Sampling in qualitative research is relatively limited and is based on saturation and representation, not merely on statistics.[48] The number of participants for this study was not specified but was dependent on data saturation. Purposive sampling was used as a sampling strategy to consciously include those who meet the inclusion criteria (see Table 3.1).

Purposive sampling is a non-probability sampling method commonly used in qualitative research, which involves a deliberate selection of certain participants that are judged to be representative of the total population and able to provide insight into the phenomenon of interest.[48,51]

The researcher requested and collected a list of names of all maternity care providers from the Clinical Head of the Department Obstetrics and Gynaecology and the Nursing Service Manager of RMMCH. The researcher then visited healthcare providers individually to explain what the study was all about, what participating in the study would entail, to answer questions they had and finally, invited them to participate. An interview date was then set with those who volunteered.

3.6 Research techniques

The purpose of a research technique is to select a method by which the researcher can obtain the information of interest.[48] The study utilised semi-structured interviews to collect data.

3.6.1 Semi-structured interviews

in qualitative research, a semi-structured interview is the most commonly used method of data collection in health services research.[48,51] Semi-structured interviewing involves an interactive conversation between a researcher and the study participant. This process is guided by an interview guide that can be modified when required, supplemented by follow-up questions, probes, and comments.[51] The method allows the researcher to collect open-ended data, explore participants' viewpoints, their personal experiences and feelings, beliefs regarding both the subject of interest and assist in gathering rich data which might involve delving into deep personal and sensitive matters.[51]

Interviews were conducted with purposively selected maternity care providers working in RMMCH until data saturation was reached. A series of open-ended questions were used to elicit the required information (see interview guide attached as Annexure A). In qualitative research, open questions are commended as they encourage participants to express ideas, suggestions, attitudes, opinions, and emotions in their own words.[51] Participants were interviewed at a time of their convenience. They were asked to communicate in English as it is the language of communication at the study site. The purpose and process involved in the study were once more explained to each participant before participating in the interviews. Each participant was once more given an opportunity to ask questions or seek clarity. Each interview was digitally recorded after obtaining permission from each participant. Each interview lasted between 25 to 60 minutes.

The researcher used verbal communication strategies such as probing, paraphrasing, and reflecting during the interviews to encourage the participants to elaborate more on their views about RMC.

The digital recordings were transcribed verbatim. Data collected reached saturation after 25 interviews however the researcher proceeded to conduct five more interviews

which resulted in a total of 30 interviews to ensure that informational redundancy was reached and to mitigate against loss of some of the interviews.

The researcher made use of communication methods and therapeutic skills such as showing empathy, reflection, probing, and clarifying during interviews.[52] Furthermore, the researcher took field notes on her observation of participants' non-verbal communication. This information formed part of the analysis.

- **Empathy**

Uys and Middleton[55] describe empathy as a feeling of another's true emotions to a point where the empathetic person can relate to that person by sensing true feelings that run deeper than those portrayed on the surface. Terre Blanche, Durrheim, and Painter[47] agree that empathy is a 'feeling with' a person or situation and placing oneself 'in their shoes'.

- **Reflecting**

The researchers listened actively to verbal messages and observed non-verbal messages from the respondents and conveyed the feelings that were not explicitly expressed by reflecting back to them like: "It makes you frustrated, does it?" The main task in interviewing is to understand the meaning of what is said thus registering and interpreting what is said as well as how it is said.[55]

- **Probing**

Probing is a verbal or non-verbal way of eliciting more from the participants.[48] Probing on the research question encourages the participants to elaborate on the topic that is being discussed. It should only be done when there is an indication that the participant has become comfortable with the situation and is not likely to be threatened by the questions.[48]

- **Clarifying**

Clarifying is a verbal communication technique that involves the researcher's synthesis of the speaker's message and communicating back to them what the researcher understands to be the core message coming from the conversation that their understanding is accurate.[55]

3.6.2 Pilot study

A pilot study is defined as a small-scale version of the proposed study that is carried out to refine the research methodology.[48] A pilot study was conducted on two providers who met the inclusion criteria, one working at RMMCH and one placed at CMJAH who rotated in the cluster. The purpose of the pilot was to test the research question and the data collection method. Furthermore, the pilot study was conducted to ensure that the researcher was able to communicate with study participants in a manner that enabled the accurate collection of data.

3. 7 Data management

The researchers followed the advice of Field and Morse[56] regarding the safe storage of the transcriptions and other data material. One more copy of each transcript was made from which the researchers worked on for analysis, and the original copies were printed and placed in a password-protected document storage box and stored in a safe to safeguard against losing the data completely in case of unforeseen circumstances. Burns and Groove[51] caution that once an interview is transcribed, the transcript becomes a source of raw data for the study.

An electronic file was created for each participant's digital recording, field notes, and transcript. A label to identify the source of the data (by allocating alphabets to participants) was attached to each file to make it easier for the researcher to identify the source of information during member checks. All the files were stored in a password-protected personal computer.

3.8. Data analysis

Data analysis is the process of transforming data into research results.[57] The researcher initiated the process of data analysis through bracketing which refers to the removal of all preconceived expectations about the phenomenon of interest.[48]

Tesch's Constant Comparative method of qualitative data analysis was adopted.[58] Data was repeatedly read and comments were made in margins where data was considered important. Topics that emerged were given codes, which were written next to each topic to allow for easy retrieval of data. Topics were then turned into categories,

which allowed the grouping together of similar data.[55] Under each category emerged subcategories. After completing the above steps, important verbatim quotations were identified for inclusion in the report. One transcribed interview has been attached as Annexure B.

Table 3.3: Tesch's Constant Comparative steps of data analysis (Tesch[58])

Steps	Description
I	The researcher starts by reading all the transcripts meticulously to get a general understanding of the whole
II	The researcher picks one most interesting interview document, read through it, and try to find underlying meaning from the information.
III	The researcher then identifies similar topics to be clustered together and topics that are contrary to the emerging themes will be listed.
IV	The researcher assigns codes to the topics and reduces the topics by grouping them.
V	Describing words are then sought for the topics and interesting and unusual quotes will from participants' interviews be selected.
VI	Final codes are attached to each category of data
VII	The researcher then assembles the data material belonging to each category in one place and start on the preliminary analysis
VIII	The researcher recodes the existing data if necessary

3.9 Engaging a co-coder

An independent, experienced qualitative researcher was engaged to co-code the data. The transcriptions together with field notes and the study protocol were sent to the co-coder for analysis. The researchers and the co-coder met to have a consensus discussion of their independent findings and agreed on the identified categories, themes, and subthemes.

3.10 Trustworthiness

Qualitative research approaches have been criticized for lack of rigor and credibility. Both reliability and validity are put into question since the homogeneity of data and coefficients of determination cannot be computed.[59] Lincoln and Guba[60] developed four precise criteria for qualitative inquiry that parallel the quantitative terminology:

- Credibility (internal validity): How truthful are particular findings? The researcher in the study ensured the truth of the perceptions of healthcare providers by dwelling long in the setting. Each interview lasted between 25 to 60 minutes and the interviews were conducted in a natural setting at RMMCH.

- Applicability (external validity): How applicable are the research findings to another setting or group? The study results cannot be generalized however the researcher enhanced applicability by safeguarding all data transcripts, audio recordings, and the consensus established with an independent coder. The data is therefore a true reflection of the view of the participating healthcare providers and these views can be tested in other settings.

- Dependability (reliability): Are the results consistent and reproducible? A pilot study was conducted with two participants before the main study to enhance consistency. The results of the analysed pilot data were not used in the main study.

- Confirmability (objectivity): How neutral are the findings in terms of whether they are reflective of the informants and the inquiry, and not a product of the researcher's own biases and prejudices? To adhere to the criterion of objectivity, the researcher gave the completed study report to five of the participants to read and verify its truthfulness.

3.10.1 Measures to enhance credibility

Brink[61] describes credibility as the truth of findings according to those being observed. Credibility in this study was enhanced by:

3.10.1.1 Prolonged engagement

According to Brink[61] prolonged engagement is necessary to form rapport and to build trust in participants.

The researcher spent time with the participants after the interview sessions, talking about general maternity care trends and challenges. Although prolonged engagement in some ways leads to an emotional bond, it allows for a more naturalistic observation of especially non-verbal communication.

3.10.1.2 Triangulation

Triangulation entails collecting material in as many different ways from as many diverse sources as possible.[47] It is an attempt to map out or explain more fully the richness and complexity of human behavior by studying it using different methodologies.[47] In this research there was a variety of data sources i.e., interviews, observation, and field notes.

3.10.1.3 Member checks

After analysing the data, formulating categories of themes, interpretation, and conclusion, the researchers went back to five of the participants from whom data were originally collected to establish the correctness of the interpretation and value of the research. From these member checks, the researchers made some necessary amendments to the report.

3.10.1.4 Peer Debriefing

The researchers made use of an independent coder to co-code the transcribed data, to provide new perspectives on analysis. The researchers analysed the data independently from the coder and thereafter came together to compare the categories and to reach a consensus. The researchers worked under the guidance of her supervisor from beginning to end.

3.10.1.5 Authority of the researcher

The researcher has completed a course in research methodology, including design and analysis. She is also a trained general psychiatric nurse and an experienced midwife which certifies her competency in using valuable communication skills during the interviews, which facilitated trust and cooperation from the participants.

3.10.2 Applicability

Brink, Van Der Walt and Van Rensburg[61] describes applicability as the probability of findings of the study to have meaning to others in the same situation. A purposive/convenience sample was selected to ensure that participants meeting the same criteria in other situations would elicit similar responses. Qualitative studies are conducted in naturalistic settings and the situation is unique in each instance thus their findings cannot be generalised.[57]

3.10.3 Dependability

To adhere to the criterion of dependability, the researcher conducted a pilot study before the main study. Thereafter the researchers conducted individual interviews until saturation of data was reached. Then the similarity and variability of the participants' perspectives on RMC were sought thereafter.

3.10.4 Confirmability

The researcher met the criterion of Confirmability by employing "prolonged contact.[60] Each interview and observation lasted between 25 to 60 minutes. Another strategy that was used to enhance confirmability is data triangulation (interviews, observation, and field notes).

3.11 Ethical considerations

Burns and Grove[51] warn that the conduct of health care research requires not only expertise and diligence but also honesty and integrity. Written permission to conduct the study was sought from the selected hospital authorities. Ethical clearance was granted by the Faculty of Health Science Ethics Committee of the University of the Witwatersrand (M210408) before the commencement of data collection. Informed consent was obtained from all participants by explaining the goals of the study, the possible advantages, disadvantages of participating, the credibility of the researchers, and audiotaping the interviews. The participants were assured of confidentiality, anonymity, and the freedom to opt out of the study at any stage without negative consequences. The study was also registered with the Gauteng Human Research database (GP_202103_017).

3.12 The quality of the study

The researcher tried at all times to respect the rights, needs, values, and desires of the participants. An honest explanation of the plan and the intended study was given; the researcher answered and clarified the participants' questions and responded to their expectations. Furthermore, the researcher tried at all times to put aside all her beliefs, values and biases that would interfere with the integrity of the study. Sincerity was adhered to at all levels of the study through the guidance by the supervisor.

3.13 Limitations of qualitative method

Mayan[62] notes that the qualitative research design has its critics, she notes a few limitations observed in this method by the critics:

- The subjectivity of the inquiry in qualitative research leads to difficulties in establishing the reliability and validity of the approaches and information.
- It is very difficult to prevent or detect research-induced bias.
- Its scope is limited due to the in-depth, comprehensive data gathering approaches required; and the findings cannot be generalized to other contexts.

Due diligence was however made to ensure credibility of the study as discussed above. Furthermore, the study was conducted in one setting at a given period in time and therefore cannot be generalised. The study did not include exploring experiences of pregnant women delivering in this institution or direct observation of maternity deliveries which would have been useful in terms of establishing whether the healthcare providers' knowledge of RMC translated into practice.

3.14 Conclusion

The research design and the steps taken to collect and analyse research data, the underlying philosophical assumption in the form of research paradigm as well as justification for the choice of research methodology , including the steps taken to collect data were presented in this chapter. The results are discussed next.

CHAPTER 4: RESULTS

4.1 Introduction

The research design and the methods of data collection and analysis followed in this study were discussed in the previous chapter. This chapter presents the study's main findings which include an analysis of the researcher's field notes.

4.2 Description of the sample

A total of 30 maternity healthcare providers took part in the study. The mean age of the study cohort was 37 years, the youngest and oldest participants were 25 and 57 years old respectively.

The majority of the participants were nurses (19, 63.3%), females (17, 56.7%), and had work experience of between 2 and 20 years (22, 73.3%). Half of the participants were midwives (15, 50%) and the majority of the doctors (7, 63%) were specialists in training or registrars. The majority of the participants (22, 73.3%) were therefore healthcare workers who were directly involved in rendering clinical maternity services and the rest (8, 26.7%) were supervisors in the maternity unit. Table 4.1 summarises the demographic characteristics of the study participants.

Table 4.1: Demographic characteristics of the sample (N=30)

CHARACTERISTICS	CATEGORIES	ACTUAL NUMBERS	PERCENTAGES
Age	25-35 years	14	46.7%
	35-45 years	11	36.75%
	45-55years	4	13.3%
	> 55 years	1	3.3%
Gender	FEMALE	17	56.7%
	MALE	13	43.3%
Qualification/Position	Basic Midwives/Accoucheurs	7	23.3%
	Midwife specialists	8	26.8%
	Operational managers	4	13.3%
	Registrars	7	23.3%
	Consultants	4	13.3%
Years of experience	< 2 years	0	0%
	2-10 years	15	50.0%
	10-20 years	8	26. %7
	20-30 years	6	20.0%
	> 30 years	1	3.3%

4.3 Findings

Two main categories each with its own themes and subthemes emerged from the study. This makes it a total of seven themes and twelve sub-themes. The first category, 'Healthcare workers' perceptions and attitudes on RMC', has three themes and nine subthemes while the second category, 'Conditions that promote the practice of RMC. Has four themes and three subthemes. The categories, themes subthemes, including the instances in which the themes and subthemes came up during the interviews are tabulated in Table: 4.2.

Figure 4.1 Providers' understanding and enabling conditions that promote the practice of RM

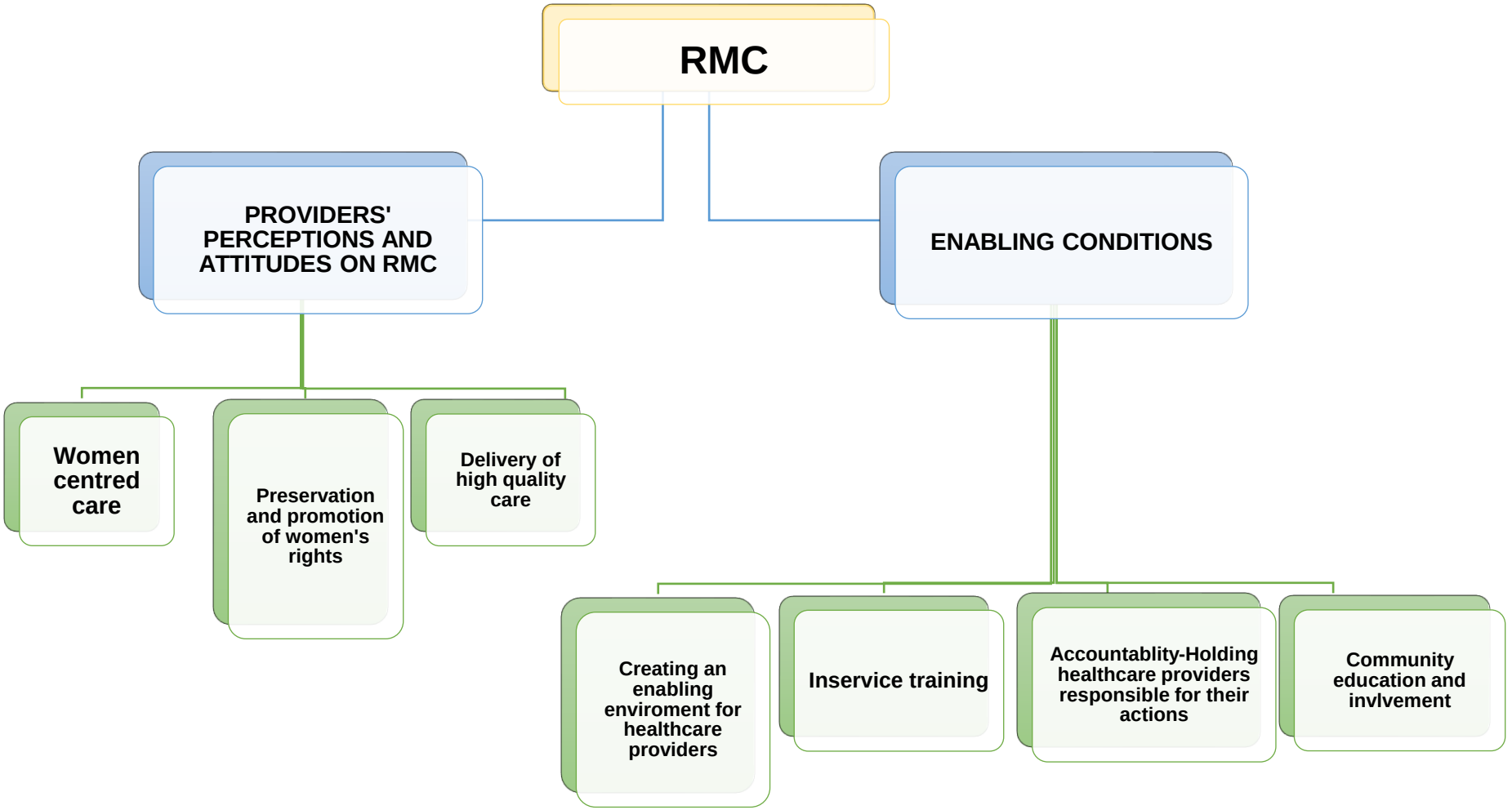


Table 4.2 The categories, main themes, and sub-themes derived from perspectives of RMMCH providers on respectful maternity care

CATEGORY	THEMES	SUB-THEMES	NUMBER OF INSTANCES EACH THEME OR SUB THEME CAME UP DURING THE INTERVIEWS (N = 30}
PROVIDERS' PERCEPTIONS AND ATTITUDES ON RMC	**Women cantered care.**	*Holistic care*	*30*
		Multidisciplinary approach	*28*
		Allowing companionship/support during labour	*18*
		Empathy and support	*22*
	Providing high quality of care	*Individualized care*	*28*
		Adherence to professional practice and professionalism	*15*
		Practicing evidence-based care: Avoiding unnecessary interventions	*18*
	Preservation and promotion of women's rights	*Ethical and dignified care*	*29*
		Respecting women's cultural rights	*24*
ENABLING CONDITIONS	**Creation of an enabling environment for healthcare workers**	*Supervisory support and involvement*	*30*
		Provision of a safe working environment and employee wellness programmes	*30*
		Availability and equitable distribution of health care resources	*30*
	In-service education		*21*
	Accountability: holding healthcare workers responsible for their actions		*15*
	Community Education and involvement		*20*

4.3.1 CATEGORY 1: PROVIDERS' PERCEPTIONS AND ATTITUDES ON RMC

Majority of participating healthcare workers had positive attitude towards RMC. They saw RMC as a tool that can (1) assist in building rapport between patients and healthcare workers (2) promote cooperation between patients and healthcare workers (3) if practiced, improve patient outcomes including reducing maternal deaths, (4) provide support to patients with anxiety, emotional and social problems and (5) assist providers to deliver quality maternity care and adhere to standards of maternity practice..

The above is supported by the themes that emerged under providers' perceptions and attitudes on RMC which are: women centered care, provision of high quality of care as well as preservation and promotion of women's rights

4.3.1.1 Theme 1: Women centered care.

The theme, *women centered care* included four sub-themes namely: holistic care, multidisciplinary approach, allowing companionship or support during labour as well as empathy and support. These are discussed in detail below:

- **Holistic care**

The healthcare providers believed that RMC should not only focus on the clinical needs of the women but believed that the psychosocial, cultural, and spiritual aspects of childbearing should be incorporated into the care that is provided to women including involvement of families, communities, as well as the public at large as seen in the quotation below:

> "*It is not just the medical management from an obstetrics perspective, but also bringing in the psychological and emotional as well as socio-cultural support that a pregnant woman needs"*
>
> *(41-year-old, Consultant, 16 years of experience in maternity care)*

- **Multidisciplinary approach**

Most providers stated that the realisation of RMC cannot be achieved by only an individual or a specific team such as midwives alone. RMC require involvement of all stakeholders (in and out of maternity care facilities) who must work together with the women to ensure that all women's needs are met as doing so would improve the overall childbearing outcomes.

> *"RMC is all about being aware and acknowledging that there are role-players involved in our daily duties as maternity service providers. Being a trained professional does not mean I know and can solely accomplish everything. Most importantly my patients also need to give their view on what I do for them or to them."*
>
> *(52-year-old, Operational manager, 30 years of experience in maternity care)*

- **Allowing companionship/support during labour**

Some providers especially midwives, voiced that allowing companionship during labour and being available to support the women, are some of the critical interventions that can reduce adverse pregnancy outcomes.

> *"So, I think most of our negative experiences and outcomes that we get in our unit can be easily corrected by a simple respectful approach, allowing women to be with their preferred companions during labour and always being there with and for labouring women. Besides. "midwife" simply means being with a woman."*
>
> *(35 -year-old, midwife specialist, 12 years of experience in maternity care)*

- **Empathy and support**

The majority of the participating healthcare providers viewed RMC as empathetic and supportive care and described such care as guaranteed compassionate care and non-humiliating treatment for women seeking maternity services regardless of their social, cultural, and religious background.

> "*Me, as an individual, if I was in a patient's shoes, I would really want to be treated with respect and given proper care regardless of who I am or where I*

come from, so it makes sense, and it is appropriate that we do the same for our patients."

(*(31-year-old, midwife specialist, 9 years of experience in maternity care)*

"Respectful maternity care is all about empathy and quality care. It is about treating patients with respect , gentleness, and then communicating with them. I think those are the most compassionate things really. A lot can happen so over and again you need to reassure the moms by communicating with them, how far they are dilated, what is the next thing to do etc."

(26 -year-old, midwife, 4 years of experience in maternity care)

4.3.1.2 Theme 2: Provision of high quality of care

Provision of high quality of care had three aspects: Individualised care, adherence to professional practice and professionalism as well as practicing evidence-based care.

- **Individualised care**

The majority of participant maternity care providers stated that women seeking maternity care services should be individualised and must take into consideration the women's unique needs, beliefs, and cultural backgrounds.

"I think that it is very important to give respect and treat pregnant women as human beings with specific needs, just like you and me. And they should also be respected in their cultural beliefs and practices."

(31-year-old, basic midwife, 5 years of experience in maternity care)

- **Adherence to professional practice and professionalism**

Adherence to professional principles emerged several times during interviews of both participant obstetricians and midwives.

"Respectful maternity care involves respecting your profession, as we are professional midwives, we are governed by the SANC that we need to respect and adhere to the stipulated regulations governing us and it also goes to respecting the patients and the patients' rights that are stipulated in the Constitution of our country, as well as just respecting the patient as a human being. So, RMC is considering and in cooperating all those aspects in our daily duties."

(35 -year-old, midwife specialist, 14 years of experience in maternity care)

- **Practicing evidence-based care: Avoiding unnecessary interventions**

Some providers emphasised that the mindset of "It has always been done like this" no longer has a place in modern maternity practice instead healthcare providers should adopt scientifically proven interventions to achieve good maternal and perinatal outcomes.

"So, we have a lot of old myths and practices, in both medicine and nursing and this is something we need to stop. Unfortunately, youngsters coming into the healthcare profession copy these and regard them as normal and acceptable. I think continuous teaching of both our older and younger population, within and beyond the maternity field, on what is scientifically proven is the way to go'"

(38 -year-old, consultant, 14 years of experience in maternity care)

4.3.1.3 Theme 3: Preservation and promotion of women's rights

The third theme on providers' understanding of RMC was preservation and promotion of women's rights. Ethical and dignified care and respecting women's cultural rights emerged from this theme.

- **Ethical and dignified care**

Some providers described RMC as the provision of a safe environment that promotes healthcare-seeking behaviour and in cooperation of ethical principles such as

autonomy, beneficence, non-maleficence and always acting in the woman's best interest in the day-to-day running of maternity healthcare services.

> *"Respectful maternity care is affording childbearing women the opportunity or a safe measure in which they can seek health care when they need to, and respectfully by abiding by their autonomy, offering them non-maleficence and beneficence in terms of always making sure that whatever you provide to them is in their* best interest"
>
> *(48 -year-old, registrar, 12 years of experience in maternity care)*

- **Respecting women's cultural rights**

Healthcare providers' understanding of RMC included acknowledging the need to approach the provision of maternity services from a human rights perspective. They mentioned that women seeking maternity care services come from different socio-cultural backgrounds and therefore healthcare workers should always make sure that the women's physical, psychological, spiritual, and cultural rights are protected.

> *"My understanding of respectful maternity care is that it is the dignified approach or treatment that is being given or rendered to pregnant women, which promotes in cooperation of the whole charter of human rights. A whole in a sense that not respecting their physical rights only but also their psychosocial, spiritual and cultural rights."*
>
> *(27 -year-old, basic midwife, 7 years of experience in maternity care)*

> *"Well, I can say though that respectful care is not and should not be only clinical. Doing a vacuum-assisted delivery or doing a caesarean section is all clinical and it's taken from the protocol book, but the protocol book doesn't teach you how to incorporate women's socio-cultural and spiritual dimensions in your care. The healthcare worker, the patient, and other people such as families are*

supposed to work collaboratively to produce healthy mothers, babies and ultimately a healthy nation."

(39 -year-old, consultant, 15 years of experience in maternity care)

4.3.2 CATEGORY 2: ENABLING CONDITIONS

4.3.2.1 Theme 1: Creation of an enabling environment for healthcare workers

Creating an enabling environment for healthcare providers had three aspects namely: supervisory support and involvement, provision of a safe working environment and employee wellness programmes as well as availability and equitable distribution of health care resources.

- **Supervisory support and involvement**

All participant maternity healthcare providers stated that visibility of managers, supportive visits, and motivation by managers, have a direct impact on service delivery including the practice of RMC. In addition, providers pointed out that another issue that has a strong hold on whether RMC is practiced or disregarded is the availability of trusted confidential employee assistance programmes aimed at assisting employees in dealing with both non-work and work-related challenges.

"Managers, play a huge role towards the care we give for example, negative or non-constructive feedback from our managers creates unnecessary pressure on us and sometimes we feel intimated. Working under such pressure or situation is not good at all for our patients as we end up projecting our frustrations towards them."

(30 -year-old, basic midwife, 5 years of experience in maternity care)

- ***Provision of a safe working environment and employee wellness programmes***

Some midwives expressed the importance of employee wellness programmes as an enabler of practicing RMC:

> "*It is my recommendation that we get some form of wellness programmes which somehow allow people to express themselves freely when it comes to their professional and social issues - the workplace should be the safe environment for people to express their issues and get them sorted out if there is a way to. They say, "behind a healthy mother and baby is a happy midwife."*
>
> *(56 -year-old, midwife specialist, 33 years of experience in maternity care)*

- **Availability and equitable distribution of health care resources**

Most providers mentioned that management of human and material resources impacts the practice of respectful maternity care and service delivery in general.

> *"Rahima Moosa hospital has an overflow of patients, and we don't have as much space, staff, and equipment to accommodate large numbers all the time. So, I think we need urgent procurement of staff, stock, and equipment because it is frustrating and tiring for doctors and midwives to be unable to render the expected care with and witness unpleasant patient care outcomes because of close-to-zero resources. How is then a frustrated employee expected to deliver respectful care?"*
>
> *(26 -year-old, basic midwife, 4 years of experience in maternity care)*

4.3.2.2 Theme 2: In-service education

All participant providers emphasised in-service training as an important enabler of practicing RMC.

"I think in-service training programmes covering burning topics like RMC for both clinical staff and managers should be in place in all maternity care institutions because you would find that a lot of people might know about such, but they don't actually understand it. The more people know about concepts such as RMC through regular talks and teachings, the greater the chances of practicing it."

(53 -year-old, operational manager, 20 years of experience in maternity care)

4.3.2.3 Theme 3: Accountability: holding healthcare workers responsible for their actions

Some providers expressed that when they entered the medical and nursing/midwifery fields, they pledged that they would carry out their duties with respect and abide by the regulations governing their profession.

"*The core of our daily duties as midwives is to provide equal, supportive, and non- humiliating treatment to women presenting at our facilities regardless of their social, cultural and religious background. Failure for healthcare providers to practice the above should be a disciplinable offense. Incidents of disrespect and disciplinary measures should not be treated as "under the carpet" matters so that all maternity service providers can learn that there is no room for disrespect in our facilities."*

(35 -year-old, registrar, 12 years of experience in maternity care)

4.3.2.4 Theme 4: Community Education and involvement

Most providers considered education and involvement of communities on childbearing issues and safe maternity practices as significant for the successful realisation of RMC.

"So, communication and education are major keys, I can say that most of our maternity care problems are related to lack of information in the communities. The public needs to be informed of the different levels of care and services available at each level. For example, a woman who has had a previous

caesarean section delivery needs to know that she cannot be assisted in an MOU when in labour."

(44 -year-old, basic midwife, 18 years of experience in maternity care)

Some providers believed that poor maternity care outcomes were much less in olden days compared to now because community members were highly involved in supporting women throughout the perinatal period.

"*I mean if we look at childbirth at the time of our great grandmothers, delivering babies was a community effort and so the holistic approach was there. You know certain cultures like in my own culture your mom, your mom in law and all other women experienced in childbirth processes and practices would come together to assist - you would deliver, you would have, a special type of bath and rituals to ensure that you and your baby are safe and healthy*."

(35 -year-old, midwife specialist, 10 years of experience in maternity care)

4.4 Field note

Hickson[48] considers taking field notes as an act of immersing oneself in the actual set of events to gain first-hand knowledge of the situation.

Written accounts of all things heard, seen, experienced during collection and reflection on the data were kept. These field notes were submitted to the co-coder for validation.

4.4.1 Observational and theoretical notes

Observational notes are descriptions of events experienced through watching and listening.[48] They contain the "what, how, and who" of a situation and contain as little interpretation as possible. On the other hand, theoretical notes represent self-conscious and controlled attempts to derive meaning from one or several observational notes.[48]

Observational and theoretical notes are tabulated in Table 4.3 in the interest of clarity. This tabulation was necessary to indicate that for each observational note, a theoretical inference was made.

Table 4.3: Observational and theoretical notes

OBSERVATIONAL NOTES	THEORETICAL NOTES
1. Most appointments for the interviews were rescheduled and some were completely canceled.	1. I interpreted this trend as suggesting that providers were aware of the disrespect and abuse happening where they practiced and were uncomfortable talking about them on record because of fear of being put on the spotlight.
2. Some of the female participants started getting emotional when they spoke about their understanding of RMC and disrespect and abuse (D&A)	2. This suggests that even though childbirth is not a permanent occurrence in a woman's life, the experiences of childbirth remain unforgettable in women's memories. Talking about RMC and D&A might have triggered some of the unpleasant encounters experienced by some female participant providers when they gave birth to their children.
3. Some providers had to be rechanneled back to the core subject of this study as they ceaselessly spoke about unsatisfactory working conditions they were faced with on daily basis.	3. This illustrated that providers might not be given opportunities to express themselves regarding their working conditions within the institution, so they used the interviews as a platform for talking about their dissatisfactions and debriefing.

4.4.2 Methodological Notes

Methodological notes are instructions to oneself, critiques of one's tactics and reminders about methods that might be fruitful.[63]

The study information sheets and consent forms for participation and digital recording were handed out to participants a few days or hours before the interviews to allow them to go through the content and seek clarity if they needed to. Participants were also informed that they could go through the above-mentioned documents with the researcher, if necessary, before the official interview sessions.

4.4.3 Personal Notes

These are notes about the researcher's reactions, reflections, and experiences.[63] The following are some of the personal notes that were recorded during the interviews:
Since the researcher is an operational manager of a labour ward in one of the Charlotte Maxeke and Cluster C institutions in the School of Clinical Medicine, at times, she had to sit with some of the providers long after the interviews were done to explain some of the things that they seemed not to understand about some maternity care practices other than RMC. They voiced out that it helped to talk to managers from other institutions about maternity care trends, practices, and challenges in general.

Secondly, the experience gained from the research study evoked in the researcher, a feeling that she, as a senior midwife and a manager should show more empathy, understanding and keep an open communication system with patients and staff as a way of keeping abreast of what maternity end-users and staff go through on daily basis.

4.5 Conclusion

In this chapter, the key findings from the study including the reflections of the researcher in the way of methodological and personal notes in line with common practices in the presentation of results from qualitative studies results were presented. A discussion of the study's main findings in the context of existing literature, recommendations, and study limitations are outlined in the next chapter.

CHAPTER 5: DISCUSSIONS, CONCLUSIONS, RECOMMENDATIONS, AND STUDY LIMITATIONS

5.1 Introduction

In the preceding chapter, the main findings from the study were presented. This chapter discusses these findings, outlines the limitations of the study as well as recommendations based on the research findings, summing up with the conclusion.

5.2 Discussion on the study's main findings

Maternal mortality is a useful indicator that is used to monitor the quality of maternal and general healthcare services as well as countries' progress towards achieving the United Nation's 2030 Development goals.[1] Despite the technological and socio-economic progress made in the 21st century, maternal deaths remains a global concern, raising question on the social commitment of government and also questions regarding the quality healthcare services that governments provide to their citizens.[27,64] Underdeveloped and developing countries are responsible for 94% of the global burden of maternal deaths and Sub-Saharan Africa and Southern Asia account for approximately 86% (estimated global maternal deaths, roughly two-thirds of those deaths occurring in SSA alone. Deliveries in hospitals that are conducted by skilled birth attendants are among key interventions known to be effective in reducing maternal deaths.[65]

However, women are unlikely to present in maternity units when in labour because of the attitude of healthcare workers and for fear of being subjected to obstetric violence or disrespect and abuse (D & A).[15,22] It has been suggested that the implementation of RMC in healthcare facilities would promote healthcare-seeking behaviour as well as encourage women to deliver in healthcare facilities. Delivering in a healthcare facility has been associated with a reduction in maternal mortality.[64] As a result RMC has been declared a standard of care for all pregnant women by the WHO.[9]

Seven themes and twelve subthemes emerged. The themes and subthemes fall under two categories, i.e. (1) healthcare workers' perception of RMC and (2) enabling conditions for the practice of RMC.

In terms of perceptions and attitudes, healthcare providers perceived RMC as an important and critical component of maternity practice that should be encouraged and practiced. Their understanding of RMC focused on three key areas: (1) women-centered care, (2) provision of high-quality care and, (3) preservation and promotion of women's rights. Healthcare providers understood women-centered care to be a holistic (takes into consideration physical, emotional, spiritual, cultural factors/needs) care approach that is delivered by a multidisciplinary team in an empathetic and supportive manner. The support is provided by both healthcare providers and labour companions. The second theme, 'provision of high-quality care' focuses on the provision of maternity healthcare that is individualised, based on available evidence and best practices, avoiding unnecessary interventions, adherence to professional practice and delivered in a professional manner. The third and final theme in this category uses a Human Rights framework and talks to healthcare providers' obligation to preserve and promote women's rights which involves but is not limited to always acting in an ethical and dignified manner as well as respecting women's cultural rights.

The healthcare providers' perceptions and attitudes on RMC reported in this study are in line with the published literature on the topic and therefore encouraging. A 2019 Rwandan study, which investigated the perceptions and attitudes of midwives towards the provision of RMC during childbirth, found that majority midwives had positive attitude towards RMC, and they perceived RMC as an act of respecting women's underlying rights.[8] Another study conducted by Moridi et al[66], which explored the perspective of Iranian midwives, found their perspectives to revolve around three themes: women-centered care, empathy, and protection of women's rights. This study had subthemes that included protecting women's dignity, supporting them in labour, creation of a safe labouring environment including women in decision making, among others.

The provision of quality maternity care also came out as a descriptive feature of RMC. Quality of care, in this case, referred to both the technical (technical competence of providers and evidence-based care) as well as emotional (women's experience of care). These are elements of care that are outlined in the WHO quality of care framework.[67] Healthcare providers in this study emphasised that the provision of substandard care services is some form of disrespect which is likely to discourage women from seeking maternity care in the future. There is evidence in support of this view. Studies done in Guinea, Tanzania, and South Africa emphasised the impact of poor quality of maternity care (often a result of lack of resources, inadequately skilled birth attendants, and poor working conditions for health providers) on women's experience of care.[65,68,69] This situation leaves them with the feeling that their care preferences were disregarded and dismissed. They therefore feel vulnerable and neglected, resulting in them concluding that the care that healthcare workers provide is not in theirs or their babies' best interest. Consequently, they vote with their feet in future pregnancies.[70]

Healthcare providers also expressed a view that RMC is founded on the human rights principle the focus of which is on the preservation and promotion of women's rights. They described RMC as the provision of consensual care with in-cooperation of ethico-legal principles into day-to-day maternity practice while acknowledging and understanding that women come from different socio-cultural backgrounds comprised of various support structures, which influence their decisions regarding childbearing matters. This is supported by the Respectful Maternity Care Charter developed by the White Ribbon Alliance in 2011,[37] which clarifies and vividly articulates the rights of women and newborns while receiving maternity care within healthcare facilities. These are rights to freedom from harm and ill-treatment, confidentiality and privacy, dignity and respect, equality, freedom from discrimination and equitable care, timely and highest attainable level of healthcare, liberty, autonomy, self-determination, and freedom from oppression and lastly information, informed consent, and refusal, as well as the respect of personal choices and preferences, including companionship during maternity care.[37]

Various studies that investigated the childbearing women's experiences validated the perceptions of maternity service providers. They indicated that the encounters of childbearing women are multifactorial, and women attested that they need more humanised rather than medicalised maternity care.[5] The study's findings are also in line with the 12 domains of RMC outlined by Shakibazadeh.[39] Perhaps what is not explicitly expressed by the healthcare providers in this study are domains of privacy and communication. This is an important omission given the critical role that privacy and communication play in the delivery of healthcare services. This is even more important given South Africa's cultural diversity and the high number of women of foreign origin who might not be able to speak local languages that are reported to be delivering in this institution.

In addition to the above-mentioned findings healthcare providers strongly expressed their perceptions about the enablers that could drive the successful realisation of RMC. The foremost enabling condition was the creation of an enabling and supportive environment for maternity service providers. Participating maternity healthcare providers believed that the establishment and maintenance of an enabling and supportive environment strongly lie with the management teams of maternity healthcare facilities. They further expressed that such an environment can be accomplished through supervisors' or managers' visibility, involvement, and support in clinical areas as well as availability and fair distribution of resources necessary for rendering safe maternity healthcare services. A study done in Limpopo, South Africa,[69] confirms the above expressions whereby maternity care workers, particularly the midwives expressed the view that they found it extremely difficult to deliver safe care to maternity patients because of the stressful workplace environment- a result of lack of support and unconstructive criticism from management if something in the maternity wards went wrong. Similar findings were reported by Ndwiga et al[6] in a study conducted in Kenya.

Another study conducted in South Africa which explored midwives' experiences of providing maternity healthcare alluded to the existence of system-wide barriers that are believed to be responsible for the poor quality of care, let alone lack of respectful

maternity care.[69] This is important finding highlights the important role played by health system factors, resources as well as the support given to healthcare providers in the provision of RMC. The enabling conditions do \ feature in Shakibazadeh et al[39] seminal work.

In-service training also emerged as a vital and enabling driver to the implementation and practicing RMC during interviews. They voiced out that awareness of and regular training of staff on not just clinical care guidelines, but on non-clinical aspects of care such as respectful maternity care including the impact of incorporating or disregarding such care aspects, are key in yielding positive overall patient outcomes. A survey report prepared by Reis et al[70] pointed out some of the drivers of disrespectful and abusive maternity care, are deficits in maternity health workers' knowledge and proposed skill development among the solutions. The report highlighted the gaps in the education of professionals, medicalized rather than woman-centered care, lack of RMC in undergraduate training of health teams, poor behavioural practices which do not emphasise respectful care or evidence-based approaches, lack of training sites that can serve as a model for the provision of RMC in education institutions as well as lack of In-service education/ or training (continuous updating of staff on best practices), were some of the underlying factors behind disrespect and abuse in maternity care.

Another aspect of successful implementation of RMC according to the healthcare providers who participated in this study is holding maternity healthcare providers and their supervisors accountable for their actions. They firmly believed that people tend to keep abreast and become more vigilant in what they do if they are held accountable for their actions. Furthermore, healthcare providers expressed strong views regarding accountability by suggesting that disrespect and abuse of childbearing women should warrant major disciplinary measures. This finding is also supported by a study conducted in Kenya. The right-based approach highlighted in the Kenyan study[6] is one of the attempts that have been implemented to eliminate discourtesy and abuse of maternity end-users. One of the strategies of this approach was to ensure that all maternity service providers and their managers took full responsibility and accountability for their actions and the services provided.

Lastly, providers attested that childbearing matters are not confined within healthcare facilities but go beyond healthcare facilities to include communities and the public at large. Constant inquiry about and integration of maternity services deemed acceptable to different communities and the public are crucial strategies that could assist in achieving good maternity care outcomes. Reis et al[70] support the above notion by noting that implementation of community activities, including educational campaigns, is one of the ways in which the issue of respectful care can be addressed.

5.3. Conclusion

According to our knowledge this qualitative study is the first study conducted in a dedicated and busy maternity regional hospital context in South Africa with the participation of a multidisciplinary team of maternity care providers. The study found that maternity healthcare providers' perspectives of RMC resonate well with published literature on the topic. The study further adds to the existing knowledge by highlighting both healthcare providers' perceptions and conditions that are needed for the practice of RMC in one study. The study calls for the inclusion of factors that would promote the practice of RMC including implementation barriers in future studies.

5.4 Strengths and limitations

This study was carried out in a single mother and child academic regional hospital in Gauteng. Results obtained may not reflect perceptions of providers on RMC in regional hospitals in other areas as well as in different levels of care, as well as other provinces. A bigger study including different levels of care in different geographical regions would have been preferred but was not possible due to limitations of time and the national Covid19 regulations. The study only explored healthcare providers' perspectives of RMC and did not explore pregnant women's perspectives or their experiences. A study exploring both healthcare providers' and women's perspectives and experiences of RMC with an observational element to verify the findings would have provided insight not only providers' theoretical knowledge about RMC but also actual practices. This approach would have assisted in identifying areas that needed attention to improve

women's experiences of maternity care and health outcomes. Regardless of these limitations, the study adds to the growing body of knowledge on RMC and supports WHO's effort to make RMC standard practice in all units providing maternity healthcare services globally.

5.5 Recommendations

The following are the recommendations derived from the study findings:

5.5.1 In-cooperation of RMC in obstetric and midwifery curricula

Curricula emphasising RMC and its practice are recommended for implementation across all nursing and medical schools. This will help instil the practice of RMC to aspiring maternity service practitioners mostly at their prime age and careers.

3.5.2 Robust training of managerial and clinical maternity staff on RMC

It is recommended that maternity care facilities have a training program in place through their clinical teaching or skills development departments. These training programs should include concepts such as RMC and should be run for both new and senior as well as clinical and non-clinical staff as part of induction and continuing professional development.

5.5.3 Improvement of working conditions in maternity care facilities

There is a need for a more supportive work environment with clear policies, guidelines, and job descriptions for maternity care providers to improve on their performance in general, and specifically for promoting the practice of RMC.

5.5.4 Future research

It is worth noting that the study was conducted only on maternity care providers conveniently selected from one regional hospital in Gauteng. The methodology used

was qualitative and contextual thus the results thereof cannot be generalized. It is therefore recommended that further research be conducted in different settings. These studies should focus on both providers' and women's perspectives on RMC, including an observational element to assess practice and alignment between theory and practice. Furthermore, future studies should utilize implementation science to look at barriers of implementing RMC in a South African setting with its known health system challenges and come up with recommendations on how best to implement RMC within the busy and overcrowded South African maternity environment.

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APPENDICES

A

INTERVIEW GUIDE

FOCUS AREA	QUESTION
Ice breaker	• Please tell me about yourself, your role and how long have you been working?
Perspectives on RMC	• Please tell me what you understand about respectful maternity care? • According to your view, do you think we should be concerned about respectful maternity care in modern obstetric practice? Why do you think so? • How best can health workers provide respectful maternity care? • Are there any enablers or hindrances that can assist or hinder health care workers from providing respectful maternity care? • How can we maximize the enablers or minimize the barriers to RMC
Concluding remarks	• Thank the study participant and ask them if there is anything they would like to add or questions they would like to ask.

INTERVIEW TRANSCRIPT

INTERVIEWEE: Good afternoon.

INTERVIEWER: Good afternoon, how are you?

INTERVIEWEE: I am well and yourself?

INTERVIEWER: I am good thanks, I'm Sthembile Zwane, I am currently doing my MSc medicine by research and my research study is on exploring health care providers' perceptions on respectful maternity care. Before we start please be at ease, it is not about investigating why you as a health care provider is not applying it or you, or applying it I just need to know if you know about it and if it is going to help us in a long run.

INTERVIEWEE: Okay.

INTERVIEWER: So before we get deep into our discussion please tell me more about yourself, who you are, how long have you been working in maternity?

INTERVIEWEE: Okay my name XXXXXXXXXXX and I started as a registrar medical officer in obstetrics and Gynaecology since 2009, I then qualified as a specialist after the Reg program in 2013, completed my M Med Masters in 2014. Worked as a consultant specialist at Rahima Moosa in the gynae department from 2014 to 2016 and then was offered a fellowship post for critical care at Steve Biko Academic Hospital I have now been working in the Charlotte Maxeke Obstetrics and Gynaecology Department since the end of 2018. And my focus essentially is to try and decrease maternal morbidity mortality by offering a very unique critical care service to the obstetric population that is very limited in a country like ours because of resource limitations. And so my passion is driven with acute management in obstetrics and Gynaecology, and my specialisation essentially has got my skillset in intensive care and critical care management of critically ill patients.

INTERVIEWER: Oh wow you have done a lot hey? Such a short space of time, okay so what do you understand about the concept of respectful maternity care, have you heard about it before, do you know anything about it?

INTERVIEWEE: So I have heard of it, I think it is very difficult to define because there are so many factors to it. I think the very first concept is the availability of care to maternal patients, so to a pregnant woman is that offering that service from any stage of health care facility, primary, community, and then as we escalate towards our type of setting as a quaternary I think is vital. The other is

affording pregnant women the opportunity or a safe measure in which they can seek health care when they need to, and respectfully is by abiding by their autonomy, offering them non maleficence, maleficence in terms of always making sure that whatever you provide to them is in their best interest. And the one limitation in our setting if we had to look at those ethical principles will be that we do need basically to then use the Justice approach where we need to provide appropriate levels of care at each level so that everyone is afforded care in terms of the maternity umbrella. The other component as well in terms of to respectful care is providing a holistic approach, it is not just the medical management from an obstetrics perspective, but also brining in the psychological and emotional as well as social support that a pregnant woman need especially in a country like ours that has a low resource support, but also in the sense of where just recently we have learned that we also have a high prevalence of gender based violence. So it is not just monitoring growth of a pregnancy, a blood pressure and a urine dip sticks but it screening woman to make sure that they are safe in their homes and in their communities, it is screening woman to make sure that they are prevented from contracting communicable diseases, that they afforded HIV testing as well as therapy and that they are basically kept well not only within them been pregnant but even after in terms of providing a service for them been mothers in the community. And I think that's why it is so difficult to define respectful maternal care because it is a huge umbrella that we need to basically live to the expectation of looking after woman in our country.

INTERVIEWER: Oh wow, thanks, so it is basically if I get you well, holistic management of patients with ethical principles coming into play a lot.

INTERVIEWEE: Correct.

INTERVIEWER: That's how you sum it up.

INTERVIEWEE: Yes.

INTERVIEWER: Okay, so do you think it should be incorporated in our modern maternity practice, is it something that you can with or you can incorporate it?

INTERVIEWEE: No I think.

INTERVIEWER: On a daily clinic?

INTERVIEWEE: I think if we do away with it we become more clinically or scientifically inclined where we have lost that entire holistic approach, and I mean if we look medicine out of child birth and we looked at you know our great grandmothers in terms of midwives coming from people who were experienced within the community

delivering these babies it was a community effort and so the holistic approach was there. You know certain cultures like in my own culture your mom, your mom in law you know all the woman would come together, you would deliver, you would have, we call it a special type of bath and rituals, some people like burn smoke, some people bind their abdomen, all of that is a holistic approach. And then we bring the science into it that does away to say that it actually makes no difference, but then we forget about the psychological aspect of the childbirth, and I think if we do away with respectful maternal care in modern science then we basically become machines, and we delivering you know within a factory versus us actually keeping the ethos of family which is what childbirth is about. And we need to contribute to the population because this is where it all starts. You want healthy babies so that they grow up into healthy adults so that we have a healthy human population, and I think a lot of people just negate how important it is that on the onset of conception and preventing unwanted pregnancies can also save lives. That there is so many different aspects when looking at maternal care, and so in a nut shell no, we should not do away with it, yes we must incorporate it in modern practice.

INTERVIEWER: Wow, so what do you think are the enablers or hindrances to this in our current practice?

INTERVIEWEE: So it think it is one is because a lot of people are not aware, so I think there needs to be more awareness, I think there is a lot of ignorance when we look at respectful maternal care because it is assumed that it is something that people know and should be practicing anyway. And it is indeed, it is very much like psychological support, you have got to be trained in certain things to afford the service appropriately and adequately. So I think the one is lack of knowledge, lack of implementation for those who do know about it, and then the other obstacle is that if we had to look at holistic approaches they are the most enduring in terms of time spent to provide that service. And because we are so overwhelmed and we are so limited in terms of how many there of us to provide that service it would be the easiest thing to neglect. It is easy to put up a drip or give a drug for an immediate type of response versus long term goals in terms of basically managing patients respectfully, holistically. And I think those would be the main things that would be the hindrance in terms of making sure that we reach this goal adequately.

INTERVIEWER: Oh wow, you have said quite as [mouthful? 08:14] hey.

INTERVIEWEE: I thought that's what you wanted?

INTERVIEWER: Is there anything else you want to add before we close?

INTERVIEWEE: So I want to say number one, congratulations on actually looking at this, I think that people who are passionate in their line of work like you are pick up on how we can actually make the biggest difference. And yes doing a vacuum assisted delivery or doing a caesarean section is all clinical and it taken from the protocol book, but the protocol book doesn't teach you how to treat a labouring woman, and it doesn't teach you how to then respect a patient in her post-partum. If I have to basically compare it to private practice you will not leave the hospital until you are confident to breast feed your baby, and that's the holistic approach.

INTERVIEWER: Shew.

INTERVIEWEE: You know people explain to you how to look after your wound, what to expect post your delivery, how you need to engage the baby to the nipple, you know how to look for problems in there is breast feeding. And I think because we are so overwhelmed we forget those fine nuances that are very practical, and I think that also falls into the you know ethos of respectful care. So by doing the study, by interviewing more of us I think there will be a great awareness and I think we will be able to prove that there is a lack in terms of providing the skill set within our discipline which would be very sad because that's what we all are here to do. We are advocating for respectful care for the maternity department. So that is what I would like to say and I wish you everything of the best.

INTERVIEWER: Thank you.

C

STUDY INFORMATION SHEET

Study title: EXPLORING PROVIDERS' PERSPECTIVES ON RESPECTFUL MATERNITY CARE IN A REGIONAL HOSPITAL IN GAUTENG

Dear Sir/Madam

I am Sthembile Promise Zwane currently enrolled for Master of Science in Medicine (Obstetrics and Gynaecology). I am doing a research study titled: **Exploring providers' perspectives on respectful maternity care in a regional hospital in Gauteng.** This research is being supervised by Professor Lawrence Chauke.

This study is intended to generate knowledge that will assist in developing guidelines to equip qualified and trainee health care practitioners with the appropriate knowledge and skills necessary for rendering safe and respectful maternity care services to women

You are hereby invited to participate in this qualitative study, and participation involves expressing your views on respectful maternity care through an interview. Interviews will be done in English, at a time convenient to you and each session will be conducted for a duration of thirty minutes to an hour.

Information will be gathered from you by asking a series of questions on respectful maternity care. The records will be kept with my supervisors for two years if the study gets published and if the study is not published the records will be kept for six years. At the end of the above-mentioned periods, the records will all be destroyed accordingly

Information for contacting eligible participants will be kept electronically for security purposes. Such information may be inclusive of participant names, age, years of experience in the maternity discipline, contact numbers, etc.

Electronic files including interview recordings will be stored in restricted access (password protected) folders on the server of the University of Witwatersrand. When accessing data on the server, the researcher and the supervisor will ensure that the method of connection is secure e.g., the server will not be accessed through a public free Wi-Fi connection. Paper records will be stored in a lockable cabinet in the supervisor's office

Your name will appear on the participation and audiotaping consent forms which will be securely kept separately from the research notes so that data from these forms cannot be linked to the participants and will not appear in any of the reports. In addition, study numbers will be allocated to each participant to further avoid the possibility of

linking research notes to participants. All written information will be treated with confidentiality except in rare cases whereby:

1. There is a requirement by law to disclose your personal information.
2. The Human Research Ethics Committees of the University requires your data to respond to a formal complaint, or for a compliance audit

Your participation in this study is voluntary and you have a right to opt-out of the study at any stage without negative consequences. There will be no payments made to any of the participants.

For further information, feel free to contact me and or my supervisor on the details provided below

Thank you in anticipation for reading this Study Information Sheet and for your participation in this study

Contact details:

Principal investigator: **Sthembile Zwane**
011 488 3149
076 318 4877
zwanepr@gmail.com

Supervisor: **Prof. Lawrence Chauke (**Assistant Head - School of Clinical Medicine, Faculty of Health Sciences, University of Witwatersrand
011 488 4178
Lawrence.chauke@wits.ac.za

PARTICIPANT CONSENT SHEET

EXPLORING PROVIDERS' PERSPECTIVES ON RESPECTFUL MATERNITY CARE IN A REGIONAL HOSPITAL IN GAUTENG

I, ……, agree to participate in this research project based on the following:

1. I have been given a Participant Information Sheet that explains the nature and processes involved in this study, which is attached hereto.
2. I was given time to read it, or had it read to me, in the language I best understand.
3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory.
4. I believe I fully understand why the study is being conducted and what the intended outcomes will be.
5. I understand that there will be no immediate benefit to me, should I agree to participate, nor will I receive any payment; conversely, participation will not cost me anything but my time.
6. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not be required to give any reasons; if that happened, any data collected about me for the study would immediately be destroyed, unless I give consent for it to be retained
7. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.

Contact details:

Principal investigator: **Sthembile Zwane**
011 488 3149
076 318 4877
zwanepr@gmail.com

Supervisor: **Prof. Lawrence Chauke**
Assistant Head - School of Clinical Medicine, Faculty of Health Sciences, University of Witwatersrand
011 488 4178
Lawrence.chauke@wits.ac.za

Name of Participant: ……
Date: ……..
Place: ……..
Signature or mark: ……,……

Witnessed by:
Name of Witness: ……..
Signature: ……..
Date: ...……

E

CONSENT FORM FOR AUDIO RECORDING OF STUDY PARTICIPATION

EXPLORING PROVIDERS' PERSPECTIVES ON RESPECTFUL MATERNITY CARE IN A REGIONAL HOSPITAL IN GAUTENG

I hereby consent to audio recording of the interview

I understand that:

- The recording will be stored in a secure location (password protected computer) with restricted access to the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed,
- The recordings will be erased within either (a) two (2) years of the publication of the research findings, or (b) six (6) years if no publications arise from this research
- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.

Name of Participant: ……
Date: ……..
Place: ……..
Signature or mark: ……,……

Witnessed by:
Name of Witness: ……..
Signature: ……..
Date: ...……..

F

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

Office of the Deputy Vice-Chancellor (Research and Innovation)

TO: Ms SP Zwane
School of Clinical Medicine
Department of Obstetrics and Gynaecology
Medical School
University

E-mail: 0501147P@students.wits.ac.za

CC: Supervisor: Professor L Chauke
Lawrence.Chauke@wits.ac.za
and <HREC-Medical Research Office@wits.ac.za>

FROM: Mr Iain Burns
Human Research Ethics Committee (Medical)
Tel: 011 717 1252

E-mail: Iain.Burns@wits.ac.za

DATE: 2021/08/23

REF: R14/49

PROTOCOL NO: **M210408** (This is your ethics application reference number. Please quote it in all enquiries, oral or written, relating to this study.)

PROJECT TITLE: *Exploring providers' perspectives on respectful maternity care in a regional hospital in Gauteng*

Please find attached the Clearance Certificate for the above project. I hope it goes well and that an article in a recognized publication comes out of it. This will reflect well on your professional standing and contribute to Government funding of the University.

MSWorks2000/Iain0007/Clearscan.wps

F

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R49 Ms SP Zwane

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M210408

NAME: (Principal Investigator)	Ms SP Zwane
DEPARTMENT:	School of Clinical Medicine Department of Obstetrics and Gynaecology Medical School University
PROJECT TITLE:	*Exploring providers' perspectives on respectful maternity care in a regional hospital in Gauteng*
DATE CONSIDERED:	2021/04/30
DECISION:	Approved unconditionally
CONDITIONS:	
NOTE:	If contact information regarding student study participants is required, please contact the Registrar's office - <Nicoleen.Potgieter@wits.ac.za>
SUPERVISOR:	Professor L Chauke
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	2021/08/23

This Clearance Certificate is valid for 5 years from the date of approval. An extension may be applied for.

DECLARATION OF INVESTIGATORS

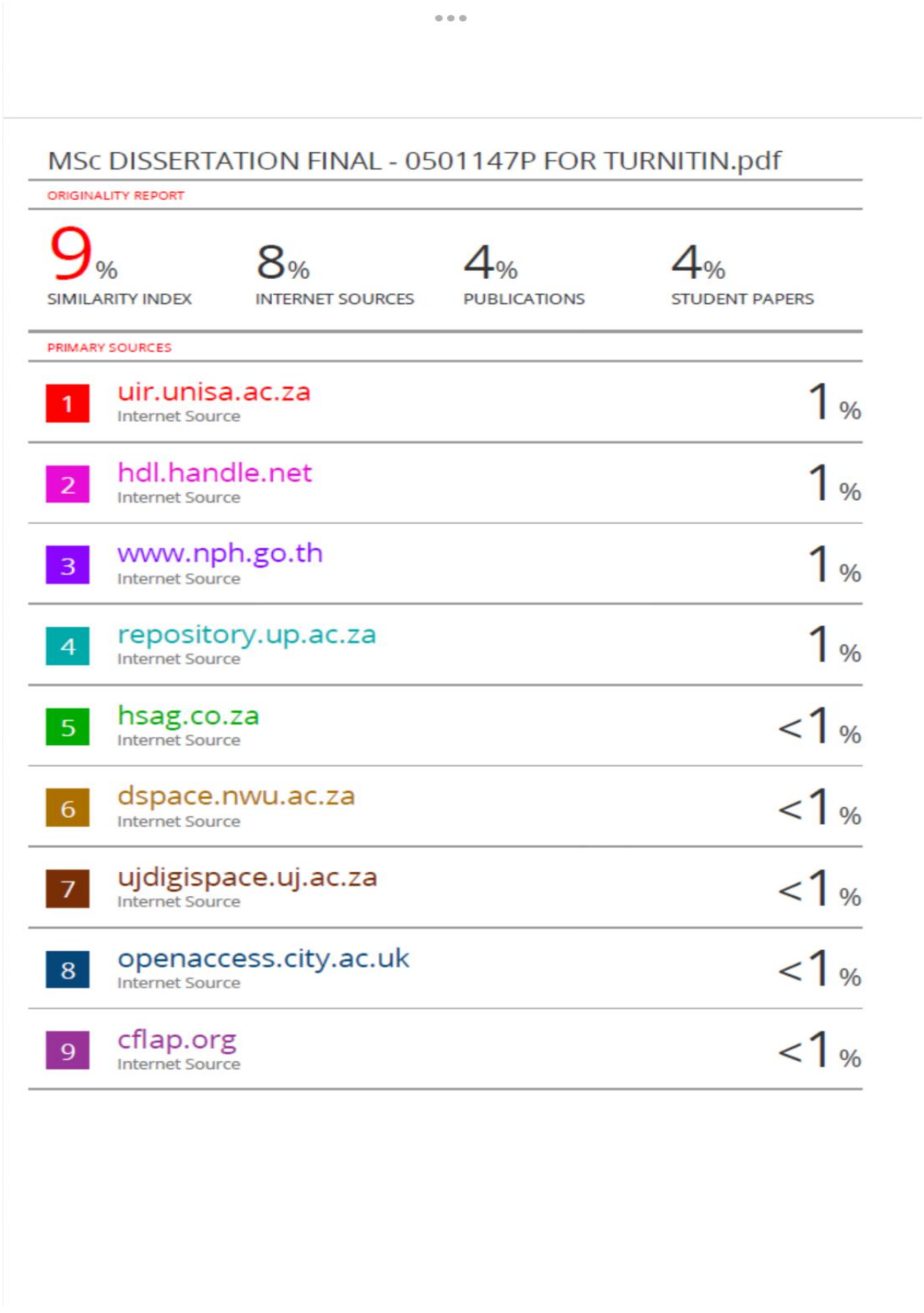
To be completed in duplicate and **ONE COPY** returned to the Research Office secretariat on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to submit details to the Committee. **I agree to submit a yearly progress report**. When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in **April** and therefore reports and re-certification will be due in the month of **April** each year. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

Signature of Principal Investigator

27 September 2021
Date

G



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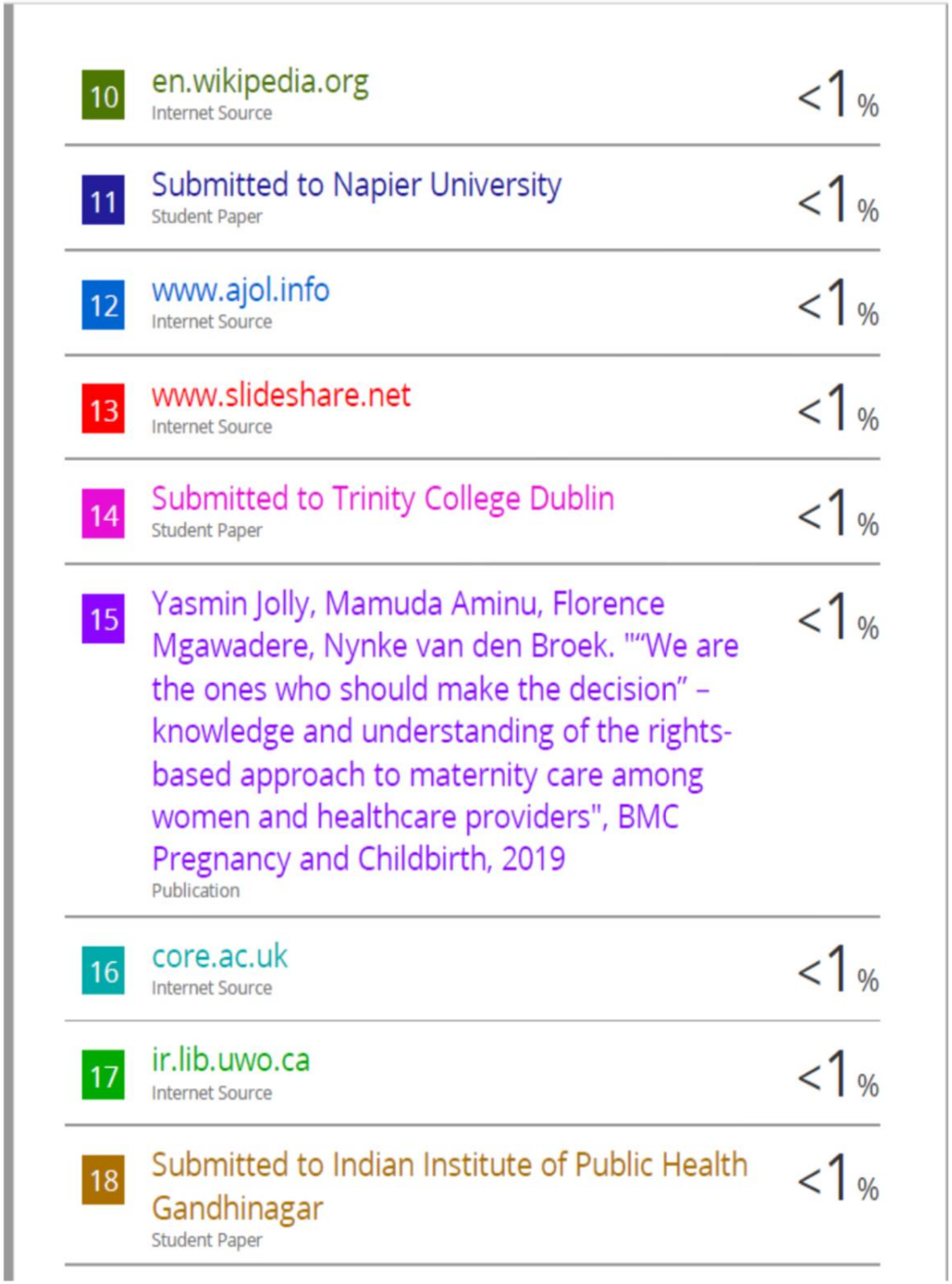
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Supervisor
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UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

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17 February 2022
Person No: 0501147P
PAG

Miss SP Zwane
308 St Johns View
96 Louis Botha Avenue
Yeoville
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South Africa

Dear Miss Sthembile Zwane,

Master of Science in Medicine: Approval of Title

We have pleasure in advising that your proposal entitled *Exploring providers' perspectives on respectful maternity care in a regional hospital in Gauteng* has been approved. Please note that any amendments to this title have to be endorsed by the faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences