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AN INTERVENTION PROGRAMME TO ENHANCE RESPECTFUL MATERNITY CARE IN LABOUR BY MIDWIVES IN THE PUBLIC MIDWIVES OBSTETRIC UNITS IN A DISTRICT IN GAUTENG

Barbara Anne Hanrahan

A thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of A Doctor of Philosophy

Johannesburg May 2021

DECLARATION

I Barbara Hanrahan declare that this thesis is my own, unaided work. It was submitted for the Degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

_____ _____

(Signature of candidate) **(Date)**

Dedication

I dedicate this thesis to women who live with the daily challenge of depression and anxiety.

We live for a time of real understanding within families, workplace and communities.

Presentations Arising from this Research

	2017 Society of Midwives in South Africa (SOMSA) Bloemfontein August 2017	
1.	Preparation for birth and emergency readiness	Paper
2.	The Rights of the Healthy Newborn (in respectful maternity care)	Paper
3	Work-related stress as a driver of mistreatment of women in labour and birth	Workshop
	2018 Society of Midwives in South Africa (SOMSA) Klerksdorp August 2018	
1.	Listening to Midwives	Workshop
2.	Respectful Maternity Care is Woman and Family Centred	Paper
3.	RMC: Tackling disrespect and abuse during facility-based childbirth	Paper
	2018 Priorities in Perinatal Care Bela Bela March 2017	
	An intervention to nurture respectful maternity care by midwives in labour wards of the Midwives Obstetric Units.	Paper

Abstract

Background: Women are experiencing disrespect and abuse in facility-based childbirth in South Africa. Most women utilise the public sector maternity facilities which include Midwives Obstetric Units – midwife-led primary health care facilities. The purpose of this study was to develop an intervention programme which would nurture respectful maternity care in labour by the public midwives in the Midwives Obstetric Units.

Methods: A multi-method design using qualitative research methods in three steps, based upon Fraser and Galinsky's intervention research framework (2010) was used. Forty-six (46) postpartum women were interviewed about their childbirth experience. Forty-five (45) midwives wrote naïve sketches and eighteen (18) midwives participated in three nominal groups. A scoping review looking at respectful maternity care interventions in sub-Saharan Africa, was undertaken, after which the results from all the data sets were collated and an intervention programme developed, using the ADDIE model as a guide. ADDIE is an acronym for analysis, design, development, implementation, and evaluation. The model is useful for planning and development of an intervention programme. The development of the intervention programme was reviewed by an expert group of midwives.

Results: Three themes with two sub themes each were identified in the process of the data analysis of the postpartum women's interviews: midwife actions and personal attributes; women's expectations and preparation; health systems and resources, and practices. These themes created a template for analysing the midwives' naïve sketches and nominal groups.

Women reported on poor communication and poor interpersonal relationships with the midwives. The midwives reported on the lack of resources (health systems) and work-based stress.

An intervention programme addressing malleable factors was developed: A respectful maternity care interpersonal communication training programme, in two parts, for midwives at the Midwives Obstetric Units, was developed to address the research findings.

Conclusion: When midwives have poor communication and interpersonal skills, it influences women's childbirth experiences. When midwives work in incredibly challenging environments with poor resources, it leads to continuous work-based stress which impacts on staff

absenteeism and performance. Debriefing work-based malleable stress and improving interpersonal communication skills are aimed at strengthening midwives working in a challenging environment.

The next step is to roll out the intervention programme according to Fraser and Galinsky's framework, as postdoctoral research, to contribute to nurturing respectful maternity care in labour by midwives in MOUs.

Keywords: disrespect, abuse, midwife, maternity care, respectful maternity care, intervention, Africa

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Table of Contents

Contents	**Page**
DECLARATION	ii
DEDICATION	iii
PRESENTATIONS ARISING FROM THIS RESEARCH	iv
ABSTRACT	v
ACKNOWLEDGEMENTS	vii
TABLE OF CONTENTS	viii
LIST OF FIGURES	xiv
LIST OF TABLES	xv
LIST OF ANNEXURES	xvii
NOMENCLATURE	xviii

CHAPTER 1 – BACKGROUND AND INTRODUCTION

1.1	Introduction	1
1.2	Background	3
1.3	The Midwives Obstetric Unit (MOU) Concept	6
1.4	Problem Statement	9
1.5	Research Question	9
1.6	Purpose of the Study	9
1.7	Objectives of the Study	9
1.8	The Research Framework	10
1.9	Operational Definitions	15
	1.9.1 Midwives Obstetric Unit (MOU)	15
	1.9.2 Respectful Maternity Care	15
	1.9.3 Disrespect and Abuse	15
	1.9.4 Seven Universal Rights of Childbearing Women: Charter	15
	1.9.5 Safe Motherhood	15
	1.9.6 Positive Childbirth Experience	15
	1.9.7 Woman-Centred Care	16
	1.9.8 Intervention Research	16
1.10	Introduction to Chapters in the Thesis	16

CHAPTER 2 - METHODOLOGY

2.1	Introduction	18
2.2	Research Design	18
	2.2.1 Qualitative Methodology	18
2.3	The Research Framework	19
2.4	Population	21
	2.4.1 Step 1.1	21
	2.4.2 Step 1.2 and 1.3	22
	2.4.3 Step 1.4	22
2.5	Sample	22
	2.5.1 The Health District	22
	2.5.2 The Health Facilities	22
	2.5.3 Sampling of Postpartum Women	23
	2.5.4 Sampling of Midwives	23
	2.5.5 Scoping Review	23
2.6	Data Collection	24
	2.6.1 Step 1.1: Semi-Structured Interviews of Postpartum Women	24
	2.6.2 Step 1.2: Midwives	25
2.7	Data Analysis	27
	2.7.1 Step 1.1: Postpartum Women	27
	2.7.2 Step 1.2: Naïve Sketches and Nominal Groups with Midwives	29
	2.7.3 Integrating the Findings of the Study	30
2.8	Step 2: Developmental Phase – Developing Programme Materials Aimed at Enhancing Respectful Maternity Care	30
	2.8.1 The ADDIE Model	31
2.9	Step 3: Confirming and Refining Components of the Programme	33
	2.9.1 Data Collection	33
	2.9.2 Data Analysis	34
2.10	Ethical Consideration	34
	2.10.1 Ethical Consideration	
	2.10.2 Context and Validity	
2.11	Trustworthiness	

2.11.1 Credibility
2.11.2 Transferability
2.11.3 Dependability
2.11.4 Confirmability
2.11.5 Triangulation
2.12 Conclusion 34

CHAPTER 3 – SEMI-STRUCTURED INTERVIEWS OF POSTPARTUM WOMEN: FINDINGS AND DISCUSSION

3.1 Introduction 36
3.2 Themes and Subthemes 36
3.2.1 Theme One: The Midwife 37
3.2.2 Theme Two: The Woman 40
3.2.3 Theme Three: Heath System 42
3.3 Discussion of Findings 43
3.3.1 The Midwife: Actions and Personal Attributes 44
3.3.2 The Woman: Expectations and Preparation for Labour and Birth 48
3.3.3 Health Systems: Resources and Practice 48
3.4 Conclusion 49

CHAPTER 4 – MIDWIVES' NAÏVE SKETCHES: FINDINGS AND DISCUSSION

4.1 Introduction 50
4.2 Understanding of Respectful Maternity Care 50
4.3 Template Analysis 51
4.3.1 Theme Midwives – Subtheme: Analysis of Midwives' Actions 52
4.3.2 Theme Midwives – Subtheme: Midwives' Personal Attributes 53
4.3.3 Theme – Mothers' Expectations and Preparation for Labour 55
4.3.4 Theme – Health System 57
4.4 Discussion of Findings 60
4.5 Conclusion 63

CHAPTER 5 – MIDWIVES' NOMINAL GROUPS: FINDINGS AND DISCUSSION

5.1 Introduction 64

5.2 Themes and Subthemes 64
5.2.1 Findings from the Midwives' Nominal Groups 65
5.3 Discussion of Findings 71
5.4 Conclusion 75

CHAPTER 6 – SCOPING REVIEW

6.1 Introduction 77
6.2 The Reviewer Questions 77
6.3 Inclusion Criteria 77
6.4 Search Strategy 78
6.5 Screening and Selection of Articles 78
6.6 The Scoping Review Matrix 80
6.7 Findings 92
6.7.1 Evidence 92
6.7.2 Interventions 95
6.8 Discussion of Findings 97
6.8.1 Theme 1: Women 97
6.8.2 Theme 2: Health Care Providers (Health care workers, midwives, doctor , or nurses) 98
6.8.3 Theme 3: Programmes and Interventions 102
6.8.4 Theme 4: Health Systems 105
6.9 Conclusion 107

CHAPTER 7 – SPECIFYING THE PROGRAMME STRUCTURES AND PROCESSES

7.1 Introduction 109
7.2 Findings 109
7.3 Meta Inferences 113
7.3.1 Findings and Inferences Generated from the Data Sets and Under the Themes Women, Midwives, and Health System 114
7.4 Designing an Intervention 115
7.4.1 Strengthening the Interpersonal Relationship and Communication between Midwives and Mothers 116
7.4.2 Strengthening Interpersonal Relationships and Communication between 119

Midwives and Managers

7.4.3 Analysis 119

7.4.4 The Planned Intervention 120

7.5 Conclusion 124

CHAPTER 8 – CONFIRMING AND REFINING THE COMPONENTS OF THE INTERVENTION

8.1 Introduction 125

8.2 An Expert Panel Review of the Initial RMC Interpersonal Skills Training: Listening to Mothers (Alpha Version) 125

8.2.1 Introduction 126

8.2.2 Activity One – A Values Clarification Exercise 127

8.2.3 Activity Two – A Communication Skills Q-Sort 130

8.2.4 Activity three – A Role Play 130

8.2.5 Activity Four – A Breathing Technique to Disrupt Negative Thoughts 131

8.2.6 Activity Five – A Personal Action Plan for Improving Communication Skills 131

8.2.7 Overall Evaluation of the Experts of the Alpha Version of the Workshop 131

8.3 Refining the Alpha Version of 'Listening to Mothers' 132

8.4 Developing the Beta Version of the RMS Interpersonal Communication Skills Training 133

8.4.1 RMC Interpersonal Skills Training: Part One – 'Listening to Midwives' Programme (Beta Version) 133

8.4.2 Activity One: Introduction to the Workshop 136

8.4.3 Activity Two: Revised Values Clarification Exercise 136

8.4.4 Activity Three: A Role Play 137

8.4.5 Activity Four: Debriefing Work Life Stressors 137

8.4.6 Activity Five: Caring for the Caregiver 138

8.4.7 Activity Six: A Sensory-based Stress Relief Exercise 139

8.4.8 Activity Seven: A Review of Respectful Maternity Care 140

8.4.9 Activity Eight: A Wrap-up Session 140

8.5 Evaluation of the Revised Beta Version of the RMS Interpersonal Communication Skills Training by the Expert Panel 140

8.5.1 Data Analysis 140

8.6 Conclusion 141

CHAPTER 9 – CONCLUSION

9.1	Introduction	142
9.2	The Main Findings	142
9.3	Limitations of the Study	144
	9.3.1 Data Collection	144
	9.3.2 Sample Size	145
	9.3.3 Lack of Previous Studies in the Research Area	145
	9.3.4 Language Fluency	145
9.4	Recommendations	145
	9.4.1 Recommendations for Research	145
	9.4.2 Recommendations for Education and Training	146
	9.3.4 Recommendations for Clinical Midwifery Practice	146
9.5	Conclusion	147

REFERENCES 148

APPENDICES 162

LIST OF FIGURES

CHAPTER 6

Figure 6.1 PRISMA diagram: search process and inclusion……..…179

Figure 6.2 Bradley *et al* Conceptual Framework of the drivers of mistreatment of women, during facility based maternity care in sub-Saharan Africa……102

Figure 6.3 HESHIMA Theory of Change……..104

CHAPTER 7

Figure 7.1 Possible barriers to effective communication……...117

CHAPTER 8

Figure 8.1 An example of a Q sort template……..128

LIST OF TABLES

CHAPTER 1

Table 1.1 Fraser and Galinsky's Intervention Research Framework……...10

Table 1.2 Overview of study components……....13

CHAPTER 2

Table 2.1 Overview of study components with sample size……20

CHAPTER 3

Table 3.1 Themes and sub themes: Postpartum interviews……..36

Table 3.2 Relationship between D&A reported and Bohren *et al* typology of D&A……..45

CHAPTER 4

Table 4 Experiences and understanding of RMC…….50

CHAPTER 5

Table 5.1 Sub themes and categories: Nominal groups……...64

CHAPTER 6

Table 6.1 Scoping Review Matrix……80

Table 6.2 Geographical distribution of articles…….91

Table 6.3 Distribution of articles according to journals……92

CHAPTER 7

Table 7.1 Recommendations to Improve Respectful Maternity Care: Findings matrix……110

Table 7.2 Tabulation of Findings and Meta Inferences under the Themes of Women, Midwives, and Health Systems…….128

Table 7.3 RMC Interpersonal Communication Skills 'Listening to Mothers' Workshop Programme (Alpha Version)…….134

CHAPTER 8

Table 8.1 Evaluation Questions give to the Expert Panel……140

Table 8.2 RMC Interpersonal Skills Training: Part One – Listening to Midwives (Beta Version)…….148

LIST OF ANNEXURES

CHAPTER 1

ANNEXURE 1.1 Charter: The Seven Universal Rights of Childbearing Women……...163

CHAPTER 2

ANNEXURE 2.1 Semi-structured interview guide……...164

ANNEXURE 2.2 Information Sheet for postpartum women……166

ANNEXURE 2.3 Informed Consent to be Interviewed Using an Audio tape-recorder...….167

ANNEXURE 2.4 Information Sheet for Midwives……...168

ANNEXURE 2. 5 Midwives Consent to Writing on their Experience of RMC……...170

ANNEXURE 2.6 Naïve Sketch Instruction……..171

ANNEXURE 2. 7 Midwives' Consent to Participate in a Nominal Group……..172

ANNEXURE 2.8 The Nominal Group Discussion with Midwives……..173

ANNEXURE 2.9 Participant's Information……..174

ANNEXURE 2.10 Consent Form……..175

ANNEXURE 2.11 RMC interpersonal communication skills 'Listening to Mothers'…….176

ANNEXURE 2.12 Expert Panel Survey: Part 2: 'Listening to Mothers' (Beta Version)….179

ANNEXURE 2.13 RMC Interpersonal Skills Training: Part One – 'Listening to Midwives' (Beta Version)……182

ANNEXURE 2.14 Expert Panel Survey: Part 1: 'Listening to Midwives' (Beta Version)...186

CHAPTER 7

ANNEXURE 7.1 Values Clarification……..189

ANNEXURE 7.2 Communication skills for Q-sort exercise……190

ANNEXURE 7.3 RMC Interpersonal Skills Training Personal Action Plan……191

CHAPTER 8

ANNEXURE 8.1 Childbirth Experience Card……..192

ANNEXURE 8.2 Affective Events Theory……..193

ANNEXURE 8.3 Group Facilitation Guidelines for Peer to Peer debriefing in a group….194

NOMENCLATURE

ADDIE: Analysis, design, development, implementation, evaluation. Model or developing interventions

ARV: Antiretroviral

BBI: Better Birth Initiative

CHC: Community Health Centre

D&A: Disrespect and Abuse

DMC: Disrespectful Maternity Care

DOH: Department of Health

HIV: Human Immunodeficiency Virus

ICM: International Confederation of Midwives

IPM: Intellectual Partnership Model

MOU: Midwives Obstetric Unit

NDOH: National Department of Health

NG: Nominal Group

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PTSD: Post Traumatic Stress Disorder

RHL: Reproductive Health Library

RMC: Respectful Maternity Care

SANC: South African Nursing Council

SOMSA: Society of Midwives in South Africa

Sub-Saharan Africa: studies were used from the following countries – Ethiopia, Ghana, Kenya, Malawi, Nigeria, Rwanda, South Africa, Tanzania

WABOTS: Ward Based Outreach Teams

WHO: World Health Organization

WRA: White Ribbon Alliance for Safe Motherhood (International)

CHAPTER 1

BACKGROUND AND INTRODUCTION

1.1 Introduction

As a midwife, respectful maternity care based on the rights of the mother and baby is the overriding principle in caring for women and their babies. Respectful care is a way of ensuring both maternal and infant wellbeing, and has been addressed in a number of studies published by Warren *et al* (2017), for example: Sowing the Seeds of Transformative Practice to Actualize Women's Rights to Respectful Maternity Care: Reflections from Kenya using the Consolidated Framework for Implementation Research (2017).

Research by Reed, Sharman and Inglis (2017) on Women's Descriptions of Childbirth Trauma Relating to Care Provider, and Ratcliffe *et al's* (2016) study titled 'Applying a Participatory Approach to the Promotion of A Culture of Respect During Childbirth', showed that respectful care has additional benefits in allowing a mother to rest, knowing that she and her infant are receiving quality maternity care.

The International Confederation of Midwives (ICM) Position Statement on Midwives, Women, and Human Rights (2017), calls on the importance of midwives recognizing and advocating for and respecting women's human rights. In the background of the ICM Position Statement on Partnership between Women and Midwives, midwifery is described as a profession that is based on a partnership between women and midwives, aiming at promoting health outcomes. Accordingly, the Society of Midwives in South Africa (SOMSA), in their position statement on Respectful care and the commitment of midwives in South Africa, advocates for "all midwives to render respectful care to women, in keeping with the articles of promotion of respectful care" (Society of Midwives in South Africa, 2019). The Safe Motherhood programmes largely focus on the medical safety of pregnant, intrapartum, and postpartum women and their babies. Such programmes have now been expanded to encompass a woman's right to respectful, dignified, consented maternity care that assists a woman's adjustment to motherhood.

Evidence regarding respectful and dignified maternity care in South Africa was comprehensively examined by Heather Brown in 2004. Brown's PhD study, published in 2007, resulted in the development of the Better Birth Initiative (BBI). BBI is a recognised program and available internationally, which examines evidence-based care and compares it to

traditional maternity care. BBI's principles include humanity, dignity, respect, and commitment by midwives and doctors (Smith, 2013). All health professionals are expected to adopt BBI as part of their clinical practice.

In September 2010, the United States Agency for International Development (USAID) funded the historical "Translating Research into Action Project" (TRAction Project) which presented the findings of a landscape scan on the evidence of disrespect and abuse in facility-based childbirth. The qualitative landscape analysis reported on many accounts of disrespect and abuse in childbirth in the published and grey literature (Bowser and Hill, 2010). However, a key finding in the review was that there was very little formal research on the topic. The authors reviewed published and technical literature, together with interviews and discussion with content experts. A coalition of international stakeholders drew up a Charter with the Seven Universal Rights of Childbearing Women (Appendix 1.1), based on seven types of disrespectful and abusive care from midwives and other facility staff. Disrespectful and abusive care includes physical abuse, non-consented care, non-confidential care, non-dignified care, abandonment of care, and detention in facilities (White Ribbon Alliance, 2017). An important goal of The Charter has been to raise awareness of the right to maternity care, free from any sort of disrespect and abuse. The Charter was made public by the White Ribbon Alliance for Safe Motherhood (WRA) internationally. The Charter identifies the international and multinational human rights tools relating to each of the seven universal rights of childbearing women.

In August 2011 Human Rights Watch launched a comprehensive report "Stop Making Excuses: Accountability for Maternal Health Care in South Africa" (Odhiambo, 2011). Human Rights Watch provided evidence that women are not respected and cared for with dignity during maternity care.

Despite these many reports, there is limited data on the prevalence of disrespect and abuse in facility-based childbirth or on interventions which have improved respectful maternity care internationally.

1.2 Background

An experience of dignity and a satisfactory childbirth is essential to all childbearing women, who are particularly vulnerable during pregnancy, labour, birth and postpartum. In Simkin's

1991 and 1992 publications, she analyses the effect of childbirth experiences on the development of a women throughout her lifetime. Childbirth and motherhood are two of the most significant events in a woman's life, and women who had satisfactory birth experiences have exhibited a favourable self-image in early motherhood, have continued breastfeeding for longer, and have shown appropriate parenting care and practices in their infant's first year of life. Reed et al drew comparable conclusions in the 2017 publication.

Simkin (1992) explained supportive care as non-clinical care that is supposed to ease a woman's feeling of uncertainty, pain, lack of contact, and fatigue, to assist her in drawing on her very own strengths. Comparatively, Hodnett *et al* (2002) continues that the advantages of supportive care by way of a non-family member, has been shown to greatly affect obstetric and psychosocial results of labour. Hodnett reported on twenty-two (22) trials involving 15 288 women. Women allocated to continuous assistance had a higher probability of a spontaneous vaginal birth, and less probable to have intrapartum pain relief or to express unhappiness with their birth experience. Additionally, they laboured for a shorter period of time, were less likely to have an intervention, such as instrument or caesarean births, did not need regional pain relief, or have a baby with a low five-minute Apgar score. This assistance was most useful when the caregiver was not a staff member of the hospital or the woman's social circle, and in places where regional pain relief was not readily available.

Childbirth has been degraded through shifting the attention away from woman-centred care to facility and doctor/midwife care. Even where there are restrained resources, maternity care can be respectful and dignified, informing the woman about pregnancy, labour, birth, breastfeeding, infant care, and postpartum recovery (Mukamurigo *et al* 2017). Romano and Lothian (2008) posit that sustained labour support is of great significance to development and empowerment of women, especially those from marginalised communities. Women are especially exposed for the duration of pregnancy and birth, so "interpersonal care that is disrespectful and abusive to women before, during or after delivery, is appalling" (White Ribbon Alliance, 2012).

Lack of respect and mistreatment of women throughout labour and birth is a human right's violation. It is an international occurrence and seems to be decidedly prevalent in developing countries. Odhiambo and Mahati's 2011 human rights report, "Stop Making Excuses", called on South Africa's Department of Health to take responsibility for intrapartum care, where women and their newborns were subjected to abusive and substandard care, particularly in

the Eastern Cape. The writers suggest that mistreatment and neglect lead to women not seeking care at the facilities, leading to delays in diagnoses and treatment, impacting on maternal illness and death. The success of patient compliant measures is constrained due to poor communication – the women saying that suggestion boxes in the facilities were "essentially defunct" (Odhiambo, 2011), and that they were reluctant to use this avenue for fear of reprisal.

A large number of women in South Africa labour alone, as their partners or family are not allowed to remain and assist the labouring woman. They are frequently dismissed at the door and instructed to wait outside the unit. South Africa's National Department of Health's Guidelines for Maternity Care in South Africa: "General Care of Women in Labour" (2015), states that the woman's family or friends should be permitted to provide support during her labour, although this is often not the case. Verbal abuse and mistreatment determine when women seek antenatal care and go to the clinic when in labour. A woman who has been subjected to maltreatment in a previous pregnancy or birth, may avoid returning to that facility, even though her access time-wise and distance-wise may be affected (Family Care International Technical Brief, 2005).

Some midwives appear to be desensitised to women's expectations that the midwife will guide them through managing the pain in labour and, consequentially, midwives then fail to offer women comfort measures during labour. Desensitization appears to include simple acts of promoting the labouring women's dignity, such as wearing the clothes of her own choice and covering the woman with a blanket (Rominski *et al*, 2017).

Anecdotal evidence (collected by the researcher during a workshop for midwives on respectful care) has shown that the majority of midwives working in the public sector in South Africa have themselves experienced disrespectful care and abuse whilst labouring and birthing their own child or children. In her seminal work on birth experience memories, Simkin (1991) found that women are affected for many years and in a number of ways by a negative birth experience.

Barrett and Stark (2010) suggest that "some nurses may lack knowledge of the evidence supporting labour care." However, labour support appears to be largely affected by poor staffing levels and, in particular, the ratio of midwives to women in many public maternity facilities in South Africa, staff turnover, absenteeism, workload, personal motivation, and unnecessary medical interventions. According to Hodnett *et al* (2007), midwives who are on duty spend their time managing technology and writing records, and in their 2015 publication,

Jewkes and Penn-Kekana posit a similar argument. Women who are well educated and have the means to research and choose their health care provider usually command more respect than poorer women. Such women, and particularly those from ethnic minorities who are the most in need of care, are treated with the greatest disrespect (Kenyan Service Provisions Assessment 2009/2010).

Women expect to have pain in labour and birth (Bowers, 2002), but they also expect support and guidance from the nurse or midwife in managing their pain. Women expect the continuous support of a labour attendant who would help them to stay calm, support their partner of choice, provide comfort measures to relieve the pain in labour, and to be treated with respect (MacKinnon, McIntyre and Quance, 2006).

Non-consensual care, which is one of the recognised forms of disrespect and abuse in maternity care, means that women are not consulted in decision making about care in labour and birth. Shared information, good communication techniques, continuity of care, and environmental influences have been shown to influence the satisfaction women have with their labour and birth experience (Hildingsson and Fenwick, 2015). Other factors which contribute to disrespect and abuse could include the normalisation of disrespect and abuse, lack of leadership, lack of standards and accountability, provider prejudice, and poor training (Wagner, 2001). Bowser and Hill (2010) identify the need to engage with policy and governance, health systems, and the community – at individual maternity facilities and moving in an increasing wider circle to address disrespect and abuse in a national and international context.

All professional nurses who trained in direct entry courses are qualified in general nursing, psychiatric nursing, community nursing, and midwifery, which should provide for more than adequate preparation to care for and teach women the basics of childbearing and childrearing. Many who work in the district health care services are also trained in primary health care and are, at least ostensibly, ideally suited to work in rural areas to empower local women with knowledge about how their bodies work and what they need to know to participate actively in labour and birth, as well as the practical skills for safe child care for newborns to under-fives. Yet, dehumanised childbirth persists. Such abuse has been reported in several countries as a key deterrent to the use of some maternity services (Misago, Kendall, and Freitas, 2001).

There were high hopes when the Better Birth Initiative (BBI) (Smith, 2001) was launched in South Africa in 2001, that dignity and respectful care would improve, but the initiative has lost ground as a driver in motivating for evidence-based maternity care, delivered with respect and

commitment, in order to change maternity care practice. The standard of applying the best available evidence to maternity care, established by BBI, however, remains relevant but only small scale improvements have been achieved, and where this occurs it is due to the presence of a health professional who champions the implementation of BBI.

Measuring respectful maternity care, or supportive maternity care is challenging and is usually based on observation of the behaviours of midwives. Barrett and Stark (2010) researched the factors associated with labour support behaviours of nurses. They found that older and more experienced nurses were most likely to develop labour support skills.

Initially, the researcher had difficulty finding studies which evaluated interventions designed to promote respectful maternity care, but recently more research has appeared in the literature. It is clear that women are an invaluable source of information about the maternity care they receive, and their *voice* needs to be heard and responded to with appropriate changes in caregiver behaviour and maternity care provision. Respectful maternity care as a multifaceted concept is achievable with very few facility-based resources. The greatest impact is made by the caregiver in the provision of respectful maternity care (Reed *et al*, 2016).

In order to understand the setting in which the research took place, an explanation of the concept of Midwives Obstetric Unit (MOUs) follows.

1.3 The Midwives Obstetric Unit (MOU) Concept

The MOUs are staffed primarily by Registered Nurses and Midwives. There are no doctors assigned to MOUs as these are primary healthcare facilities. The midwives work independently within their Scope of Practice and other Acts and Regulations which govern a registered midwife's clinical practice. They are supported by enrolled nurses and nursing auxiliaries who do not have formal midwifery training. Furthermore, emergencies are transferred by ambulance to referral hospitals, once the hospital has been contacted and the transfer arranged.

The MOU is funded and managed by the provincial health authorities. The district health team oversees the unit's professional performance and provides support to each MOU in the district. For example, the Johannesburg Metro Health District has 11 MOUs. The MOU usually has a number of small (local authority) feeder clinics at which women receive antenatal and postnatal care. Most MOUs do offer antenatal and postnatal clinics, but these services are not attached to the labour ward. The labour ward usually features an admission room where women are assessed on arrival and during the course of labour. There is usually a general ward of 4 – 6

beds where women go through the first stage of labour, after which they are moved to a delivery room. The delivery room usually houses 2 beds or more, with a curtain in between the beds (no auditory privacy if two women are in the second stage of labour at the same time). Immediately after the birth, the woman and her baby are moved to a postnatal room usually featuring 4-6 beds. The length of time the mother spends in the postnatal room is dependent on how busy the MOU is and the time of day or night.

During pregnancy, women are advised which MOU to go to when they are in labour. Women in the public sector carry their own Maternity Record (provided by the National Department of Health who provides these records through provincial health services to the antenatal clinic services). Hand-held records means that wherever a woman may present herself for care, she has her full medical record with her.

Women labour and give birth at the MOU, and they are provided with a bed after birth for a short period of recovery. The woman and her baby then wait for a relative or friend to accompany them home (mostly using the general taxi system in the area).

MOUs do not have cooking facilities, so relatives are called to bring food for the mother once she has given birth. Women are only provided with maternity pads and possibly a gown to labour in. The woman needs to bring a bag with her to the MOU primarily with clothes for the baby and herself after birth.

Many MOUs rely on Pinnards stethoscopes to auscultate the foetal heart as few MOUs have a functional electronic foetal monitor. The delivery room has a neonatal resuscitation bed with an overhead warmer and light source. Some MOUs have a functional incubator. Midwives do any neonatal resuscitation required and if further specific health care is needed, the baby is transferred to a referral hospital by ambulance. MOUs service low risk women.

Each district has a district-specialist health team and is made up of a specialist obstetrician, advanced midwife, paediatrician, paediatric nurse, family medicine or primary health care medical specialist, and a family medicine nurse. These teams do offer support and training to MOUs and CHCs. District Health teams are not based at any one particular MOU in the district.

Maternal child (under 5 years old) health services are offered free of charge in the public health care sector, including at referral hospitals.

When the mother leaves the MOU, her baby has been immunised with a BCG and polio drops. Health education has been provided regarding breastfeeding, baby care, and immunisation

visits at the CHC. Each woman baby dyad receives a Road to Health booklet which captures information regarding the necessary immunisations, vitamin supplementations, the growth of the child, and tracks the child's development according to the milestones for a growing child.

Women who birth normally at the MOU attend the nearest postnatal clinic on the third day after birth. The midwife checks the baby thoroughly, discusses any feeding or baby care issues that have arisen since the birth, checks the neonate for physiological jaundice, and assesses the mother for involution of the uterus and any problems relating to feeding the baby as well as any other health related issues.

Women who were transferred to a hospital facility in the intrapartum period, and who have had a caesarean, return at 10 days to the nearest postnatal clinic for the mother baby check and removal of stitches.

MOUs in the Johannesburg Metro Health District face staff shortages so there are often only two midwives on duty per twelve-hour shift. The ambulance service is often delayed so a referral for an obstetric condition or emergency has still to be managed at the MOU until the woman and/or her baby are transferred. When there is a delay in transferring a patient, the midwives are put under a great deal of stress and may influence an adverse outcome due to the time taken to actually transfer the woman to the nearest hospital. At times, one of the midwives may need to accompany the woman in the ambulance to the hospital.

1.4 Problem Statement

Respectful care and dignity are the guiding principles of the Better Birth Initiative (Brown, 2004) and evidence shows that the quality of maternity care affects women's perceptions of birth and influences early parenting (Simkin, 1991; 1992). Human Rights Watch (HRW) (2011) and Brown (2004) have, however, found that women are being subjected to disrespectful care in the public sector in South Africa. Respectful maternity care has not been fully defined and explored in the public sector in South Africa. By gaining greater insight into the issues related to respectful maternity care, it will be possible to design an intervention programme to improve the quality of care in the Midwife Obstetric Units (MOUs) where the majority of births in Gauteng take place.

1.5 Research Question

What intervention programme can be developed for enhancing respectful maternity care in labour by the public midwives in the Midwives Obstetric Units (MOUs) in a health district in Gauteng?

1.6 Purpose of the Study

This study was done, firstly, to gain greater insight on the nature of respectful maternity care from the perspectives of both the midwives and mother's perspectives, in Midwives Obstetric Units (MOU) in the Johannesburg District, Gauteng, South Africa. Secondly, the study aimed at developing a validated intervention programme that could be used to reduce abusive and disrespectful maternity care by midwives towards women in labour and birth and so enhance respectful maternity care in labour by public midwives in MOUs.

1.7 Objectives of the Study

- To determine women's intrapartum experiences of respectful care received in labour by the public midwives in Midwives' Obstetric Units in a health district in Gauteng.
- To establish midwives' notion of respectful maternity care in labour by the public midwives in Midwives' Obstetric Units in a health district in Gauteng.
- To establish the constraints and opportunities which exist for the midwife in terms of providing respectful maternity care in labour by public midwives at Midwives' Obstetric Units in a health district in Gauteng.
- To review international literature on intervention programmes enhancing respectful maternity care in labour by public midwives in maternity facilities.
- To develop an intervention programme that will foster respectful care towards women during labour by the midwives in the public sector in a health district in Gauteng.
- To confirm the structure and contents of an intervention programme, to enhance respectful maternity care in labour by public midwives in Midwives' Obstetric Units in a district in Gauteng, based on the findings of the study.

1.8 The Research Framework

The first three steps of the five steps of intervention research framework, developed by Fraser and Galinsky (2010) for the design and development of social programmes, were used to guide this study.

This framework was selected as it can be used for the development of interventions at all levels, from individual through to organizations, groups, and societies. The framework allows for, and in fact encourages, the use of multiple research methods to develop an intervention in the acknowledgement that there can be many factors and role players whose opinions can guide the development of a relatively simple intervention that can be applied in multiple settings.

The framework specifies the link between problem theory comprised of risk, prevention and promotive factors, and the content of the intervention. As this study sought to develop an intervention to improve the provision of respectful maternity care, this seemed appropriate as there is little doubt from existing literature, such as Mukamurigo's 2017 study, Reed's 2017 study, and Ratcliffe *et al's* 2016(a) and 2016(b) publications, that there are multiple risks related to the lack of provision of respectful maternity care. In addition, the researcher wished to develop an intervention that would promote respectful care and prevent the problems associated with the provision of respectful maternity care.

Below, Table 1.1 describes the steps of the model and demonstrates how the first three steps were used in this study. The last two steps of the model were beyond the scope of this study but will be utilized in post-doctoral work when the intervention will be implemented.

Table 1.1 Fraser and Galinsky's Steps in Intervention Research and how the first three steps were used in this study

Fraser and Galinsky	Steps	Research Study
Develop programme and programme theories: -Involves defining the problem and potential malleable risk factors and developing the programme theory.	One	Data was collected from women (post-birth), midwives' naïve sketches and nominal groups and the scoping review. Through data collection and analysis, the problem was defined, malleable risks identified, and an intervention programme was developed.
Specify programme structures and processes: -designing the intervention based on the malleable risk factors in the practice setting -first draft reviewed by stakeholders and intervention change agents.	Two	From the data analysis an intervention programme was developed by blending the research and theory with the knowledge of the practice setting. First draft presented to an expert panel for review.
Refine and confirm intervention programme components: Negative comments will lead to reconceptualization of part or whole intervention programme. Refine using an iterative process. Redesign should fit the research question. Develop rules for future adaptations. Run a pilot test to assess implementation versus outcomes: E.g. Can the intervention programme be delivered in the time provided? Does the content sequence make sense? Is intervention programme culturally congruent? Does it engage participation?	Three	Intervention programme was modified in response to the expert review. The intervention programme was refined – sent back to experts: Delphi exercise. The experts have a deeper understanding of organisational and other contingencies affect practice. Development continues until the intervention programme is fully feasible and coherent with the programme theory, and it has the potential to be effective.
Test effectiveness in practice setting: testing the intervention programme for estimated effects. The effect must be greater than other interventions in the field. A well conceptualised intervention programme may be compromised by poor implementation	Four	
Disseminate programme findings and materials: Publish findings and materials. Supervise and train intervention agents. Develop training manuals and certificates. New challenges may arise. Practice may find some parts of the intervention programme useful and others not. As the intervention programme penetrates practice it will be used beyond the population it was designed for. Programme activities may need to be adapted for cultural and contextual relevance. Adaptation should be a collective process undertaken at organisational level.	Five	

Table 1.2 Overview of study components

PHASE (Fraser and Galinsky, 2010)	OBJECTIVE	POPULATION	SAMPLE	METHOD
STEP 1 Developing the programme & programme theory	1. To determine intrapartum women's experiences of respectful care received during labour and birth.	Women who delivered in MOUs in a district in Gauteng	Convenience sample of five women at each of eight MOUs = 40 women	Semi-structured interviews
	2. To establish midwives' notion of respectful maternity care.	Midwives employed in MOUs in a district in Gauteng	Purposively selected midwives from each of the above units (45 midwives)	Naïve sketches
	3. To establish the constraints and opportunities which exist for the midwife in terms of providing respectful maternity care.	Midwives employed in MOUs in a district in Gauteng	Convenience sample of midwives from the MOUs (3 groups of 3 with a total of 18 participants)	Nominal group technique
	4. To review international literature on the provision of respectful maternity care	Data bases: Science Direct, Scopus and PubMed	Peer reviewed literature published in English between 2013 and 2018 was searched with search words "disrespect and abuse" "intervention" "respectful maternity care" and "midwife".	Scoping review according to JBI guidelines
STEP 2 Specify programme structures and processes	5. To develop an intervention programme that will foster respectful care towards women during labour and birth, by the midwives in MOUs in a district in Gauteng		Data collected from step 1 of the study	Five phases of ADDIE model (Kurt, 2017) used as guide to develop intervention programme: 1.Analysis 2. Design 3. Development 4. Implementation 5. Evaluation
STEP 3 Refine and confirm intervention programme components	6. To confirm components of the intervention programme	Midwifery experts in a district in Gauteng	Six purposively selected midwifery experts with expertise in each of the categories: Clinical midwifery; midwifery education; midwifery management; quality in midwifery	Nominal group with follow up Delphi study

1.9 Operational definitions

1.9.1 Midwives Obstetric Unit (MOU)

In South Africa Midwives Obstetric Units are freestanding maternity facilities at Community Health Centres (CHC) that serve the community around the centre.

1.9.2 Respectful Maternity Care (RMC)

Respectful maternity care is when women receive care that is dignified, confidential, and free from harm or mistreatment.

Respectful maternity care is the provision of woman-centred care that enhances relationships between women and maternity care providers. At the centre of RMC is the understanding that birth is a human experience and not just a medical event.

1.9.3 Disrespect and Abuse (D&A)

Disrespect and abuse in facility-based childbirth is mistreatment, interactions or conditions which are humiliating, or undignified.

1.9.4 Seven Universal Rights of Childbearing Women: Charter

The charter is a collaboration by a wide range of stakeholders internationally that advocates for a human right's based approach to caring for childbearing women that includes: freedom from harm and ill treatment; informed consent, refusal and respect of a woman's choices; confidentiality and privacy; dignity and respect; equality, freedom from discrimination and equitable care; and health care to the highest attainable level of health.

1.9.5 Safe Motherhood

Safe motherhood involves a series of initiatives, practices, protocols, and service delivery guidelines that are designed to ensure that women receive high-quality prenatal, intrapartum, and postpartum care, thus achieving optimal health for the mother, foetus, and infant.

1.9.6 Positive Childbirth Experience

A 'positive childbirth experience' is defined as a childbirth experience that fulfils or exceeds a woman's prior, personal, and sociocultural beliefs and expectations, including giving birth to a healthy baby in a safe clinical and psychological environment, with continuity of practical and emotional support from the birth companion(s) and kind, technically competent clinical staff. It is based on the assumption that most women want a physiological labour and birth, and

desire to have a sense of personal achievement and control through involvement in decision-making, even when medical interventions are needed or wanted.

1.9.7 Woman-Centred Care

Woman-centred care focuses on the woman's unique needs, expectations and aspirations; recognizes her right to autonomy in terms of choice, control and continuity of care; and addresses her social, emotional, physical, psychological, spiritual and cultural needs and expectations.

1.9.8 Intervention Research

Intervention research is the design and development of interventions which lead to purposeful change.

1.10 Conclusion

The background and introduction provided the reader with an overview of the challenges in providing respectful maternity care internationally, and in South Africa. The concept of midwives' obstetric units in the South African context, is described. This is important as the study was conducted at eight MOUs in a health district in Gauteng. This chapter presented the problem statement, purpose and aim of the study, and the objectives. The first three steps of Fraser and Galinsky's framework for international research, was used to guide the design and development of an intervention programme to enhance RMC by midwives in public obstetric units in Gauteng. Table 1.2 gives an overview of the study components aligned to each of these three steps. Operational definitions were given for commonly used lay terms in this study.

1.11 Introduction to Chapters in the Thesis

The research methodology is discussed in chapter two. In chapter three, the in-depth interviews with women about their intrapartum experiences is described and analysed using Tesch's content analysis. Chapter four describes the data collection and analysis from the midwives' naïve sketches and chapter five features the data collected and analysed from nominal groups, with midwives. In chapter six, a scoping review focuses on intervention studies carried out in Sub-Saharan Africa. Chapter seven is the design and development of an intervention programme to enhance respectful maternity care in labour, by midwives in MOUs. Chapter eight describes refining and confirming the components of the intervention programme. Chapter nine features the conclusion, limitations and recommendations from the research.

The next chapter will present the research methodology.

CHAPTER TWO

METHODOLOGY

2.1 Introduction

In this chapter, the methodology used in this study is explained. Table 2.1 provides an overview of the steps in the research according to Fraser and Galinsky's research framework. Step 1 (one) relates to developing the programme and programme theory, in which data were collected from intrapartum women, midwives and the literature. Step 2 (two) specifies the programme structures and processes in developing an intervention to nurture respectful maternity care in labour, by the midwives. Step 3 (three) relates to refining and confirming programme components by an expert panel review. Step 4 (four) - implementation of the programme and step 5 (five) - evaluation of the implementation process - were outside the scope of this study and will be implemented in post-doctoral work. The chapter concludes with a discussion on trustworthiness and ethical considerations.

2.2 Research Design

A multi-method design with qualitative research methods and interpretive phenomenology using three steps, based upon Fraser and Galinsky's (2010) intervention framework was conducted. Various qualitative data collection methods were used in an attempt to explore respectful maternity care with mothers and midwives, which will be described in the section on data collection. The findings were used to develop an intervention programme aimed at promoting respectful maternity care practices in the MOUs.

2.2.1 Qualitative Methodology

Qualitative research requires an in depth understanding of a social phenomenon within its natural setting. It relies on human experiences to make meaning of the phenomenon (Hennink, Hutter and Bailey, 2011). In this study the social phenomenon being researched was respectful maternity care, but, inevitably, disrespectful, and abusive care of women in labour and birth by some midwives was identified.

In qualitative research, multiple systems of inquiry are used for the study of human behaviour, rather than statistical procedures. The most important function of qualitative research is that it gives a voice to the participants' needs. Bradshaw, Atkinson, and Doody (2017) point out that qualitative methods are particularly useful when conducting research in busy maternity units

where it is important to hear the participants' voices, who, in this study, are postnatal women and midwives in the MOUs.

Researchers doing qualitative research seek to explore a phenomenon, in order to describe and understand it (Cresswell, 2009). According to de Vos *et al* (2011), qualitative research can produce a large amount of information about a relatively small group of people, which aids in developing a rich understanding of the phenomenon but reduces generalization. Qualitative research gives meaning to the way in which people see the world, in the world where people act, and through inductive reasoning examines why people act and behave as they do. Neuman (2006) describes the qualitative research process as "spiraling" rather than being linear – a constant process of refining. Qualitative data is data that describes something and can be recorded. This data can be arranged into categories that do not have a number associated with it (de Vos, *et al*., 2011).

In qualitative research, a common method of analysis is thematic analysis, which is used to identify and discuss the phenomenon (in this case, respectful maternity care) through the voices of women and midwives. The process of reaching themes is by coding words, the arise from participants' phrases that relate to the study. Then grouping the initial codes into an idea, or more comprehensive categories and then interpreting these categories in to encompassing themes. (Grove, Burns, and Gray, 2013).

2.3 The Fraser and Galinsky (2010) Research Framework

Fraser and Galinsky's (2010) five step model of intervention research was developed to assist them in designing and developing social programmes, and was thought useful in guiding the researcher's study on respectful maternity care as it is based upon human behaviour and can be used for designing varying complexities and sizes of intervention. It also takes cognizance of risk identification as one of their premises is that an intervention should only be designed around what they refer to as 'malleable' risk. In other words, interventions should only be designed around issues that can be subjected to change and improvement.

The five (5) steps of the intervention are: (1) develop problem and program theories; (2) design program materials and measures; (3) confirm and refine program components; (4) test effectiveness in a variety of practice settings; and (5) disseminate program findings and materials. These steps are illustrated below in a table which summarises how they were applied in this study.

Table 2.1 Overview of Study Components

Fraser & Galinsky's steps	Research study objective	Population	Sample	Method
Step1 Developing the programme and programme theory	1.1. To determine women's experiences of respectful care received during labour and birth by the public midwives in obstetric units in Gauteng	Women who delivered in MOUs in Johannesburg	Convenience sample of 5 women at each of 8 MOUs n = 40	Semi-structured interviews
	1.2. To establish midwives' notions of respectful maternity care at MOUs in a district in Gauteng	Midwives employed in MOUs in Johannesburg	Purposively selected midwives from each of the above units n = 45	Naïve sketches
	1.3. To establish the constraints and opportunities which exist for the midwife in terms of providing respectful maternity care at MOUs in a district in Gauteng	Midwives employed in MOUs in Johannesburg	Convenience sample of midwives from the MOUs (3 groups of between 4 and 8 participants each) N = 18	Nominal group technique
	1.4. To review sub-Saharan African literature on the provision of intervention programmes enhancing respectful maternity care by midwives in maternity facilities	Data bases: Science Direct; Scopus; PubMed	Peer reviewed articles published in English between 2013 and 2018. Search words "disrespect and abuse"; "intervention"; respectful maternity care; midwife.	Scoping review according to JBI guidelines
Step 2 Specify programme structures and	2.1. To develop an intervention programme that will foster respectful care towards women during labour and birth, by the midwives at obstetric units in Gauteng		Data collected during the first step of the research study	Programme developed according to ADDIE model (Kurt, 2017)
Step 3 – confirm and refine programme	3.1. To confirm structure and contents of the intervention programme to enhance RMC by midwives in a district in Gauteng, based on the study	Midwifery experts employed within Johannesburg district	Six purposively selected selected midwifery experts with expertise in each of the categories: Clinical midwifery; midwifery education; midwifery management; quality in midwifery	Modified Delphi technique
Steps 4 and 6 are not included in the scope of this study				

The objectives in Step 1.1, 1.2, and 1.3 relate to data collection and analysis from women and midwives. The objective of 1.4 relates to data collection and analysis from the literature using the format of a scoping review.

Steps 2 and 3 relate to the development, design, and refinement of the project components of a proposed intervention.

Steps 4 and 5 relate to dissemination and testing the effectiveness of the intervention and are not within the scope of this study.

This study was conducted in eight Midwives Obstetric Units (MOUs) in a large metro health district in Gauteng, with 7 sub-districts serving 5 006 517 people. In this district there are 421 Ward-based Outreach Teams (WABOTS), 107 municipal clinics, 10 community health centres and MOUS, two district hospitals, 2 referral hospitals, as well as 3 tertiary hospitals (Gauteng Department of Health, 2018/9 – 2020/1).

As described in Chapter 1, a Midwife Obstetric Unit provides facility-based maternity services to low risk pregnant women and is operated and managed by midwives. When a woman develops a complication of pregnancy or labour, she is transferred to a hospital where obstetricians and 24-hour theatre facilities are available. The nursing activities at an MOU reflect standardized nursing care of labouring women, as outlined in the Guidelines for Maternal Care in South Africa, 2016 Edition. Midwife Obstetrics Units have been selected as this is where 'normal births' take place and where women deliver within their own communities.

A wide cross section of the community lives in this Metro Health District, in a range of abodes from informal shacks to formal housing. The areas around each CHC and MOU represent different socio-economic, tribal, cultural, and religious groups, with a tendency for foreign nationals to live in clusters in specific parts of the health district, together with South Africans. Most of the women using the services of the Midwife Obstetric Units are from the lower socio-economic group and/or do not have the services of a medical aid scheme.

2.4 Research Setting

The research setting is the physical and social environment in which the study was conducted. The research setting reflects the participants in the study, the way data was collected and the interpretation of the study findings. The description of the research setting provides the context in which the study findings are applicable (Grove, Burns and Gary. Spirit-Statement 2021).

The participants in this study were mothers and midwives within the natural, uncontrolled, real-life setting (Grove, Burns and Gary 2013) of MOUs, in a health district in Gauteng. MOUs are within Community Health Clinics at primary / community health level (please refer to chapter 1.3 for the detailed outline of the MOU concept). These units look after low risk women, in a low technology environment. Most of the time, the midwives work on their own, with the presence of doctors or other members of a multi-disciplinary team.

In this study, the research took place in the natural setting of the MOUs in a district of Gauteng.

Data collection methods:

The data collection methods of having the midwives write naïve sketches on their (lived) experiences of RMC as midwives, and the interviews with women on their intrapartum experiences, are both forms of descriptive phenomenological methods used in the study. Both methods embrace the core of Giorgi's phenomenological psychology method where "the meaning of one element is understood in relation to the whole" (Isabirye and Makoe 2018). However, the research design was not a phenomenological design.

Chokwe and Wright (2012) described the naïve sketch, a self-report technique where participants wrote about their personal experiences and perceptions, answering a specific question.

The naïve sketch technique was used in this study for data collection on the midwives' experiences of RMC. This data collection method was chosen as it allowed the midwives in the MOUs to think about what they wished to share, anonymously (Speziale and Carpenter 2007).

The instruction was: "Please write down your experience of respectful maternity care. The form of writing is unstructured and free style. Write as your thoughts flow."

The instruction was pre-tested with three midwives from a local hospital not included in the study. No adjustments were made to the instrument following the pre-test.

2.5 Population

Population is defined as a specific group of people who meet the sampling criteria. An accessible population is the portion of the population the researcher has reasonable access to (Grove *et al*., 2013).

2.5.1 Step 1.1: The population for this step was **women** who had delivered in MOUs in Johannesburg three days prior to the data collection, and who were attending their routine third day postnatal follow-up visit.

2.5.2 Step 1.2 and 1.3: The population for these steps were the **midwives** employed in the MOUs included in this study. The total population for midwives (at the time of the study) at eight MOUs was sixty-four midwives. The characteristics of the target population were midwives who were all registered nurses and midwives (i.e. all midwives in South Africa have to be registered nurses).

2.5.3 Step 1.4: The literature accessed for this study was found in Scopus, PubMed and Science Direct data bases.

2.6 Sample

Sampling involves selecting a group of people, events or other elements with which to conduct a research study. Sampling is the way to reflect the population being studied (Grove *et al*., 2013). The sampling required in this study included sampling of the health district, the health facilities, the women, and midwives as well as the selection of literature.

2.6.1 The Health District

The Metropolitan District of Johannesburg was chosen as it serves the highest population in Gauteng where the health facilities were geographically accessible for the researcher. The areas around the CHCs were diverse in the communities they served – inner city, residential and peri-urban; and in terms of nationality - South Africans and foreign nationals mostly from Mozambique, Zimbabwe, Malawi, and Nigeria. The Metropolitan Health District services Alexandra Township (which has a mixture of informal and formal housing), Hillbrow (which is a densely populated, high rise living, inner city suburb) and greater Soweto (including formal and informal housing), Lenasia (a mainly residential area) and Orange Farm (a peri-urban area, some distance from the city centre), which is one of the largest informal settlements in the country.

2.6.2 The Health Facilities

There are ten MOUs in the district but while the researcher was given permission by the district management team to use all ten health facilities, two facility managers declined access to the MOU. A total of eight MOUs was therefore included.

2.6.3 Sampling of Women at the Postpartum Clinics

Inclusion criteria: the women were all postnatal, almost exclusively on day three post-birth, when they visited the clinic. The ability to speak understandable English was necessary.

Exclusion criteria: women who did not understand English. No interview was conducted and systematic sampling continued (please see explanation on the use of a field worker).

A sampling framework was used to determine equitable representation of women from all of the 8 research sites.

Systematic sampling was used to select the women to participate in the study. Once the first interview had been conducted, the researcher selected the third woman next in the queue to participate in the study to ensure she did not delay the examination and that the women did not lose their place in the queue. All the women were interviewed at their third day postpartum visit to the CHC so that they had fresh recall of their childbirth experience and the care they received from the midwives**.**

Five women from each of the eight MOUs were interviewed with a sample size of 40 women. Saturation was reached after 34 interviews.

2.6.4 Sampling of Midwives

The intention was to use a total sampling method for the health facilities, which is a type of purposive sampling that includes all the facilities in the sample. This is done to ensure that all characteristics of those in the sample are equitably represented (Laerd, 2017). Purposive sampling was used with the midwives as the study only utilised the midwives who volunteered.

Naïve sketches: Purposive sampling only took into account the midwives who volunteered to complete the naïve sketches. The researcher visited each MOU at the early morning handover to explain the research to midwives going off from night duty and midwives going on duty. Each MOU was visited twice to explain the research to midwives working on two alternating teams.

All midwives who agreed to participate were included. Forty-five (45) midwives participated which represented 69.23% of all the midwives employed at the eight MOUs. Quotes from this group of midwives are reflected as ‘M’ i.e. M1 = first midwife, M2 = second midwife.

Inclusion criteria: midwives currently working in a labour ward at an MOU.

Exclusion criteria: Labour Unit Managers – this encouraged the midwives to share freely without fear of censure.

Nominal groups: Convenience sampling was used in this stage. Three nominal groups were held and midwives attending the monthly MOU and clinic meetings were approached to participate. Eighteen midwives agreed to participate in the three nominal groups. These midwives were not necessarily from the same subset of midwives who wrote naïve sketches. There were three nominal groups of midwives, with six in each group n=18). The midwives who participated in a nominal group were volunteers who were available at the time of the nominal group discussion. Quotes from the midwives participating in nominal groups are reflected NG (nominal group) and number (participant number) i.e. NG1:6 = nominal group one, participant six.

Inclusion criteria: midwives currently working in a labour ward at an MOU.

Exclusion criteria: Labour Unit Managers – this encouraged the midwives to share freely without fear of censure.

2.6.5. Scoping Review

Peer reviewed articles published in English between 2013 and 2018 were accessed from the data bases. Search words included "disrespect and abuse"; "intervention"; "respectful maternity care"; and "midwife". Details of the scoping review including the population and sampling will be found in chapter six.

2.7 Data Collection

The data collection methods for Step 1.1, i.e. interviews with women, Step 1.2 i.e. the naïve sketches of the midwives, and Step 1.3, i.e. the nominal groups, are described below. The data collection for the scoping review is discussed in Chapter 6.

2.7.1 Step 1.1: Women's Intrapartum Experiences

By using semi structured interviews, the researcher sought to capture women's perceptions of the manner in which they were treated by the midwives during their labour and birth experience (Hennink *et al*., 2011). This interaction between the participant and researcher leads to data comprised of words (Grove *et al*., 2013). The interviews were conducted at the MOUs, which are situated within a local community, which assisted the researcher to identify the context where women received maternity care.

The semi structured interview guide (Annexure 2.1) was developed by the researcher based on the seven categories of disrespect and abuse, as identified in the Charter of the Seven Universal Rights of Childbearing Women (White Ribbon Alliance, 2011). Probes were included to encourage the participants to provide clarity and further information to assist the researcher to understand the participant's point of view. Prior to its use in the study, the semi structured interview guide was pretested to check for credibility on three women, who had recently birthed at one MOU in the district. It was important to check that the language was easily understood and that it did not include medical jargon. Two questions and probes were rephrased after the pre-testing to improve clarity regarding the information being sought. Question 2 was rephrased to include the word "care" instead of "help". These probes were detailed as part of the semi structured interview guide. In question 4, the words "labour companion" were replaced with "birth partner".

The researcher visited each MOU postnatal follow up clinic and spent a morning at each MOU interviewing postpartum women about their recent childbirth experiences. Each MOU was able to provide the researcher with a private room in which to conduct and audio record the interviews.

At the beginning of the researcher-mother interaction, the research was explained to each woman, using the participant's information sheet (Annexure 2.2). The researcher then asked the woman to explain what she understood about the research to check for understanding. Consent was obtained from each participant who agreed to participate in the study (Annexure 2.3). This form was signed by each woman, consenting to audio recordings of the interviews for the purpose of verbatim transcription and data analysis. Included in this consent was the woman's agreement for the use of anonymous quotes to be used in the research report.

The interviews were conducted in English. Interviews with women who were not sufficiently proficient in English to enable the researcher to understand their points of view were thanked for their participation, however, the interviews were not included in the sample. The interviews were conducted in a closed room, thus ensuring confidentiality for each participant, so that their responses were not heard by anyone else in the postnatal clinic.

In order for the researcher to create rapport with each interviewee, the researcher and participant sat facing each other with no barrier in between them. The researcher asked a few general questions leading to small talk to help establish this rapport and create a relaxed environment, after which the interview commenced.

Some women interviewed had presented in labour at the MOU and had subsequently been transferred to a hospital in the district due to complications. Although these women had not delivered at the MOU, the researcher interviewed these women to gather insight into their experience of being diagnosed with a complication at the MOU, the time it took for an ambulance to transfer the woman to hospital, the transition from a midwives unit to a hospital high risk unit, and how they were treated by the staff at the hospital as it was thought that these were all important aspects of respectful care.

The interviews were transcribed verbatim shortly after each interview to ensure maximum recall of the experience.

2.7.2 Step 1.2: Midwives

2.7.2.1 Naïve Sketches of Midwives

Naïve sketches can be used to investigate a person's experience, perceptions, attitudes and feelings (Moagi, 2014). Naïve sketches are brief essays written by the participants in response to a probe or question, thus the context of the participant's experiences is established.

The midwife participants were given a participant information letter (Annexure 2.4) and signed consent (Annexure 2.5) to provide the naïve sketches. In this consent form, there is a sentence that refers to agreement of the participant to the use of their responses (words), being used in the research reports, the thesis, presentations, and training i.e. verbatim quotations.

The instruction on the naïve sketch tool (Annexure 2.6) asked midwives to write freely about their experience of respectful maternity care. The purpose of using this data collection method was to explore and understand the midwife's personal experience of respectful maternity care.

2.7.2.2 Nominal Groups with Midwives

Nominal Group Technique

Nominal group technique is used to engage participants in dynamic group decision making to gain consensus for prioritizing issues.

A nominal group process is structured in a manner that provides orderly proceedings in order to obtain information from specifically chosen target groups. The strength of using a nominal group technique is that the group participants determine which issues are for further inquiry and raise issues that have not yet been identified (Ven and Delbecq 1972).

In nominal groups, domineering participants are noted and redirected, so that all participants participate equally in the group discussion – which is often highly problematic in focus group discussions.

Using a nominal group technique has other benefits, including limiting the researcher's influence on the prioritization of issues requiring inquiry or development. The nominal group technique is particularly useful when the research group is culturally different from the researcher, and may lead to the researcher gaining an understanding of different perceptions influencing the ideas being generated and discussed (Van der Laenen 2015).

The ideas discussed in the nominal groups were then used to guide further development of the intervention programme as raised by the participants.

The quality of data obtained from nominal groups in research is influenced by the successful recruitment of participants who have experience and insight into the phenomenon being researched and developed (Olsen, J 2019).

The researcher was invited to attend the monthly meetings of the MOUs which are held in the closest affiliated Community Health Centre. The nominal groups were held after each meeting with those midwives who had agreed to participate. A total of eighteen midwives participated in the nominal group discussions. Three groups were held with between four and six members each.

The nominal group discussions were held in the CHC's boardroom or training room where the participants sat around one big table. The researcher had provided food and refreshments to promote a more relaxed atmosphere for the discussions taking place. All the participants knew anonymity was not possible. However, the researcher did request that no information from the discussion would be shared outside the group. The participants were given the information sheet (Annexure 2.6) and completed the consent to participate in the group (Annexure 2.7) as well as a second consent form for the group discussions to be audio recorded.

The researcher used the Centre for Disease Control and Prevention (USA CDC updated 2018) guidelines to run a nominal group. The steps outlined in this guideline are as follows, and provide the rationale for using a nominal group discussion:

Step 1 Generating Ideas: The researcher provided a card and pen to each participant and asked them to identify opportunities and challenges relating to the provision of respectful maternity

care from the midwives' perspective. Each person silently generated their ideas and wrote them on the cards.

Step 2 Recording Ideas: Each participant was given a chance to speak about the challenges and opportunities which they had written on the card. Once every midwife had been heard, the group discussion occurred, ideas were captured, and care taken that all members' ideas had been recorded.

Step 3 Discussing Ideas: The researcher, who was facilitating the group, encouraged discussion around how the ideas generated would make a difference. This invoked a great deal of discussion and it was difficult to move to the fourth step as the midwives appeared to find it cathartic to discuss the issues raised.

Step 4 Voting on Ideas: In this stage, the midwives were asked to 'vote' on the five most important challenges to providing respectful maternity care and then, as a group, to reach consensus on the priorities. The researcher noted what criteria were used to prioritize ideas.

In all 3 nominal groups, the researcher found that the nominal group technique worked well for giving individual members a chance to respond to the questions posed. The participating midwives expressed that the exercise had helped them debrief the situations they faced at the MOUs.

2.7.3 Integrating the Findings of the Study

The research objectives (Table 2.1) guided the methods of data collection and the data analysis process. Recommendations from each data set are identified in Table 7.1 Findings Matrix. The meta inferences in Table 7.2, made through inductive reasoning, guided the design of the intervention programme.

2.8 Data Analysis

Data analysis in qualitative research is a process where the researcher is immersed in the data with the purpose of finding the meaning and interpretation of the study participant's experiences to form an evidence-based understanding of the research topic (Hennink *et al*., 2011). The process of data analysis is to follow established procedures in order to provide rigour and structure to the findings. Data analysis has an interpretive nature (Hennink *et al*., 2011) as, according to Corbin and Strauss (2008), the researcher seeks to understand and explain the participants' experiences of the study phenomenon. Data analysis in this study

involved making sense of both the mothers' and midwives' perspectives in order to develop a suitable intervention to promote respectful maternity care in labour by the public midwives in the MOUs in a district n Gauteng.

In analysis of qualitative data, it is common to use thematic analysis which gives more depth of explanation to words that have been used in a specific context. It also relates to the research question and research objectives.

2.8.1 Step 1.1 Women's Intrapartum Experiences

The data gathered from the women's interviews regarding their intrapartum experiences, were analysed using thematic analysis according to Renata Tesch's 8 steps for organizing unstructured qualitative data in *Qualitative Research: Analysis Types and Software Tools* (1992). The analysis was done manually rather than using software. The process of determining themes is by identifying three to six key issues from the abstract ideas that summarize the entity being researched (Grove, *et al*., 2013). In order to identify the themes and sub themes, quotations from the transcribed data were used. These quotations increased the transparency of the analysis and its interpretation.

Tesch (1992) suggests that in **step one** the researcher needs to become familiar with all the data. The researcher had transcribed the data which made reading through it easier. By reading through the data a couple of times, the researcher was able to get a sense of the whole concept of respectful midwifery captured in the interview.

In **step two**, Tesch (1992) suggests rudimentary coding. The researcher again read through each interview and identified topics which she wrote in the margin of the transcript.

In **step three**, the researcher studied the topics she had identified and formatted them onto one document with columns, in which she wrote common or similar topics. She then began clustering the topics and naming those clustered topics.

In **step four** the researcher started organizing the topics by checking them against the data to ensure the list of topics were relevant and represented the data. During this process, changes were made to the names of the topics and groupings, after which the data were coded line-by-line according to the codes and themes agreed upon at this stage with the researcher's supervisor, who acted as a co-coder.

In **step five**, Tesch (1992) suggests refining the organizing system. This was done, and final decisions made about naming the categories and themes, after which the data were mapped. The final map is shown in chapter 7, table 7.1 and 7.2 of the study. During this stage, the researcher included elements that Tesch suggests should be **stage six** i.e. the naming of the categories and the assignment of abbreviated codes for easy management of the data.

Once coding is complete, then, in **step seven,** the researcher started to do some preliminary analysis by looking at the data in one category at a time. By re-reading the quotes that had been put into a category, it was possible to develop an in-depth understanding of what was being said in relation to the category. During this stage, the researcher regularly checked the research question to ensure the relevance of the data and the appropriateness of the analysis.

Step eight involves refining the organizational system and categories which may lead to recoding some data. As the decision was taken early in the study to use the themes and categories arising from the women's interviews as a template for analysing the data from the midwives, there were inevitably some changes made to the final organizing system, which were then useful, collectively, in addressing the outcome of the study.

2.8.2 Step 1.2 Naïve Sketches and Nominal Groups with Midwives

The themes and sub themes identified from the thematic analysis of the data from the women were then used as a template to analyse the data from the midwives' naïve sketches and nominal groups, in order to have a common method of data analysis.

Template analysis is used to organize and analyse text data according to a coding template of themes and sub themes (King, 2016). The value of using template analysis is that it helps reduce large amounts of unstructured text into a relevant and manageable format. The researcher found that template analysis helped significantly in comparing the perspectives of the two sets of participants – that of the mothers and midwives. Template analysis can be used to explore relationships and trends in the data, which may aid the understanding of the data. The templates serve as a base for the researcher's interpretation of the data sets and for writing the findings (King, 2016).

The midwives' naïve sketches were written, which made it unnecessary to transcribe in the usual manner, but they were all typed up onto a common template to ease the management of the data. The discussions in the nominal group were transcribed verbatim and the field notes made by the researcher were also used in the analysis.

The data was then integrated and triangulated with the findings from the scoping review. This data was used to identify potential programme materials to be used in the development of an intervention to promote respectful maternity care in the MOUs.

2.8.3 Integrating the Findings of the Study

The research objectives (Table 2.1) guided the methods of data collection and the data analysis process. Recommendations from each data set are identified in Table 7.1 (Findings Matrix). The meta inferences in Table 7.2 guided the design of the intervention programme, made through inductive reasoning.

2.9 STEP TWO: Developmental Phase: Developing the Intervention Programme Materials Aimed at Enhancing Respectful Maternity Care

The data collected and analysed in the first step of the intervention programme development, which included data collected from the mothers, data from the midwives (both described above), and data collected from the scoping review (described in Chapter 6), were used to develop the intervention programme. The ADDIE model described below was used to facilitate the process of developing the intervention programme itself.

2.9.1. The ADDIE Model

The origins of the ADDIE model appear to be obscure, but Kurt (2017) recommends its use in designing education and training programmes. Molenda (2003), who went to a great deal of trouble to find the origin of the model, concluded that there is no original, fully elaborated model. Instead he suggests that the term is an umbrella term that refers to a family of models that share a common structure, which is the stages of the model, and all, including Kurt (2017) refer to the five phases as follows:

A – Analysis
D – Design
D – Development
I – Implementation
E – Evaluation

The ADDIE model provides for a systematic approach where the end of one phase informs the subsequent phase. These phases provided a useful guide to developing the intervention for

respectful midwifery care, as the data collected in stage one of the study, largely became the analysis phase of the intervention programme.

The ADDIE model has been used in the development of courses in many different disciplines and there are examples of its use in the last 5 years in the development of courses in on-line learning (Quesada-Pallarès, Sánchez-Martí, Ciraso-Calí *et al*., 2019); language learning (Ghani, and Wan Daud, 2018); behavioural health; teacher professional development (Trust and Pektas, 2018); chemistry teaching (Shibley at al., 2011); and nursing. This indicates how flexible it is which also added rationale for its use in this study.

Each phase will be described in terms of the theory of the model, followed by the actions taken by the researcher to design the intervention.

2.9.1.1 Analysis – Goal Setting

The analysis phase consists primarily of establishing the characteristics of the group for whom the course is designed (Shibley *et al*., 2011), and there is general agreement among authors that it should also establish the learning environment, the needs of the learners, and the goals of the course (Peterson, 2011; Kurt, 2011; Drljača, Latinović, Stanković *et al*., 2017; Khalil *et al*., 2016).

With regard to the **characteristics** of the learners, the researcher established the socio demographic data and educational background during the data collection phase of the naïve sketches and the nominal groups. As a lecturer in midwifery with experience both at college and university level, she is familiar with the formal programmes that midwives follow in their basic training and in the Diploma in Advanced Midwifery. The database of the South African Nursing Council (SANC) was also accessed for pertinent regulations and training course frameworks to verify information. These included the following: The South African Nursing Council (SANC) Regulation 254 (Diploma in Midwifery) and Bachelor's Degree in Nursing and Midwifery Framework and The Advanced Diploma in Midwifery Framework and the Nursing and Education Training Standards.

The researcher spent more than 48 hours in the MOUs during data collection and during this time observed the settings as well as collecting information about the **environment** during the data collection phase.

The **needs of the learners** were established during the analysis of the data collected from both the mothers and the midwives, as the goal was to establish what was required to improve the standard of respectful midwifery care. The assumption of the researcher was therefore that the gap between what the mother wanted and needed, and what was delivered, would form the basis of the content of the course. The needs of the midwives were also established as the constraints for providing respectful midwifery were also explored.

2.9.1.2 Designing the Intervention Programme

Drljača *et al* (2017) explain that the main purpose of the design phase is to create the course by using the information gathered in the analysis phase, and, in conjunction with learning theories and models, explain how learning will be acquired. Durak and Ataizi (2016) suggest the purpose is to respond to the question of how the objectives that were created in the analysis phase, will be answered. Both these authors, in addition to Kurt (2011), indicate that lesson planning should occur during this phase. This should include decisions regarding content which should be broken down into manageable tasks, the selection of media and resources to be used, and the methods of instruction and format of the course.

The researcher chose to use a constructivist approach (Chaves, 2008) for the development of the course. This approach is based on the theory that people construct their own understanding and knowledge by means of experience, and should be given a chance to reflect on those experiences (Fernando and Marikar, 2017). Learning is therefore an active process and requires interaction with others. One of the issues that became clear during the data collection phase was that the midwives did not understand, or chose not to understand, the needs of the mothers. It was therefore important to the researcher to give the midwives a chance to 'hear' what the mothers had said, which lent itself to an active participation workshop approach.

The content was therefore turned into experiential exercises using different learning techniques and time was built into the workshop for reflection on the issues raised as well as time to discuss issues.

2.9.1.3 Development Phase

Durak and Ataizi (2016) refers to the development phase as "the phase of preparation of the elements determined in the design phase." Khalil *et al* (2016), while agreeing that the design phase informs the development phase, refers specifically to this development phase as being

the one in which content is created and developed. It is in this phase where the structure and flow of information to be presented is considered.

Gomide, Bernardino, Richter *et al* (2004) named the first prototype of their intervention "the alpha version"; subsequent ones, "beta version"; and once they were satisfied with the design and it had been through testing with experts, the "gold version", which was the version which will be used for the roll out.

In this study the researcher developed the equivalent of the "alpha version", which was then shared with a panel of experts who made inputs, after which an amended version, which the researcher refers to as the "beta version", was developed as the roll out, and is not within the scope of this study and will be done as post-doctoral work.

Once the decision had been taken in the previous phase to use a constructivist approach, and therefore use interactive learning activities as well as having decided an in-house workshop was the most feasible approach, the task of developing the learning materials began. This was done as an iterative process where the researcher and her supervisor decided upon the best learning materials to use, based on a good understanding of learning theory. The sections of the workshop each had various possible activities, and these were carefully considered while constructing the alpha version of the workshop. Details of the decisions will be found in chapter 8 where the intervention is described.

Once this was done, step 3 of the research design of Fraser and Galinsky (2010) was entered, which involved confirming and refining components of the programme. This phase however, in terms of the ADDIE model is the continuation of the development stage.

2.10 Step 3: Confirming and Refining Components of the Intervention Programme

As stated above, this step in the research study was a continuation of development in terms of the ADDIE model. In this phase, the alpha version of the intervention was taken to a group of experts with the intention of reviewing and confirming the contents of the intervention.

2.10.1 Data Collection

A group of six (6) purposively selected midwifery experts, all from the Johannesburg district where the research study was carried out, with expertise in each of the categories: Clinical midwifery; midwifery education; midwifery management; quality in midwifery, and midwifery

research was convened with the purpose of reviewing and confirming the elements and form of the proposed intervention programme.

The participants were selected by requesting the District office to recommend midwives who had the expertise to participate and to ensure that they represented the population. Those who were nominated were then approached individually, and once they gave informed consent were invited to attend a workshop at a neutral venue to ensure there were no interruptions. Six midwifery experts attended the session.

A facilitator with expertise in facilitating groups managed the process. The researcher and her supervisor were observers at the session. The discussions were digitally recorded and notes taken during the session, both on a flip chart for the participants to see and by a scribe which were used as field notes to assist in confirming the content and nature of the discussions.

The data collection method used was a nominal group. The alpha version of the intervention programme was presented to the group who attended a session. Participants were asked to review the intervention programme, one activity at a time, discuss their opinions within the group, and then vote on whether to accept an aspect or not. This was done to promote participation, as there was concern that the experts might not complete an on-line, or paper-based questionnaire.

The copy of the alpha version of the intervention programme, which was given to the experts, can be found as Annexure 2.11. It showed all the activities, and a separate ‘voting sheet’ (Annexure 2.12) was provided for participants to record their responses. The participants were asked to record their determinations regarding the acceptability, feasibility, practical constraints, and challenges in offering the workshop to midwives working in MOUs. The facilitator encouraged discussion around each aspect of the intervention, after which the participants noted their decision.

Consensus was reached with slight modifications on the alpha version of the intervention. Participants however, required a second workshop to be developed to address ’Listening to Midwives’ to address midwives concerns. The researcher was therefore obliged to design a second workshop, as well as make the small amendments to the alpha version.

The experts indicated that they would review the beta version including the amendments to the alpha version and the new workshop online, as they were unable to convene as a group again.

A modified Delphi technique (ie. not a full Delphi study) was therefore used for the second review (See Annexures 2.12 and 2.14). The activities were listed, and participants were asked to indicate whether each was acceptable, feasible, and practical, bearing in mind the constraints and challenges in offering the workshop to midwives working in MOUs. The questionnaires were sent out by email and received back either by email or collected from the place of employment by the researcher. Of the six participants who received the beta version, five (5) responded. Repeated attempts were made to ask the sixth expert to respond, which were unsuccessful.

2.10.2 Data Analysis

There was 100% consensus on the acceptability, feasibility, practical constraints, and challenges of the alpha intervention presented. The participants felt that it was inadvisable to run a workshop purely from the mother's point of view, and agreed that a second part was required to ensure the midwives' needs were met.

The modified Delphi was analysed by calculating the mean score the participants assigned to each of the activities for all three criteria i.e. acceptability, appropriateness and feasibility.

2.11 Ethical Consideration

An ethical clearance certificate for this study was obtained from the Human Research Ethics Committee (Medical) of the Witwatersrand University (Johannesburg, South Africa).

Prior to its use in the study, the semi-structured interview guide was pretested to check for content and face validation on three women, who had recently delivered. It was important to check that the language was easily understood and that it did not include medical jargon.

2.12 Trustworthiness

Efforts to ensure this study was trustworthy used the criteria of Lincoln and Guba (1985) namely, credibility, transferability, dependability, and confirmability.

2.12.1. Credibility

Credibility refers to the confidence that can be placed in the truth of the findings of the study (Kortjens and Moser, 2018).

In this study, the criteria used to satisfy credibility were prolonged engagement, triangulation and persistent observation.

With regard to **prolonged engagement**, an effort was made to allow the participants to get to know the researcher before the interviews commenced. This was of particular importance in the case of the mothers. The researcher talked to each participant individually and developed a rapport with them prior to commencing the interview. As a result, the participants were made to feel comfortable to share their experiences in an open manner, whether the experiences had been positive or negative. In the case of the midwives, the researcher attended local meetings where she was introduced to the midwives. Following this, she made contact with them individually, to ask them to participate in writing the naïve sketches.

The participants were assured of confidentiality and the researcher was able to build trust and rapport with participants in all phases of the study. The researcher remained in the field until data saturation had been reached.

Triangulation was used as another method of assuring credibility. The study was divided into phases and the various data collection activities were designed to confirm findings from different sources, including the mothers, the midwives and the international literature.

Persistent observation was made possible by spending time in the field to establish the factors most relevant to the research problem. By using three data sources, the researcher was able to look for, and find, multiple influences during the data analysis of the different sets of data.

2.12.2. Transferability

Transferability refers to the generalisability or the degree to which the findings of the study can be transferred to other settings.

In order to facilitate transferability, the researcher included not only a thick description of the methods used, but also of the context of the study – the research setting. The concept of Midwife Obstetric Units was carefully described, as well as the actual setting – that of the Johannesburg District. Purposive sampling and data saturation also assisted this process, however, as the study took place in one district only, transferability cannot be assured and will need to be explored in post-doctoral studies.

2.12.3. Dependability

Dependability refers to the degree to which the findings can be confirmed by other researchers (Korstjen and Moser, 2018). Sufficient information or evidence needs to be supplied to ensure

that, should the study be repeated with a similar group of participants, in a similar setting, at another time, the findings would be similar.

An audit trail was kept so that records of the research path were kept. In addition to this, the researcher's supervisor provided guidance to encourage her to adhere to the research plan and acted as a co-coder during the analysis phase of the data. She also provided feedback and advice regarding the integrity of the data and the write up of the findings of the study.

2.12.4. Confirmability

Confirmability refers to congruency of the data. The data needs to reflect what the participants said, and the interpretation or analysis of that data must also reflect their meaning, rather than that of the researcher.

All interviews were audio recorded and transcribed verbatim so that the voice of the participant was recorded and is kept should there be a need to check for authenticity. During the process of data analysis, the researcher's supervisor acted as a co-coder. This assisted in guarding against researcher bias. The triangulation of the data referred to earlier also assisted in the process of assuring confirmability, as did the keeping of field notes with observations of the people and processes in the field, which the researcher was able to use to examine her own perceptual lens, and guard against these impacting on the research decisions.

Careful note of any factors that may have impacted on confirmability were recorded in the limitations of the study.

Confirmability means that the conclusions drawn from the study accurately reflect the subjective opinions of the participants rather the researcher's underlying assumptions (Brink *et al*., 2012; Polit and Beck, 2010). An audit trail was created by the following measures:

- The interviews were digitally recorded to capture all information given by the participants and they were transcribed verbatim
- All the raw data were held securely and would be kept safely for two years after publication and six years without publication.

CHAPTER 3

SEMI-STRUCTURED INTERVIEWS OF WOMEN ON THEIR INTRAPARTUM EXPERIENCES: FINDINGS AND DISCUSSION

3.1 Introduction

The methodology for this study was presented in chapter two and included the data collection and methods of analysis of the data for various steps. This chapter describes step 1.1 of the study where postnatal women were interviewed and was done to fulfil objective one of the study viz. to determine women's experiences of respectful care received during labour and birth. In analysing the data, key issues in the women's experiences, were identified, and themes and sub themes developed.

The interviews took place in the MOUs where the women were registered for maternity care, and where they returned for a mother and baby postnatal check up on day three (3) for vaginal births, or day ten (10) for caesarean sections.

A convenience sample of forty (40) women were interviewed, with saturation at thirty-four (34). However, the researcher continued until all forty women had been interviewed.

All the women were classified prenatally as low risk. There was a mix of primigravida and multigravida women. The women all live in the community in which the MOU serves (note: different communities may reflect different people groups eg. Mozambicans, and language groups eg. Pedi, and may have different cultural practices, which the midwives at the MOU are familiar with).

3.2 Themes and Sub Themes

Three themes with two sub themes each were identified during the process of data analysis as shown in Table 3.1 below. The categories of labour were, in several instances, derived from categories of disrespectful care that were cited by the mothers, which have been made into positive statements for the purpose of analysis, in order to demonstrate respectful maternity care.

Table 3.1 Themes, Sub Themes and Categories: Interviews with Women

Theme	Sub theme	Category
Midwife	Actions	● Being with the woman ● Listening to the women ● Allowing presence of birth companion ● Absence of verbal and/or physical abuse ● Provision of consensual care
	Personal attributes	● Politeness ● Kindness, empathy, and compassion ● Supportive and helpful
Women	Expectations	● Pre-conceptions ● Birth companions
	Preparation	● Labour bag
Health Systems	Resources	● Consumables ● Staff ● Equipment ● Ambulances ● Operating theatre availability
	Practices	● Healthcare policies ● Common practices

Each theme and sub theme are explained before the findings are discussed.

3.2.1 Theme One: The Midwife

This theme comprises of the issues raised by the women, which related to the actions and personal attributes of the midwives who cared for them in labour and birth. Women described both positive and negative aspects of midwives' actions. For example, a negative action would be where a woman describes how she did not receive the same care as other women did during labour and birth. An example of a positive action would be the midwife performing an action that the woman needed and appreciated.

3.2.1.1 Sub Theme: Actions of the Midwife

The questions posed to the women during data collection were framed around 'respectful maternity care', in other words, they were framed in a positive manner. The first question asked

was “Please tell me about your experience of respectful care and dignity in labour and birth.” Despite this, most of the responses described negative experiences, or disrespectful care. However, some positive responses were received.

Most of these positive responses were quite vague with terms such as “the midwives were actually quite nice” (P8); they were helpful (P8, 10, and 27); they gave “good care” (P27); they were respectful (P27); it was a “good experience” (P27); and “I got everything I needed” (P56). The more specific actions that women identified were that the midwives explained what was happening (P10); called the woman by her name (P28) and that the midwife attended to the patient immediately (P41).

Some examples of the women’s quotes relating to the midwives included: “*They ask please may I check you*?” (The midwife was wanting to do an internal examination). This woman was called by her name and wore her own gown during labour and birth. She continued, “*Good care in the postnatal ward – helpful and respectful, same care as other women. Good birthing experience*” (P51).

Other responses include: “*Ja, they (the midwives) helped me just to calm down. They kept on praying because they see the time now is too much*” (P28) (‘Ja’ is a South African term for ‘yes’), and *“They were informing me on mostly everything*” (P56) – who had a premature baby at 32 weeks gestation.

Some of the women experienced negative or disrespectful care from the midwives. The midwives’ negative actions were grouped in five categories viz. being alone and ignored or abandoned; not listening to the women; exclusion of birth companions during labour and birth; verbal abuse or physically abusing the women; and provision of non-consensual care or not asking permission to perform procedures.

Women talked about how distressing it was to be alone in labour and without a midwife attending to them. Some responses include: “*She look at me and she didn’t take care of me*” (P2) (i.e. the midwife just ignored the labouring woman). The absence of the midwife referred to times when the midwives were not physically present in the labour room/s: “*If she sits somewhere (in the tearoom) you don’t know what is going on*” (P2). Another participant (P4) said, “*If they decide to go and sleep or to go and sit, they will do that.”*

Women expressed an expectation of midwives to help and encourage labouring women, as stated by P35 who said, "*I think they are supposed to be there all the time when someone is in labour*."

Women in this study talked about the midwife not listening to them when she called for help, which was usually because the woman was in a lot of pain, or when she felt that the birth was imminent: *"I had the baby on the floor, three times I tell her, hey I am feeling toilet. She did not respond"* (P1). Another statement includes: *"When you tell them it is time, you must come, they don't listen to you which made you very unhappy. They say, 'no, it is not coming - it is far'* (P9), and *"I called her again, this thing is strong now again, can't take it anymore – she says 'no man you don't want to listen'"* (P52).

As the presence of a birth companion was one of the probes in the interview, most women expressed who they would have liked as a companion of choice to support them during labour and birth. One of the negative midwife's actions reported was exclusion of the companion who had accompanied the woman to the MOU, from being with the woman at birth: *"My husband was denied entry"* (P10). This is despite the fact that the woman delivered in a private delivery room (only one bed). *"My partner was told to stay outside"* (P4). This woman's husband had been present at the previous birth, also in the public sector. *"I wanted my mother with me in labour, but she was not allowed in"* (P10).

More incidents of verbal abuse were reported by the women interviewed than incidents of physical abuse. Women talked about the midwives shouting at the women during labour and birth. One woman reported being sworn at by the midwife: "*She swore at me but in the next hour she was asking for forgiveness"* (P2), and *"The midwife mustn't shout"* (P11).

Women talked about the way a midwife spoke to them as well as what the midwives said. This overlaps with the discussion on the midwife's personal attributes as experienced by the women: *"If I tell her, I am feeling pains strong. She said, you too lazy, too lazy ja"* (P1), and, *"In labour the midwives were horrible and not kind. They shouted at you. Torture we were tortured. You see others who deliver, and their children fall out of bed, horrible experience for a mother*" (P55).

Two women interviewed described physical abuse. "*They even slapped me on my hip*" (P7), and "*Sometimes they get rough with you*" (P12).

Women talked about midwives being disrespectful and rendering undignified care. The women's experiences of undignified care related predominantly to non-consensual procedures. Non-consensual care was described especially about the way a midwife did an internal vaginal examination, which seemed to be a distressing procedure for a number of women: "*She didn't ask me if she could check me, she just said I should open my legs*" (P8), "*She just said open your legs, I am doing my job*" (P52). Another example of undignified care that clearly bothered several women was being undressed and uncovered during the birth: "*And then I was naked I didn't put anything on (during the birth)*" (P4). She was told to remove her gown for the birth.

Some women reported being frustrated when the midwife did not communicate with them. For example, the findings on internal examination: "*Then after AROM (artificial rupture of membranes) she could not tell me – there was no communication*" (P4) and "*The communication is too small most of the time they don't communicate, just like it after checking you, she doesn't tell you, okay*" (P4).

3.2.1.2 Sub Theme: Midwives Personal Attributes

This sub theme refers to the qualities and the characteristics the midwives displayed as perceived by the women, as opposed to the midwives' actions which were included in the previous category.

Some midwives' negative attributes described by the women, included rudeness (P4 and P24), not speaking kindly (P9 and P52), poor communication (P4), and an unsupportive attitude (P7 and P12). Positive attributes included respectful (P28) and helpfulness (P8).

The midwives' positive personal attributes described by some women included being respectful (P49 and P38), kind (P27 and P26), being called by their own name versus 'mama' (P46) as a universal term for women: "*The midwives were helpful and called me by name"* (P49), and "*Midwives should be kind – just to support her, just to encourage her*" (P27).

The women said that midwives needed to show compassion and empathy towards women in pain: "*The nurses were supposed to understand the pain we have. They behave like they don't give birth at all"* (P4), and "*So, they have to understand it's painful as well, but some they don't understand this".* Women commented on the insensitive way in which some midwives spoke to them: "*The person attending to me was so rude*" (P4), and "*She did not speak nicely*" (P2). The women reported a poor response at times when they asked the midwife for something

during labour: "*They just want you to keep quiet"* (P4), "*They give you attitude every time you ask for something*" (P52), and *"a nice lady like you no screaming*" (P46).

3.2.2 Theme Two: The Women

This theme relates to the women's possible roles pertaining to respectful care during labour and birth, and include their expectations held and the impact of any preparation the woman made for coping with pain in labour, and the practicalities of having a bag ready to take into labour with her. The theme consisted of two sub themes of women's expectations and women's preparation for labour and birth.

3.2.2.1 Sub Theme: Women's Expectations: this sub theme arose as it was clear that women's expectations of the midwives being respectful during labour and birth can and do influence respectful care. Women's expectations of labour and birth were closely linked to the midwives' actions, attitudes, and communication. However, they were also influenced by their peers and the negative stories they had heard in the community about the midwives. For example: "*If you want this kind of job, ne', you must think carefully. You have to think the things you are going to face and you have to have a heart"* (P4). Several women reported stories circulating around the community about midwives: "*Because before I gave birth you know people talk outside stories that they say, ja, midwives are very bad, they say some midwives will beat you on your legs if you can't push"* (P8).

There were women who reported that they experienced supportive care despite their negative expectations formed by the stories they had heard. One woman said "*I really thank God because I really had good care there – I've already prayed to God because of what people say outside. I told God I didn't want to meet those kind of people. I had good care"* (P8).

Almost every woman interviewed expressed the desire to have a birth companion, either her mother, sister, or (male) partner as the companion of choice, to support her through labour and birth: "*At least a woman, not a man, not his father, no."* (P28), "*Ja, like my sister"* (P24), or, "*I would choose my husband*" (P1). One woman expressed the opinion that having a companion of her choice might protect her from adverse treatment by the midwives: "*I think if you come with your mom or sister"* (P51). This woman had a female companion for support in labour. P8 stated that "*They (mother or sister) will take care of you".* This woman had experienced physical and verbal abuse from the midwives whilst giving birth.

Women expected the midwife to support them in labour, understand the pain in labour, help them with ways to reduce pain, and care for them during labour: "*To give good care. When you feel pain they [the midwives] must attend to you"* (P7), and "*They have to communicate because giving birth is another thing, a painful thing"* (P4).

Few of the women interviewed volunteered their expectations of respectful maternity care unless they were prompted. None of the women talked directly about their rights to respectful maternity care.

3.2.2.2 Sub Theme: Women's Preparation for Labour

The sub theme addresses the effect of preparation, if any, that women had made for labour. Preparation for labour could be mental and physical preparation through education sessions in antenatal clinics or attending specific labour and birth preparation classes. Alternatively, it could have been the act of preparing a bag to take to the clinic with provisions and clothes for the mother and baby, airtime on a cellular phone, and money for a taxi to take mom and baby home.

In this study women who came prepared with their own gown or a change of clothes did not feel exposed at the time of the birth: "*Wore my own night gown. Yes, it made me so comfortable, I just put it on and went there. But I had already packed my bags and in my bag was a change of clothes"* (P8).

Women expressed that they had expected to remain clothed or covered during the birth, but this was not what some women experienced. Of interest is that 9 (nine) of the women interviewed spoke about taking and wearing their own clothes or night gown in labour and that they were not naked at birth (P8, P10, P11, P12). Five (5) women were given a gown by the facility (P27) and some of these women were told to take the gown off for the birth (P4).

The remaining women were naked and uncovered during the birth and third stage of labour. (P7 and P9).

3.2.3 Theme Three: Health Systems

Health systems refers to the organisation of institutions, people, and resources involved in delivering health care services for a specific target population. It is the arrangement of components and their interrelatedness with each other and the community they serve (World Bank, 2007).

There were two sub themes identified: health systems resources and health systems practices. Health systems resources are consumables, staff, equipment, and ambulances. Health systems practices are healthcare polices and common practices. For example, transferring women or new-borns at risk, from a primary healthcare facility (the MOUs), to a hospital. Health system practices includes the lack of policy on inappropriate provider behaviour and a facility culture that normalises certain disrespectful and abusive practices.

3.2.3.1 Sub Theme: Health Systems Resources.

In this sub theme very few women mentioned consumables and other resources at the MOUs. The women who did comment on resources were some of the women who transferred to a hospital. The referral hospitals were better equipped than the MOUs. The women who were transferred out of the MOUs expressed appreciation for the resources available at the hospital: "*Electronic foetal monitoring (EFM) was done [the midwife predicted a big baby]"* (P26), and "*They just helped me to hear the baby*" (P35). Electronic foetal heart monitoring assisted the participant in hearing her baby's heartbeat, which she found very reassuring, during a long, induced labour. P42 went into spontaneous labour and immediately went to a tertiary hospital because she had had a previous caesarean section. At the hospital she was told "*the womb still closed, no space and no nurses"*. Beds and staffing are health system resources. When this woman went back to the hospital in established labour, she was transferred to another or second hospital that had an available theatre (another health system resource involves supplies and operating theatre availability). This woman was pushing when she was transferred to another facility where she had an emergency caesarean: "*Baby was tired after the birth*" (P42). The baby spent 4 days in the neonatal intensive care unit.

Participant 46 went to the MOU in labour and was transferred by ambulance to the hospital: "*There was a lot of water and blood. No delay in getting the ambulance*". P45 stated that "*When I complained about bleeding to the doctor he did a sonar*" (P45). Her comment indicated the availability of equipment was at the hospital, not the MOU. Another woman was referred "*to the hospital because the iron was low. Went to the hospital on 30 May for caesar, had to wait till 6 June [lack of theatre availability], scan showed problem with placenta (42 weeks) so I was first on the list on 7 June"* (P54).

This section reflects the limitations of equipment and resources at MOUs – which are primary health care facilities. It also reflects the obstetrical reasons for transferring a woman out of a MOU.

3.2.3.2 Sub Theme - Health System Policies and Practices

This sub theme is about the policies and institutional practices of the health system as they affect women in labour and birth**.** The health system practices reported by the women interviewed all related to the reasons for a transfer from the MOU to a tertiary hospital: "*Baby weighed 4.340kg and was transferred to hospital overnight to observe the baby's sugar level. I was stressed*" (P44), and "*Transferred me to hospital. My centimetres were moving slow*" (P32).

As described in the section 3.2.3.1, almost every woman interviewed expressed the desire to have a birth companion, either her mother, sister or (male) partner as the companion of choice, to support her through labour and birth. The provincial policies may allow for this, but it seems that there is an institutionalised rule that does not allow birth companions, even if they arrive with the labouring women, into the labour ward in the MOUs.

3.3 Discussion of Findings

This section provides a discussion on the findings relating to the women's experiences of respectful maternity care during labour and birth.

3.3.1 The Midwife: Actions and Personal Attributes

In this study, women in labour and birth had mixed experiences of the midwives caring for them. Some women described positive actions from the midwives and experienced respectful and helpful care from the midwives, whilst other women experienced disrespectful and, at times, abusive care from the midwives.

Sandall, Devane, and Soltani *et al* (2010) reported on the fact that a midwife who is present and supporting a woman throughout labour, on a one to one basis, develops a more therapeutic relationship with the labouring woman, which leads to continuity of care and improves a woman's satisfaction with her labour and birth. This is much harder to achieve when fragmented care is provided by several midwives during a woman's labour, and the low staff-patient ratios and the shift system mitigate against continuity of care.

Dahlberg and Aune (2013) wrote about a supporting relationship between mother and midwife being a combination between meeting the woman's needs and the competence and ability of the midwife. That the competence and ability of the midwife influences her actions and personal attributes seems self-evident but has not been shown in the literature.

The study participants seem to be implying that they would like to receive women centred care. Women centred care refers to holistic care which incorporates women's specific needs (Moore, Britten, and Lydahl *et al*., 2016), but on reviewing the data, the needs that are expressed seem to be universal, rather than specific in terms of what they want from the midwives in terms of their actions. What is known is that if women centred care is given, the women's outcomes improve (De Labrusse, Ramelet, and Maclennen, 2016).

Interestingly, most of the women who were transferred to hospitals expressed positive experiences of the midwives' care. This could be linked to the presence of a multi-disciplinary team and access to more resources, including a higher staff to patient ratio, or alternatively, it may indicate dissatisfaction with the resources available at the MOUs.

Women talked about their experiences of disrespectful or abusive care from the midwives, often by way of giving a specific example that illustrated the midwife's actions during labour and birth.

Bohren, Vogel, and Klutsiv *et al* (2015) developed a seven-category model classifying instances of disrespect and abuse in maternity care. This model was developed from the findings of a systematic review of 65 studies which covered all geographic and income settings (Bohren *et al*., 2015). These categories are physical abuse; sexual abuse; verbal abuse; stigma and discrimination; failure to meet professional standards regarding informed consent, confidentiality, painful examinations, failure to provide pain relief and neglecting or abandoning a woman in labour and birth; poor rapport between woman and provider; and health system constraints. This evidence-based classification is useful as a guide to the types of disrespectful and or abusive actions by midwives during labour and birth.

The midwives' negative actions, reported by the women in this study, fell into five categories: being alone and ignored; the midwife not listening to the woman; not treated with dignity and respect; excluding birth companions during labour and birth; verbal or physical abuse; non-consensual care - right to information and informed consent. This is closely linked to the findings of the study by Bohren *et al* (2015) as shown in Table 3.2 below.

Table 3.2 Relationship between D&A Reported and Bohren *et al's* Typography of D&A

Reported in this study	Bohren *et al* (2015)
The midwife not listening to the labouring woman	Poor rapport between woman and provider
Verbal abuse	Verbal abuse
Physical abuse	Physical abuse
Not reported	Sexual abuse
Non-consensual care and right to information Not treated with dignity and respect Being alone and ignored	Failure to meet professional standards regarding informed consent, painful examinations, abandoning a woman during labour and birth.
Not reported	Stigma and discrimination
Excluding companions during labour and birth	Health system constraints

It should be noted that 'not reported' does not indicate that a particular form of disrespect did not occur, but rather that none of the women interviewed reported on either of these categories.

The mothers reported similar forms of disrespect and abuse from the midwives in the MOUs as those reported in the other articles found in international literature. Disrespectful maternity care (DMC) is a complex concept as mothers and midwives' experiences are often subjective in nature (Manning and Schaaf, 2015). Freedman and Kruk (2014) suggest that DMC "reflects on the relationship between expectations, rights, normalisation and the link between an individual's actions and the systemic condition that sustains it". In this study the women's expectations, their apparent lack of understanding of their rights, or unwillingness to insist upon them and the normalization of certain practices (or lack of them), appear to influence DMC as was seen in the findings. It would appear that this is not unusual as demonstrated in the article by Mselle, Kohi and Dol (2019) whose findings of disrespect in maternity care in Tanzania echoed the findings of this study. These authors conducted their study in both an urban and a rural area of Tanzania and found little difference between the two. They suggest

that this indicates that the level of education and the availability of resources makes little difference to the way women are treated in labour and birth.

Women explained that amongst women in the community, there is a widespread perception that some of the midwives in the MOUs were abusive, unhelpful, and punitive. Thus, some women entered the MOUs with a certain degree of negative anticipation and negative expectations regarding the care they expected from the midwives. Not listening and a lack of presence was interpreted as a lack of empathy by the women. In terms of the Universal Rights of Childbearing Women Charter (White Ribbon Alliance, 2017) this lack of attention and care can be classed as "abandonment of care."

In each of their individual publications, Lungren (2010), Maputle (2018), and Mselle *et al* (2019) all reported on midwives not listening to women in labour, and are of the opinion that this factor may be responsible for causing a negative birth experience, together with the negative practice of not displaying any emotional support during birth.

Verbal abuse was far more frequently reported than physical abuse. Many women described being shouted at by the midwife(s). The women found this particularly disrespectful and distressing. In the literature, Burrowes, Holcombe, Jara *et al* (2017) reported "that providers sometimes mocked women in an unpleasant tone of voice and shouted at the women in labour and birth. Additionally, Mselle *et al* (2019) reported that women who ask (beg) for help are referred to as "troublesome women" and as the midwives were desensitized to women's cries, they did not to respond and ignored the women's calls.

There were few incidences, described by the women interviewed, of physical abuse such as slapping the women, during a procedure or during labour and birth. Of interest, however, was that during the nominal group held with midwives, they discussed the practice and debated whether it was abusive behaviour or not. One considered it as 'part of telling the mother what to do during the delivery'. This demonstrates that slapping is done, and this negative behaviour may have become institutionalised. Burrowes *et al* (2017) reported on the physical abuse by providers observed by other providers. The most common form was slapping women on their legs in order to comply with the midwife's instructions during labour and birth.

There were women who described not being informed about procedures, not being asked for their permission to have these procedures done, and/or not being told the outcome of any procedures done. This seemed mostly to relate to vaginal examinations during labour. The studies conducted by both Bohren *et al* (2015) and Mselle *et al* (2019) refer to this issue and

the latter study indicated that consent is not obtained for surgical procedures which would also fall into this category of failure to inform and has legal consequences. Malavasi *et al* (2019) demonstrated a need for 'targeted consent' for performing an episiotomy but indicated the difficulties in setting out a procedure to follow for obtaining consent. The World Health Organization (WHO, 2018) however state that consent is essential.

In this study, the legal issues of informed consent were not the focus of the women, but rather not being informed of what was being done to them. This is not only disrespectful, but there is evidence (Verhoeven Spence, Nyman *et al*., 2019) that an absence of care, including information has a negative impact on the physiological processes of giving birth. While the experiences may not be described as abusive by the mothers, the absence of information is clearly problematic.

The WHO (2017) recommends social support for all women during labour and birth, and that the mother should be accompanied by the companion of her choice. Vogel, Bohren, and Tuncalp *et al* (2016) point out that while the choice of a labour and birth companion should be the woman's choice, it is a complex issue in South African public sector labour wards. Midwives seem opposed to having even a female companion of choice to support the women in labour. The most common reason given is that there is no privacy in the facilities and that the facilities are already overcrowded without the companions being present (Ngidi, 2017). The midwives expressed being fearful that these companions would interfere in or disrupt the woman's care. However, it is encouraging that there are some maternity facilities in the public sector are starting to include female companions in the woman's antenatal and perinatal care.

3.3.2 The Women: Expectations and Preparation for Labour and Birth

Only a few of the women interviewed expressed expectations they had of the care they would like to receive in labour and birth. Some women had been exposed to reports in the community of the midwives being unhelpful and abusive. Women who have been influenced by the negative stories being told in the community may well present in labour as being compliant and non-demanding in order to fit in with the image they have formed of the midwife. A small number of women had prepared mentally and practically for labour and birth. These women expressed that being prepared led to a more positive birth experience

Howarth, Scott, and Swain (2017) have shown that when women know what to expect in labour and have prepared themselves for the labour and birth, they are more empowered going into the birth, and they are less dependent on the midwife during the labour. Beake, Chang, and

Cheyne *et al* (2018) indicate that women not only want information, but that having information significantly reduces their anxiety when going into labour. Aksoy, Yücel, and Aksoy *et al* (2016) have demonstrated that if women expect less pain in labour, they actually experience less pain, which also indicates that good preparation and information will assist women.

3.3.3 Health Systems: Resources and Practices

The impact of poor health systems resources was not discussed by many of the women, but they became aware of the difference in resource provision when transferred from the MOUs to hospitals. As stated earlier, the study by Mselle *et al* (2019) showed that the level of respectful care, or lack of it, does not appear to be influenced by the provision, or lack of, resources.

Horner and Mashamba (2014) documented the referrals at an MOU in Tshwane North sub district, in the Gauteng province, which shows that referrals to hospitals are a relatively common practice. Forty five percent (45%) of the women booked at the MOU delivered in the MOU, 41% delivered at a hospital, 3.4% delivered at home (termed BBA – born before arrival), and 10.3% delivered somewhere else unknown to the MOU.

Midwives at the MOUs are often faced with obstetrical emergencies which may significantly impact the availability of midwives on duty (Ngidi, 2017). This may serve, in some way, to explain the intermittent lack of attention by the midwives which the women found distressing in labour and particularly in advanced labour.

The women who were transferred to a district or tertiary hospital gave positive feedback on experiencing respectful care from the midwives (at the hospitals) and the midwives' personal attributes of helpfulness and kindness. This was not universal, but it did come up repeatedly in the interviews with the women. Perhaps it can be explained by more resources, including staff, offered by academic specialist hospitals. There is a need to understand why midwives in the MOUs are not perceived as providing similar levels of respectful care.

3.4 Conclusion

The findings have shown that women had mixed experiences in the care from the midwives in the MOU. It is encouraging that some women had good experiences with midwives and were provided dignified and respectful care. Listening to the women has helped identify areas of care the midwives need to be aware of and strive to improve, which informed the development of the intervention developed in this study.

In Chapter 5 of the Guidelines for Maternity Care (2015, page 47) it states, “Treat all women in labour with respect and courtesy. Address the woman by her name. Ensure privacy and perform intimate examinations behind screens, with a chaperone, if needed. Allow family and friends to provide companionship during labour**”.** Based on the findings of the women’s interviews, this has not yet been achieved and points to the need for an intervention.

This chapter analysed and discussed the women’s experiences of respectful maternity care during labour and birth. The next chapter will address the thematic analysis and discussion of findings from the two data sets obtained from the midwives who participated in this study. Data set one is from analysing the naïve sketches written by the midwives. Data set two are from analysis of the nominal group discussions conducted with the midwives.

CHAPTER FOUR

MIDWIVES' NAIVE SKETCHES: FINDINGS AND DISCUSSION

4.1 Introduction

Chapter three discussed the analysis and findings from the data collected from interviewing women who had recently given birth, about their intrapartum experiences. This analysis led to the development of a coding template with three themes, six sub themes and six categories. The themes were Midwives, Women and Health Systems.

This chapter discusses the data analysis and findings from the data collected from the naïve sketches written by the midwives on their experience of respectful maternity care, which was done to address research objective 1.2: to establish the midwives' notion of respectful maternity care.

The instruction given to the midwives was "Please write down your experience of respectful maternity care. The form of writing is unstructured and free style. Write as your thoughts flow"

It was clear from the analysis of the naïve sketches that the midwives had taken the instruction 'to write freely' seriously, as most used it as an opportunity to 'debrief' and wrote about their concerns and some pleasure relating to their work as midwives in the MOUs. Of the 45 naïve sketches collected, only seventeen (17) (37.8%) wrote about their understanding or experience of respectful maternity care as such.

All the midwives responded as a midwife and did not reflect on their personal experience of RMC in labour and birth.

4.2. Understanding of Respectful Maternity Care

The responses which explained the midwives understanding of the term, or their experience with what is done, were categorised into three (3) themes (column 1) as indicated in Table 4.1 below. Examples of midwives' activities are given for each theme (column 2) and reflect which midwives gave these examples in their narrative sketch (column 3).

Table 4.1 Experiences and Understanding of RMC

1: Theme	2: Examples	3: Mentioned by midwife's number
Communication (Total 12 midwives)	Introductions and greeting the patient	8, 11, 16, 33, 41
	Listening to the patient and answering questions	8, 11
	Providing information/education (without being asked)	1, 2, 8, 9, 10, 11, 12, 16, 28, 30, 33,41
	Non-verbal communication	33
Patient rights (Total 12 midwives)	Respect (her wishes and preserving dignity)	8, 9, 18, 28, 29, 33, 41
	Individualized care	11, 24, 28, 29, 33, 41
	Privacy	8, 11, 16, 18, 28, 29, 30, 33
	Confidentiality	8, 18, 29
	Safety	9, 10, 11, 28, 29, 30
	Consensual care	16, 29, 30
Professional care-giving (13 Midwives)	Reassurance and encouragement	1, 2, 8, 10, 11, 16, 28, 31, 33
	Patience	31
	Providing for physical needs including pain relief	2, 8, 9
	Involvement of the patient and the family	10, 12, 41
	Adherence to policies and protocols	2, 38

It was clear from reading the naïve sketches that most of the midwives felt extremely stressed and challenged by their working environment and the nature of the work they were responsible for. Thirteen (28.9%) of the midwives recorded positive sentiments about their work, but most of these were followed by a caveat. An example was of M3 who said, "*I enjoy being a midwife in … MOU, but there are challenges that we face in the unit, for example shortage of staff*". M24 said: "*My experience in maternity care is awesome. I love it that each day is unpredictable, there is no routine".* M14 stated that "*Some patients appreciate the care that you give them. Other patients come in already with a negative attitude from home and expect the worst".* M38 said: "*I had a great experience in maternity care for the past 8 years. Delivering a baby and bringing it into the world is a great experience but this comes with a package".*

Thirty (30) of the midwives (66.7%) were clearly distressed by their experiences and did not say anything positive about the experience although many gave examples of how respectful maternity care should, or possibly is, carried out.

It was obvious from analysing the responses that the midwives from two of the MOUs were much 'happier' than those in the remaining MOUs. It is of interest that these same two MOUs have the best quality ratings, in terms of management, in the District.

4.3. Template Analysis

As stated above, the intention of this stage of the research was to establish the midwives' experience of respectful maternity care, but the responses were a mixture between their experience and understanding, as well as commentary on what it is like to be a midwife in the MOUs. As a result, further analysis was done of the naïve sketches, which commonly were over a page in length, according to the same template as was used for analysing the mothers input and the input from the nominal groups held with the midwives. There was a great deal of overlap between the data from the nominal groups and the naïve sketches, and the data provided further useful evidence for building the intervention programme.

The template used was derived from the themes and sub themes determined through the analysis of the interviews with the women (Chapter 3 Table 3.1). This method was used to align the findings from the midwives with findings from the women, in order to present a coordinated, comprehensive integration of findings at the end of Step 1 of the study.

Forty-five (45) naïve sketches were obtained from the midwives who volunteered to participate in the study. The sketches were numbered as the researcher received them back from each midwife. Participating midwives' quotes have been reflected as M1, M2 etc.

4.3.1 Theme Midwives – Sub Theme: Analysis of Midwives' Actions

In this sub theme, data that midwives wrote about which pertained to what midwives do, or should do, to promote respectful maternity care was included and referred to as 'actions of the midwife'. In the naïve sketches, 10.7% of the participating midwives wrote about actions to promote respectful and dignified maternity care. The most common midwives' actions described included explaining procedures, such as building the midwife patient relationship, providing information (e.g. how to breathe in second stage of labour), and health education (family planning, breastfeeding etc.). One participant, M16, elaborated on what explaining the procedure means. She said: *"Inform the patients of your findings immediately after the assessment"* (M16). Another (M28) said, "*Explain each and every procedure you do to the patient. Allow her to sign consent if she agrees*". And another, "*Inform the patient about procedures that are going to be performed to gain cooperation*" (M20). Midwives emphasized the need to gain the woman's cooperation and implied that the motive for giving explanations was more to do with getting good outcomes than out of respect for the patient. M1 said: *"Advise the woman how to behave in labour so that a healthy newborn baby is delivered".* Additionally, M9 said: "*I explain to all my clients what I am expecting from them. Explain the*

outcome of positive and negative behaviour in labour…If I have a compliant patient, I get a good delivery".

Midwives wrote about how a midwife might contribute to building a good relationship with women. They included mentions of privacy, empathy, communication, confidentiality, and consent. Examples are: "*Respectful maternity care is a good thing because it creates a good relationship between mother and midwife*" (M1), *"So how you as a midwife address the woman, your tone, your dress code and all the other gestures of non-verbal communication. RMC also includes – respecting patient's rights, culture, age, race, privacy and treating patient as a holistic being"* (M33)*, "Greet the patient with a smile. I found that puts the patient at ease … tell patients your name and orientate them to the unit. Address the woman by her name*" (M16), and *"When the patient comes for an admission, you greet the patient and ask how you can help her. Introduce yourself as a midwife … tell the patient to ask questions if she does not understand. You inform her about any expectations during the stay whilst she is in labour"* (M8). It was not clear from M8's response whether the 'expectations' were those of the midwife or the mother. The term 'telling' was used more frequently than terms such as 'explaining', 'informing', or 'answering questions'. Many of the responses were similar to one another and read almost like a textbook.

Midwife 18 raised the issue of positive actions of the midwife being important to prevent litigation: *"If we could respect our maternity care, we could decrease the rate of litigation that we are facing as midwives"*(M18).

Midwife 38 expressed how much she enjoyed maternity care but included a caveat: *"Delivering a baby and bring it into the world is a great experience but this comes with a package because you must learn extensively the rules and regulations of midwifery, the protocols, the policies which will guide you to preserve life between the mother and baby. There are problems when juniors are left on their own"*.

Three of the participants were more direct in relation to the fear of litigation. M25 said that "*Two midwives in a shift is not safe. When more patients come in and are not well managed causing staff member's problems and appearing at the Nursing Council for negligence*". M45 said: "*Litigations – causing young nurses to fear maternity hence resort to primary health care*". And M43 said: "*Lawyers must go back to court, so that we practice freely – serve community respectfully without fear of litigation*" (midwife 43 is referring to lawyers who are involved in advertising their medico legal litigation practices – reflecting on the effect this

widespread advertising has in inciting women to sue more frequently than in the past). All these comments may indicate that midwives feel the need to practice defensively and that their actions are motivated by the need to avoid litigation, rather than the principle of providing good quality care.

One participant did mention that respectful practice was beneficial to both the woman and the midwife. She said that *"Respectful maternity care is beneficial to both myself, as a midwife and the woman, because we both get positive outcome, the woman gets a live baby and a midwife achieves the results of better births initiatives*" (M21).

4.3.2 Theme Midwives – Sub Theme: Midwives Personal Attributes

A great deal was written in the naïve sketches relating to the personal attributes of midwives. Some midwives were clearly proud to practice well and enjoyed their work which assisted them in having positive personal attributes. They saw themselves as contributing towards providing respectful maternity care and described enjoying their work. Their pleasure in providing a service was almost always linked to statements regarding a positive working environment.

M2 said that "w*orking in labour ward is a great experience even though we sometimes face different challenges though manageable"*. M3 said*: "I enjoy being a midwife but there are challenges we face in the unit",* and, M12 said: *I can say with pride that our clinic is the best when it comes to respectful maternity care. Fortunately, our clinic has got good and respectful staff most of the time. There has been some positive comments on Mom Connect* (see footnote) *that some midwives are trying their best"*.

Personal positive attributes were also mentioned which, midwives thought, contribute to respectful maternity care. These included broad statements such as having a 'good attitude' (M1) towards the women, to more specific attributes such as respecting the woman's wishes; 'loving' the woman (M10 who referred to showing 'motherly love'); good communication with the woman and her family (M12); making them feel welcome (M11 and M12); a willingness to listen and responding appropriately to the woman; not ignoring women when they are crying or calling for the midwife; professionalism and experience.

Despite evidence from the mothers, gathered during the interviews, that companions were not welcome, M8 said *"Respect any wishes that the patient may request i.e. if she wants to have a doula*", which seems to negate what the mothers said.

Although asked about how midwives can contribute to respectful care, some midwives made comments that stated what should be done, but indicated that this is not the case, and therefore identified negative attributes of midwives. They commonly reflected those negative attributes mentioned by the mothers during their interviews. M11 said that *"Listening and responding in an appropriate manner instead of shouting. When a person is crying, don't ignore that patient. We need to respect them as human beings"*.

Footnote: MomConnect is a cellular phone App managed by the National Department of Health (NDOH). Each antenatal clinic/maternity facility has a registration number. In pregnancy, women are encouraged to register on the App. The woman will start receiving twice weekly prenatal messages aligned with her gestation age. Once her baby is born, the woman registers on the App for postpartum messages which terminate after 6 weeks postpartum. The app has a second stream for pregnant women who are HIV positive. The app allows for feedback of the maternity care each woman has received.

While midwives described personal attributes that are necessary for a midwife to do her job, many spoke of the difficulty in practising appropriately due to the challenging environment. The negative impact of work stressors resulted in midwives expressing their feelings in a negative light. They expressed feeling frustrated, angry, demoralised, and demotivated. This, in turn, led to absenteeism and high staff turnover.

According to M21, *"To deal with pregnant women who are in labour, you need to be proficient and experienced and patient"*. Midwives also described their concerns about providing care in the face of challenges: *"I fear for midwives because the MOU has a shortage of equipment and that puts the midwives at risk of litigation" (*M5), *"I find it difficult to work as a midwife due to the challenges we are coming across"* (M7), and, "*Since I have been working as a midwife my experience was very interesting but a person stay on daily fear more than enjoying her practice*" (M14).

In both the naïve sketches and nominal groups, midwives' negative attitudes were largely attributed to work environment stressors such as under staffing, management, supplies and patient related issues. These issues are strongly linked with the issues arising under health system resources and will be discussed under that heading.

Frustration impacting on personal attributes arose and was evident in many MOUs caring for migrant women from other provinces and across the South African borders. Where a language barrier exists, the midwives find it very "*strenuous*" (M6) to care for these women, as they

cannot comprehend what the midwife is saying. In return, migrant women cannot communicate their understanding and needs to the midwife: *"Respectful maternity care is lost when there is a language barrier"* (M33).

Frustration was also reported in response to the lack of support from managers and poor working environments with overcrowding and lack of equipment, medication, and consumables. According to M39, *"In some instances midwives take out their frustration on patients, leading to patient care not being the best"*, and, as stated by M7, *"Midwives don't enjoy anymore to work in labour because they don't get support from management"*.

The perceived lack of support from managers seems to exacerbate the feeling of the midwives that the working environment makes it difficult for them to have 'good attitudes'. One of the most desired forms of support from management was for counselling after a traumatic event with a mother and/or baby: *"No wellness to assist the staff because most of the cases are traumatic*" (M7). Some midwives reported that when a mother or baby dies, they "*feel demoralised and demotivated"* (M6). These feelings also occur where there is poor support from the MOU management: *"If you do good you are not praised to do better which discourages us"* (M22), *"Sometimes you get difficult patients and trying to talk to them has no results instead it makes your morale go down" (*M22), and *"Low morale makes staff not to come to work or resign. We don't have meeting where we are able to verbalise our concerns*" (M19).

4.3.3 Theme – Mothers' Expectation and Preparation for Labour

Very few of the midwives talked about the women's expectations of care during labour and birth or the women's lack of preparation for labour and birth, be it knowledge about birth, or physically preparing a bag for their stay at the MOU, which seemed to have been an important issue for the mothers. The one midwife who did raise the issue indicated it was the women's fault that they were not prepared for birth rather than the midwife carrying some responsibility for preparing the women: "*Most patients still do not know signs of labour pains. Do not plan for their newborn – clothes, transport, money, etc*" (M4).

The most prevailing issue raised by midwives in their naïve sketches, classified under this sub-theme, was the community's perception of the midwives. Some midwives reported negative perceptions and others reported good relationships with the labouring women: "*The community perceives midwives as cruel and inhuman. Pregnant women come to labour ward with that perception, and it causes a barrier between the patient and the nurse"* (M9), and "*Patient*

comes to labour ward with the attitude that nurses are non-caring. They don't understand the process of labour and are unable to take verbal instructions. They have a mind-set that nurses are shouting at them" (M6).

Of those who spoke of having a good relationship, the comments in the naïve sketches were sometimes guarded: "*Some patients appreciate the care that you give them. Other patients come in already with a negative attitude from home and expect the worst from nurses*" (M24). Others were unreservedly positive: "*Respectful maternity care is expected from both parties- a midwife and a client. We communicate with our clients and their partners and families to make them comfortable and happy with us*" (M12), "*Most of the time about 80% of women end up being friends with us as they appreciate our work towards them"* (M31), and "*Our community rely fully on us. We need to give them the best that we can irrespective of the challenges we have*" (M43).

Two of the major challenges the midwives reported on relating to mother's preparation for birth, were unbooked women, especially those who were HIV positive. If a woman is unbooked and only diagnosed in labour, or not adherent in taking ARVs, it causes difficulty for midwives and is time consuming: "*Unbooked patients they come to facility to deliver, they come with lots of health problems… We end up having maternal deaths and stillbirths*" (M7), "*Sometimes the patients are so ignorant, they don't book at the antenatal clinic in time for proper management and education. Others come to clinic being unbooked with caesarean section times 2 or 3 and they want to deliver at the clinic*" (M25), and "*In most cases those unbooked patients they come when they are fully dilated knowing very well that we will be busy delivering them. No questions to be asked from them*" (M27). Additional statements include: "*Being unbooked, some HIV positive and not on medication…*" (M32), "*High percentage of late booking for ANC due to denial of positive HIV status, if the mother knows that she is being faithful to her husband. Especially those trying to push the queue. Especially those who test HIV positive, there is no time to sit down and counsel the patient*" (M34), *"Born before arrival babies of unbooked mothers and migrants*" (M40), and "*People come from rural areas and from other countries and deliver at MOUs, others unbooked or booked late*" (M42). A more generalized comment was made by M4 who said, "*Most patients still do not know signs of labour pains. Do not plan for their newborn – clothes, transport, money, etc*".

One midwife wrote that RMC means giving encouragement and communicating with the client. She then went on to give an example: "*Admitting a woman into labour, who happened to have*

ingested traditional muthi /remedy (Isihlambizo), well known about speeding up progress of labour. Initially she was secretive about it, but after I explained what Isihlambizo does in the body, and the effects, including the outcomes of the labour, she started to understand and to open up. She disclosed about a family member giving her the muthi and told her to never tell the nurses. Labour was very painful for her even after being offered sedation. Eventually I transferred her to hospital with hypertonic uterine contractions" (M21).

Three other midwives wrote about problems related to the use of traditional medicines which impacted on their ability to care adequately for the patient: "*Sometimes we admit patient with precipitated labour, because they drink some stuff that causes them to dilate fast*" (M19), and "*Some patients go to Sangomas when in labour and are given stuff that affects the baby at birth requiring resus as they are born lifeless. In the long run the midwife is summoned to court for the low Apgar*" (M32). A 'Sangoma' is an African traditional healer – usually using a combination of herbal medicine and rituals to diagnose, prescribe and treat an illness or ailment.

4.3.4 Theme: Health System

4.3.4.1 Resources

This sub theme was the area most midwives covered in their naïve sketches. They expressed that the lack of resources was the greatest barrier to rendering RMC rather than stating what RMC meant. Although no notions of respectful care could be discerned in this section under resources, the responses have been included, as it is essential to understand the context of the midwives to develop an appropriate intervention. The issues arising under health system resources included shortage of staff, lack of consumables such as linen savers for the delivery beds, lack of medication e.g. ARVs, broken equipment, delays with the ambulance services, overcrowding of the facility, translators, and lack of support by managers.

The shortage of staff, and specifically midwives, was the single greatest challenge to offering respectful maternity care in the MOU. Staff shortages had an impact on the women, on the midwives, on the provision of quality maternity care, and on medico legal litigation: *"We are working in the unit – being 3 midwives and 1 ENA. If one midwife goes on sick leave or annual leave, no replacement is being done. This becomes strenuous for us on busy days as one midwife will have more patients to care for. It means caring for patients is compromised"* (M3), *"Staff end up being exhausted hence results in absenteeism, workload becomes a problem" (*M7), *"Too much workload. It's very stressful and exhausting" (*M19), *"Shortage*

of time sometimes make it difficult to introduce, orientate" (M20), "*Midwives have to overwork themselves and no time to rest"* (M36), and "*Absenteeism because of tiredness caused by overcrowding MOUs and also burnout syndrome due to poor working environment*" (M42).

Some midwives identified the dangers of staff shortages: *"Being two midwives on a shift is not safe when more patients come in and patients are not well managed"* (M25), and *"The challenge of some MOUs being short staffed also puts patients live at risk*" (M32).

The midwives, writing about the shortage of consumables, described having to put newspaper on the delivery beds in the absence of linen savers and linen; using masking tape to secure intravenous therapy lines; lack of sutures to stitch perineal trauma; no identity bracelets for the women including for the newborn babies; no plastic aprons/gowns to protect the midwife from blood and body fluids during the birth and if the perineum needed suturing.

The midwives were clearly aware of the problems that could result from these shortages as illustrated by M3 who said that "*Using a masking-tape instead of Opsite to secure a drip is not good quality care. There are lots of mistakes that can happen because of that practice as you are unable to assess the drip site. We do it because we don't have a choice*". M7 said: "*It's difficult to work without stock. No identification belts which is a hazard, no linens, no linen savers and we are dealing with blood specimens*". M35 and M45 wrote about how shortages impacted on care of particularly vulnerable patients: "*The respective maternity (unit) must also have equipment, BP machines, fetoscopes, dopplers etc. There must also be enough medication e.g. calcium carbonate especially for women prone to or with pre-eclampsia*" (M35), and "*Shortage of stock –it creates a problem with the management of emergencies i.e. shortage of drip sets*" (M45).

The midwives working in the MOUs may be called on at any time to manage obstetric emergencies or complications. When there is a need to transfer the labouring woman or a newborn in difficulty, the midwives and women are reliant on the availability and efficiency of the ambulance service. Midwives are often compromised, waiting with ill women or neonates for long periods of time for an ambulance to arrive: "*It can be so stressful for a pre-eclamptic patient when the needs of the patient are not met in time e.g. calling an ambulance and it took 3-4 hours before coming to fetch the patient*" (M25). This midwife also wrote about the fact of only being two midwives working per shift. When there is an obstetric emergency both midwives are often involved in stabilising the patient and the other women are unattended: "*Maternity can be very stressful as sometimes we have emergencies that require hospitalisation*

e.g. patients with an antepartum haemorrhage and we then wait for hours for an ambulance." (M32), "*Delaying ambulances causes a lot of constraints (to RMC*)" (M42), and "*Ambulance delay / closure of hospital (i.e. referral hospital has no beds) creating frustration amongst care-givers"* (M45). Additionally, according to M27, "*Ambulance takes some hours to come… problems we encounter such as a PPH. These are emergencies whereby we have to work hard and very fast as a team to stop bleeding and call ambulance to transfer before we lost the mother. We have to resuscitate pre-term neonate and refer to hospital. Sometimes the ambulance takes 3-4 hours to come put us at risk of losing a neonate by delayed ambulance*" (M27).

Midwives wrote extensively about the constraints to RMC which the language barrier causes with so many migrant women seeking care in labour at the MOUs: "*Language barrier – high influx on non-South African migrants and it is difficult to communicate with them*" (M45), "*We are receiving more migrants who are unable to communicate and apprehend (sic) the language the nurses are using. It is very strenuous to take care of these patients*" (M6), and "*Language barrier most of the patients they are not South Africans, they don't even know African languages so it's difficult to help such patients*" (M7). The midwives expressed the need for translators, but also were concerned about the lack of confidentiality with using a translator. This is of particular concern to them if the translator is not a woman.

The lack of space was also identified as a problem. M6 wrote about some of the constraints to RMC because of the conditions in the facility, such as overcrowding, no privacy during birth, and other people in the room: *"Privacy is limited for patients because of the lack of room compared to high number of patients. Patients are attended to in a room which is full of patients hence their privacy is violated. We need single rooms for delivery of patients and to allow their doulas into be present*" (M6).

4.3.4.2 Sub Theme - Health Systems Practice

This sub theme explored how the midwives felt about their practice within their unit(s) and facilities. Midwives frequently linked insufficient consumables with medico legal hazards such as infection (M17) and emergency care (M45): *"Midwives are unable to provide the quality of care they should be providing to their patients mainly because of the shortage of equipments.... don't have enough linen and the beds are not changed after every patient as they should be"* (M17), and *"Shortage of stock –it creates a problem with the management of emergencies i.e. shortage of drip sets"* (M45).

The issues which impact on health systems practices reported by the midwives included the clients ignoring the instruction that high risk women must attend antenatal and intrapartum care at a hospital to which they had been referred; not being able to get a hospital bed for an MOU client who needs emergency transfer and poor communication and records from antenatal clinics: *"High risk patients such as previous caesarean (section), (and) patients with medical problems are being told to deliver in hospital but they still come to the clinic. Then we have to arrange an ambulance to come and fetch them. Ambulance takes some hours to come*" (M27), *"They progress themselves at home during labour and come to the clinic with previous caesarean section which requires a hospital delivery. Babies being born at home in unfavourable conditions"* (M32), and *"Those who are discharged from the hospital for whatever reason like low Hb (*haemoglobin) *will refuse to go back to the hospital as they were told"* (M4).

All the MOUs which participated in this study work with antenatal clinic(s) that send their clients to deliver at the MOU. These antenatal clinics are usually run by the local authority whereas MOUs are run by the Gauteng Province. M4 mentioned that the referral system is sometimes problematic: *"We still experience with the other (feeder) clinics as for no green card (antenatal record), no follow up as for (booking) bloods"* (M4).

4.4. Discussion of Findings

The seventeen midwives' input, experience, and their expansion of their understandings of RMC clearly indicates that they have the theoretical knowledge of RMC. The World Health Organization (WHO, 2018) defines respectful maternity care as referring to, "care organized for, and provided to, all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth – is recommended."

As a group, the seventeen midwives covered all of the aforementioned aspects, however, none mentioned all the aspects in the WHO definition. It was interesting to note that when midwives wrote about the need to explain any procedures to the woman, rather than being from the principle of informed consent, most midwives wrote that by explaining the procedure they would gain the 'cooperation or compliance' from the woman. They would instruct the woman 'on how to behave' in labour. So explanations are, in effect, methods of ensuring midwife-centred care and the use of their power and authority.

It was also of note that while the concepts of respect, privacy, and individualized care were mentioned frequently by the seventeen midwives, these aspects were notable in their absence in the opinion of the mothers. This almost certainly means that while midwives have an understanding of the need for these aspects of care, they are either constrained from implementing them or lack the motivation to do so.

Constraints that were explicitly mentioned, apart from the resource issues, were migrants and HIV status of women. A great number of responses addressed the difficulties of caring for migrant women, especially unbooked migrant women, from other provinces and from outside South Africa. Midwives reported that when there is a language barrier, caring for a migrant woman is stressful. Many of these women do not know their HIV status and may be diagnosed as HIV positive for the first time in labour. The midwives were also concerned that many of these women had booked late for antenatal care, presented in labour unbooked, and left the area quickly after labour and delivery, without having postnatal care.

The problems of providing quality care to migrant women is not unique to South Africa. Evidence from countries as far afield as Canada (Peláez, Hendricks, Merry *et al*., 2017), Nordic countries (Leppälä, Lamminpää, Gissler *et al*., 2020), and Scotland (Crowther and Lau, 2019), all report on the complexities of caring for migrant women due not only to language issues but differing norms and values, and cultural practices.

Authors from several countries including Malawi (Sethi, Gupta, Oseni *et al*., 2017), Nigeria (Ashipa and Ofili, 2016), Poland (Baranowska, Doroszewska, Kubicka-Kraszynska *et al*., 2019), and South Africa (Ngidi, 2017), indicate that HIV positive women are more likely to be subjected to disrespect and abuse than their HIV negative counterparts. Ngidi (2017) is of the belief that this is due to the inconvenience and concern of having unbooked HIV positive women, as it delays treatment and can negatively impact on the outcome of the birth. It is possible that the issue of HIV positive women and migrants is linked, as many of the women referred to by the mothers in this study talked about migrants who accessed the clinic without booking. In a study undertaken by Kyaddondo, Mugerwa, Byamugisha *et al* (2017) in Uganda, it was found that HIV positive women access the health care facilities for labour and birth, as they know that they need good care in order to have a safe birth, due to their vulnerable status.

Midwives' personal attributes were discussed under positive and negative influences. Positive personal attributes included respecting a woman's wishes (e.g. to have a companion present), communicating and listening to women, not ignoring a woman who is calling the midwife (e.g.

the birth may be imminent), being proficient, professional, and experienced. Negative personal attributes and behaviour were seen to have arisen from work environment stressors. In particular, the impact which the shortage of staff has a on the midwife's workload and her ability to provide quality RMC has been identified. The lack of support from managers results in a low staff morale, with midwives feeling demotivated and demoralised. Midwives described a heavy workload leading to absenteeism and high staff turnover. They also explained that when one staff member of a two to three person shift takes sick leave or annual leave, no one is sent to replace them, thus exacerbating the impact of the perceived shortage of staff for midwives and for the care of the women in labour.

Management support of midwives is known to be most important in preventing adverse events and improving the quality of care (Ribeliene, Blazeviciene, Nadisauskiene *et al*., 2018) and to be lacking in South African maternity hospitals (Mothiba, Skaal, and Berggren, 2019). In this study, the fact that the midwives in the two well-run MOUs were more positive, supports this notion.

The midwives wrote very little about the expectations that women delivering in the MOUs might have about their preferences for options in childbirth and care during labour and birth. This could be that midwives are not really aware of the rights of childbearing women, which could fuel specific expectations for their care during labour and birth. Aside from the seven midwives who wrote specifically about RMC, the midwives did not give any comments on women's expectations and perceptions of care in labour.

Although there were midwives who gave comprehensive answers in their naïve sketches about what RMC is, it seems that RMC may be difficult to put into practice. It may also be a sign that so few women voice their expectations whilst at the MOUs, perhaps as a result of thinking that they had no choice and no real rights whilst in the MOU. There is a need to empower women in childbirth with knowledge and skills as suggested by Burrowes, Holcombe, Jara *et al* (2017), but there is a greater need to address the midwife–women relationship to provide for better equality in the power dynamics between midwives and the labouring women, which would lead to more successful practice in RMC (Freedman *et al*., 2018; Solnes Miltenburg, van Pelt, Meguid *et al*., 2018), and to acknowledge that, as Arnold, Teijlingen, Ryan *et al*, (2019) state, "multifaceted initiatives (are required) because the factors leading to suboptimal care or mistreatment are complex and interrelated." It is absolutely clear that the midwives are

struggling to provide good quality, respectful maternity care in MOUs that are affected by health system failures.

4.5. Conclusion

This chapter has provided discussion on the findings from the analysis of the midwives' naïve sketches. If the results from the interviews with women are read alongside the comments on the midwives' sketches, there is a clear difference in focus between the women and the midwives. This is discussed in chapter seven.

Chapter five will present the discussion on the findings of the nominal groups held with the midwives.

CHAPTER FIVE

MIDWIVES' NOMINAL GROUPS: FINDINGS AND DISCUSSION

5.1 Introduction

Chapter four discussed the analysis and findings from the data collected from the naive sketches written by the midwives. A template analysis was used in analysing the data in chapter 4, using the themes of Midwives, Women and Health Systems.

Chapter five discusses the findings from the data collected from the nominal group discussions held with three groups of midwives in three different locations.

The research objective for this phase was to establish the constraints and opportunities which exist for the midwife in terms of providing respectful maternity care through nominal group discussions.

5.2 Themes and Sub Themes

The researcher applied a template analysis to the data from the nominal groups. The template used is derived from the themes and sub themes determined through the analysis of the interviews with women (see Table 3.1 in Chapter 3). The same template was used to analyse the data from the midwives' naïve sketches.

As with the data from the mother's interviews, negative issues were reversed into positive statements for the purpose of the coding below, as the study was designed to develop an intervention to promote respectful maternity care. The sub-themes and categories arose from the nominal group discussions as seen in Table 5.1 below.

Table 5.1 Sub themes and Categories: Nominal Groups

Theme	Sub Theme	Category
Midwife	Actions	● Health education ● Provision of consensual care ● Personalized care ● Competent practice
	Personal attributes	● Resilience ● Confidence ● Cheerfulness
Women	Expectations	● Community education
	Preparation	• Antenatal classes/visits • Hospital bag
Health Systems	Resources	● Consumables ● Staff ● Equipment ● Space ● Translators
	Practices	● Teamwork ● Communication ● Supportive management ● Debriefing ● Confidence building

5.2.1. Midwives' Nominal Groups

The nominal groups focused on the constraints and opportunities to practicing RMC. Eighteen midwives participated in three nominal group discussions, in groups of six participants each (NG1=6; NG2=6; NG3=6). Some of the participant midwives in these groups were from municipal clinics (only offering pre and postnatal clinics) that send women to the MOU for labour and birth. Each participant was given a card and asked to write down five constraints and opportunities to practice RMC. Each midwife was given a chance to share her ideas and then the group discussed the issues that had been raised. Participating midwives' quotations have been reflected as 'NG1 -2'i.e. nominal group 1, midwife 2.

5.2.1.1 Midwives' Actions

This sub theme covers the issues raised by the midwives during the nominal groups relating to what the midwife could or should do to promote respectful maternity care.

Midwives spoke about the need for explaining procedures and said, "*Give education so women know what to expect and what is expected of her.*" (NG1-3). Not all agreed that it was necessary to explain all procedures with one midwife in NG1-4 posing the question, "*Does the midwife ask permission to do an internal or does she just do it/tell the woman*?"

Midwives spoke about how a midwife contributes to building a good relationship with women. The qualities the midwives discussed included privacy, empathy, communication, confidentiality, and consent: "*Address the woman by her name*." (NG3-2), "*Non-judgemental history taking and observations*" (NG3-4), and "*Do not discriminate e.g. with foreigners, treat the patients with respect at all times.*" (NG3-3).

Midwives in the nominal groups expressed frustration regarding caring for migrant women from other provinces and across the South African borders. The greatest frustration for the midwives was where a language barrier exists, midwives find it very difficult to communicate with a woman who does not speak a South African language (e.g. speaks in French or Portuguese): "*Language barrier, especially with HIV positive women – having an interpreter leads to poor confidentiality. Language barrier for deaf and dumb – communication by writing takes extra time.*" (NG1-5). In nominal group one, a participant put forward a positive suggestion on learning the most common foreign language in the community that the MOU serves: "*I think with the language barrier, what can help is if maybe we can be trained on different languages on those patients that come here. Portuguese, so that we can be able to help those patients*." (NG1-5) and "*Yes. Common, we will look at which language is common, the most common one, maybe then..."* (NG1-5). The midwife went on to explain the impact of a woman not understanding English -*"Sometimes it's not working because you write on the card and you normally go to this clinic, but you find she can't even read and you can't talk to her, and then she is in pain and she comes to a non-delivery facility because she didn't understand."* This group went on to discuss whether body languages and gestures were of any value in overcoming the language barrier - *"Sometimes with body language it's so difficult. I remember last month I had this lady from Malawi, she just came a day before from Malawi just to come and deliver. Even with the body language, she doesn't understand anything. You have to go to her and say stand up and you pull the patient really just to be able to check that patient. You have to clap your hands. It was so difficult even doing this and pulling the patient."*

Two midwives, in two different nominal groups raised issues of professional competence: "*Midwife's lack of confidence and skills."* (NG1-2), and "*There are problems when juniors are*

left on their own." (NG3-4). This indicates their concern about the quality of maternity care and expressed a fear of the MOU being involved in cases of litigation as a result.

5.2.1.2. Midwives' Personal Attributes

This sub theme describes midwives' opinions of the personal attributes of a midwife that are helpful in promoting respectful maternity care in the MOUs.

Midwives from nominal group one spoke about the personal attributes that are necessary for a midwife to do her job in a challenging context. Some midwives talked about an individual's determination: "*Midwife needs to have a will and determination to give the best service and to listen to her patients"* (NG1-4), and "*Holistic approach, willingness and determination to give the best service*" (NG-4). The group felt midwives needed resilience to withstand the challenges they face working in the MOUs: "*Midwife's resilience has to do with self-respect and not permitting people to disrespect you. Confidence to communicate*" (NG1-5), "*You really have some positive feedback from Mom Connect against all odds, you do have nurses who are trying their best"* (NG1-5), and "*The midwife must smile, greet the patient and welcome the patient*" (NG1-2).

Midwives also described negative personal attributes of a midwife largely attributed to work environment stressors such as under staffing, management, supplies and patient related issues. They expressed feeling frustrated, angry, demoralised, and demotivated. This, in turn, led to absenteeism and high staff turnover: "*I think somewhere, somehow midwives are overwhelmed. Most of the time because of staff shortages"* (NG1-1), and, *"The constraints, shortage of staff, overflow of patients from other areas and provinces, language barrier, lack of resources, delay of ambulances, especially when you have a patient with a serious emergency"* (NG1-3). When asked about opportunities for providing RMC, one of the participants in nominal group one spoke about a support structure where midwives could report their problems: *"Maybe we can vent to Mamu, to Nurses Connect"* (NG2-3), *"We need to talk about problems and must be able to support midwives who are in labour ward"* (NG3-1), and "*But we've got our wellness (to consider). I should think our wellness (program) should be active" "They don't come and visit nurses. It's only once in a year" "Most of the time those programs (are not helpful) because on night duty and working, awkward as she is busy with a patient and they do not have a chance to ask"* (NG3-1).

Some MOUs have a system of internal rotation where midwives spend time working in the antenatal and postnatal clinics and are rotated through labour ward: *"It's a good thing to do the*

rotation." "Rotation is good because it also helps us because we had enough midwives at the non-delivery institution (local authority clinic). So, we used to come here (MOU). So, it was good, it was very nice, but now most of the midwives have gone and we are very few, so we are not – anymore." "The skill is dying to deliver the babies and to manage emergencies" (All from NG1). Midwives felt that internal rotation helped alleviate the stress of working in labour ward and aided the midwives in retaining their labour and delivery skills.

The midwives expressed frustration with the number of 'unbooked' women who present in labour having had no prenatal care and having no obstetric records. This frustration was heightened when the woman was tested for admission for HIV and found to be HIV positive. This meant that on top of labour care, the midwife now had to initiate anti-retroviral medication and do post-test counselling: "*This is an added burden on to the midwives*" (NG2-1), and "*Midwives expect clients to be cooperative and take responsibility for their health and adhere to medicine* (referring to ARVs) *and advice"* (NG2-3).

5.2.1.3 Women's Expectations and Preparation for Labour

This theme relates to what women expect during maternity care and how they prepare for labour and birth.

One midwife, who works in the antenatal clinic of a feeder clinic run by the local authority, spoke of women's expectations when they attend the clinic: *"The patients in the line, threaten me if I take time for tea or lunch"* (NG1-5). This midwife explained that she worked non-stop from 08h00 – 16h00 in order to see all the women in the line daily. However, if there were still women who had not been seen that day, they then threatened the midwife if she attempted to leave for home. It is every woman's expectation that she will be seen for antenatal care on the day she has been waiting and she expects to be attended to on the same day.

The most prevailing issue midwives raised under women's expectations was the community's negative perception of the midwives at some of the MOUs. They described some women presenting in labour with a 'negative attitude', and that this made the midwives' care for these women much harder: "*Unbecoming attitude from patient*". "*Patient complaints*". "*Patient comes with negative attitude due to treatment in the past*" (NG2-4), and "*Patients distrust the midwives*" (NG2-3). One of the midwives attributed this distrust to "*the adverts for lawyers, over the media and television, a lot of women complain because they think they can get easy cash*" (NG2-4). They referred to the complaints system which they felt resulted in negative consequences for the midwives: "*If the patient is unhappy in the clinic she goes to the manager.*

The manager comes down hard on the midwife. Or they go to the district or provincial offices" (NG2-5). The midwives expressed feeling that the complaints system is an invitation for women to complain and not necessarily about significant issues.

The midwives expressed the need for 'the community to change their negative attitudes'. According to the midwives, not all women need the same amount of time or the same kind of maternity care. "*The community needs to understand that a midwife has priorities – if a woman tests HIV positive, the midwife has to sit with her and initiate ARVs and conduct post-test counselling, and that takes time. But a postnatal check-up takes fifteen minutes. So, the midwife's priorities are different to the clients. The clients don't understand what the time implication is. They just think one person is getting more care and they go and complain in the office*" (NG2-3). One midwife in NG2 said that "*If the midwife says the woman is wrong, she calls the midwife cruel*" (NG2-1).

5.2.1.4 Health System Resources

Most of the discussion in the nominal groups fell into this theme, whereas it was the least mentioned one by the mothers. The midwives expressed that the lack of resources was the greatest barrier to rendering RMC. The issues arising under health system resources included shortage of staff, lack of consumables such as linen savers for the delivery beds, lack of medication e.g. ARVs, broken equipment, delays with the ambulance services, and overcrowding of the facility.

Midwives felt the single greatest challenge to offering respectful maternity care was the (perceived) staff shortage. Staff shortages had impact on the patients, the midwives, the provision of quality maternity care, and on litigation: "*Affects individual midwife's ability to provide best care"* (NG1-1). As a result of the high workload and poor working environment, there was frequent absenteeism leading to staff turnover: "*Absenteeism because of tiredness caused by overcrowding MOUs and also burnout syndrome due to poor working environment*" (NG1-4), and "*Shortage of staff, and then rate of absenteeism, they get burnt out and then they hire staff, turnover rate resulting in shortage almost every month we've got nurses resigning"* (NG1-4). A midwife from a feeder clinic (local authority) talked about the staff turnover amongst midwives in the feeder clinic: "*They come and go most of them resigning after a few months and they go back to province because the salary disparity, workload at local government is much more. Their expectations are too high*" (NG1-5).

The midwives spoke about the shortage of consumables: "*The shortage of medication*." "*Drugs e.g. oxytocin in short supply*" (NG1-3). Midwives linked insufficient consumables with medico legal hazards. They spoke about unreliable, poorly maintained equipment: "*Equipment like BP machines, we use the older stuff like Dynamaps. Yes, since they were ordered in January and even now we don't have them*" (NG1 -2), and "*Sufficient batteries so all equipment is functioning*" (NG2-5). The midwives disclosed that at the time of the study, nurses paid out of their pockets for batteries and airtime to get test results from the laboratory despite there being no system in place to reimburse the midwives for the costs they incurred.

Midwives spoke about some of the constraints to RMC related to the facilities themselves. "*Overcrowding of the patients. We are not able to give proper care to them. Sometimes we turn them away because of time*" (NG1-3), and *"Buildings are dilapidated, no running water, no toilets seats"* (NG2-2). The midwives raised the issue of a woman's privacy while birthing: "*There are no private birthing rooms*" (NG1-3).

Midwives raised the issue of an unreliable and unpredictable emergency transport system and its impact on the outcomes of the complication: "*To get an ambulance it can take less than forty minutes, but sometimes the delay can be three hours*" (NG1-3). The midwife who made this statement, continued to explain that there had been a prolapsed cord and the ambulance was delayed: "*fortunately they sent a private ambulance and fortunately the foetal heart rate was there, nice and beating and she had a cord collapse since 09h00 in the morning. It was round about 11.00, but the outcome was she had a life birth by caesarean section*" (NG1-3).

5.2.1.5 Health Systems Practice

This sub theme explores how the midwives felt about their practice within their unit(s). This included poor teamwork, communication difficulties, poor working environments, lack of support from managers, need for translators, high risk women presenting at the MOU, and personal debriefing.

The midwives spoke of poor teamwork: *"Poor communication within the department"* (NG1-4), "*Poor communication breakdown within the shift on duty"* (NG3-2), and *"Staff undermining the competence of another midwife"* (NG1-3).

Frustration was also reported in response to poor working environments with overcrowding and poor support from the MOU management and how this impacted on job satisfaction: "*We have a lot of inspection day in and day out and it gets exhausting. Because we've got a high*

number of patients. Even if they come as managers, they only care for those inspections, not for the patients" (NG1-1), "*Even with some material resources, it's still a problem. You don't have admission forms. Someone will come and say whatever she likes about your effort, buying exercise (book) to put to the patient but they don't provide*" (NG1-1), *"Very poor communication with managers and they don't listen"* (NG2-2), "*Lack of support from management"* (NG3-4), and "*Lack of job satisfaction*" (NG3-5).

The issues of resilience and not feeling respected by management came up in the discussion: "*I feel that one of the things that is negative is how you get treated by the management. Because if they treat you with disrespect, with lack of dignity, clearly I don't see anything better except if you are a tough cookie and a strong person because whatever they say will just roll off and you'll still be in a good mood to see your patients"* (NG1-2), and "*Some things really don't come from the nursing background. It just has to be in you. Resilience, it's not something everyone has." "Being able to bounce back after that." "They don't resign because they don't have resilience, they resign because, I always say I respect myself so much and I will not tolerate anyone disrespecting me. If I have to move away from you, I'll move. Not because I don't have resilience to be in this. I'll rather go somewhere where I will be appreciated and respected"* (NG1-4).

One midwife posed a specific question on how individual midwives can try to address poor care and the mistreatment of women: "*What can be done to build midwife's self-confidence to speak out about poor patient care?"* (NG2-5). The group did not respond to this question which might be due poor patient care not being seen as a problem generally at this MOU, or it was an issue that the group did not choose to address in a group.

The midwives expressed the need for translators but also were concerned about the lack of confidentiality when using a translator. This is of particular concern if the translator is not a woman, and if the patient was HIV positive: "*One of the constraints is the language barriers, where you can't communicate properly with the patient, especially now when we are dealing with HIV and AIDS. You need another person to interpret. So, confidentiality of the patient"* (NG1-1).

One of the issues which has an impact on the health systems practices reported by the midwives, was the clients ignoring the instruction that high risk women must attend antenatal and intrapartum care at a hospital to which they had been referred, not being able to get a

hospital bed for an MOU client who needs emergency transfer, and poor communication and records from antenatal feeder clinics.

Midwives raised the need for personal debriefing: "*Staff members talk about debriefing sessions. But we don't do debriefing sessions, even after an adverse incident. We did not get a briefing and it is very traumatic for the nurses"* (NG1-4). "*Yes, you talk to your colleagues." "There is no time because they're supposed to write incidents and after that nobody cares"* **(**NG1-2**).**

5.3 Discussion of Findings

In reviewing the findings from the nominal groups, it shows that midwives understand the concept of respectful maternity care and what should be done to provide it, but that they recognize it is not always given, and that there are many constraints that prevent the exercise of RMC.

Midwives in the nominal groups referred to getting feedback about the care at their clinic from Mom Connect and using Nurse Connect to report their work environment challenges. These two cell phone based systems were rolled-out by The National Department of Health (NDOH). It is worth noting that in South Africa most people have cell phones or access to a cell phone. The possibility of using these programmes to provide the community with education that the midwives believe would assist in dealing with unrealistic expectations of the mothers, would be worth investigating.

Mom Connect aims to electronically register all pregnancies in the public sector, send health promotions to pregnant and newly delivered women about their pregnancies and caring for their infants, and provides women with a forum to give feedback on the health services they used. The services are free to the user, and messages are available in all eleven official languages of South Africa. Mom Connect is voluntary and the pregnant woman can opt out at any time. The mothers gain access using the code for the facility at which they receive antenatal care. There is also an option for HIV positive women to receive HIV related health promotion messages.

Nurse Connect is an extension of Mom Connect to support nurses and midwives in their daily work. Nurse Connect gives midwives access to targeted support messages and advice, as well as in-depth information on maternal and child health issues. Nurse Connect has a backup website that midwives can access for more information.

Filby, McConville, and Portela (2016) have mapped the barriers to quality maternity care, and the authors cite quality of care being compromised by insufficient basic resources, including drugs, equipment, and protective supplies, such as gloves. Midwives in all three nominal groups reported struggling to provide good quality, respectful maternity care in MOUs that are affected by health system resources failures. This formed a major portion of the nominal group discussion. This was also written about, extensively, in the midwives' naïve sketches (Chapter Four). Of particular interest is that in the interviews with the women about their intrapartum care, the lack of resources and consumables was hardly mentioned.

It was clear that the midwives are aware of the principles and practice of respectful maternity care, at least, in theory (Chokwe and Wright, 2013). The findings illustrated that the midwives had excellent theoretical knowledge of caring, but some of them did not display caring behaviour during clinical practice. Most of the midwives chose to focus more on the constraints that they felt impeded the practice of RMC. Only a few midwives raised the issue of opportunities provided to them to practice an aspect(s) of RMC or to improve the delivery of RMC.

It is not unusual for there to be a disparity between women's accounts of negative interactions with the midwives and the midwives' reluctance to discuss infringing the code of RMC (Onasoga *et al*., 2012).

Effective communication between the midwife and the woman is mutually beneficial as good communication improves a woman's perception of her childbirth experience and satisfaction in the childbirth experience (Reed *et al*., 2017). Poor communication between health care providers leads to a breakdown in the unity of the midwives on a shift and to staff undermining another staff member's competency (Behruzi, Klam, Dehertog, *et al*., 2017).

In the nominal groups, the midwives scarcely talked about the women's expectations of care during labour and birth or the women's lack of preparation for labour and birth, be it knowledge about birth or physically preparing a bag for their stay at the MOU. Yet the lack of birth preparedness is anecdotally acknowledged to be difficult for midwives taking care of the woman in labour. The midwives did raise the issue that some women come into labour with defensive and negative attitudes that make it harder for the midwife to build a rapport with their client.

The problem relating to 'unbooked' patients is well documented. Botha (2004) and Mutihir and Nyiputen (2007) discuss the impact of unknown HIV status in labour and poor compliance

with ARVs in pregnancy, and both sources indicate that these are issues that impact on both the health system resources and practices. Botha (2004) wrote about the higher neonatal mortality rate amongst infants of 'unbooked' women in South Africa, whereas Mutihir and Nyiputen (2007) wrote about the obstetric complications that are associated with 'unbooked' women in Nigeria. Mom Connect offers women an opportunity to register early in their pregnancies with the aim of encouraging women to book in early at the antenatal clinics and the protocols for managing HIV positive women are clear (NDOH, 2015). It would appear from the data collected during this study that many of the problems relating to 'unbooked' women are due to migrants not registering timeously and therefore not receiving antenatal care.

A South African study by Moodley, Moodley, Sebitloane *et al* (2016) demonstrates that pregnancy outcomes for HIV positive women were significantly improved if they received triple anti-viral treatment, that women who were unbooked and had not received antenatal care had higher chances of poor birth outcomes (Moodley *et al*., 2016). There is, therefore, compelling evidence to deal with the problem of 'unbooked' women at the MOUs, as it not only frustrates midwives as shown both in this study and that of Ngidi (2017), but, as shown in Moodley *et al's* 2017 publication, results in poor outcomes among women. This also parallels Uzabakiriho and Maswime's 2019 study, titled 'Causes of maternal death at Natalspruit Hospital'.

The midwives spoke about having the number of midwives' posts increased at each MOU, in order to provide quality, individual, and safe care of women and their babies in labour and birth. Staff feel they are not valued for the demands made on a midwife in the MOU and the impact of staff shortages and the health system place midwives at risk of challenging patient care which could lead to litigation. The USAID/MCHIP RMC Country Experiences Survey Report (2012) indicates that adverse working conditions were some of the underlying factors leading to disrespect and abuse in maternity care (Reis, Deller, Carr *et al*., 2012).

Language barriers have been shown to increase health workers' frustration levels, decrease the health workers' approachability, and decrease empathy. Having to communicate with someone who does not speak the health workers' language, makes communication time-consuming. While Naidoo (2014) indicates that making an effort to communicate in this situation is a sign of respect for the women, it needs to be acknowledged that with South Africa already having eleven official languages, and a documented immigrant population of 2.2 million (STATS SA, 2012) as well as an estimated one million undocumented immigrants (Mwiti, 2015), the

diversity of languages is challenging and alternative ways of communicating other than using language are often sought by the midwives.

As reported in the findings, midwives discussed using body language to communicate. One resorted to physically pulling the woman to a standing position when she could not communicate, which would undoubtedly have caused discomfort and concern on the woman's behalf, and may well have been done out of frustration rather than good intent on the part of the midwife. When discussing body language, most however, resorted to the more conventional interpretation of the word and used signs and visual representations. The Migrants in Countries in Crisis (MICIC, 2016) have issued very useful guidelines which include using cell phone apps, contacting faith based organizations for assistance and using call centres to supplement what the midwives are already doing, and what the guidelines refer to as "using multiple traditional and innovative communication channels." The additional challenge for the midwives is that there is usually little time to contact others to assist when a woman is in advanced labour.

During the nominal group sessions, there was a discussion on the practice of slapping women during labour and birth. Some midwives explained that they did not view this as abusive and rather considered it part of telling the mother what to do during the labour and birth. This is an example of a negative behaviour that has become a social norm and has therefore become a part of the culture in the delivery room. This was discussed by Jewkes and Penn-Kekana (2015) in their explanation of how power relationships between providers and women arise in maternity care.

An aspect of support the midwives talked about was debriefing, mainly following an adverse event, but also related to the work environment and workload. Vaithilingram, Jain, and Davies (2008) indicate there is a need to set up peer-driven debriefing after a "critical incident" or adverse outcome. Exposure to traumatic events affects health professions who experience varying degrees of traumatic stress reactions. Vaithilingram *et al* (2008) also refer to Mitchell's (1983) seven phases of stress reduction, which may be a useful model to initiate debriefing support for the midwives in the MOUs. It is important to acknowledge that midwives involved in adverse events are, what are termed, second victims and support them appropriately (White, Brock, McCotter *et al*., 2015).

Many maternity facilities hold a morbidity and mortality meeting on a weekly and/or monthly basis. This is a good forum for analysis of the critical incident. However, this process needs to

be one of collective learning versus naming and shaming. Guidelines for Perinatal Review Meetings are provided in The Guidelines for Maternity Care in South Africa (National Department of Health, 2015). These meetings aim to improve the quality of maternity care and perinatal outcomes. Midwives in the MOUs need to be encouraged to call a critical incident meeting for the staff in the MOU as soon as possible after an incident occurs and not to just wait until the next formal perinatal review meeting.

5.4 Conclusion

In this chapter, the findings from three nominal group discussions were discussed under the three themes 'midwives', 'women', and 'health system' and each of their sub themes. At each nominal group the midwives spoke a lot about the challenges they were experiencing that contributed to high levels of work life stress, which often made it difficult to render respectful maternity care. They spoke very little about the opportunities for respectful maternity care.

The next chapter reviews the findings from all four data sets which will inform the development of an intervention to promote respectful maternity care in the MOUs.

CHAPTER SIX

SCOPING REVIEW

6.1 Introduction

This chapter describes the fourth part of step one of the research study which was done to meet the fourth objective which was to "review sub-Saharan African literature on the provision of respectful maternity care". In planning this study, it was decided to conduct the scoping review after the data had been collected from the mothers and the midwives, as this assisted in seeking information that would assist in designing an appropriate intervention. A brief introduction was given in chapter two where the methodology was described, but this chapter covers the detail of the methodology used, as well as reporting on the findings and discussing the results of the scoping review.

The Joanna Briggs guidelines for a scoping review (2017) were used to guide this section of the study.

6.2 The Review Questions

The scoping review questions were:

- What is the evidence of disrespect and abuse (D&A) in maternity care in sub Saharan Africa?
- What interventions have been developed to promote respectful maternity care in sub Saharan Africa?
- What was the role of the health care provider in these interventions?

6.3 Inclusion Criteria

Peer reviewed articles, as well as grey literature, published in English between 2013 and 2018 were included in the review. Literature pertaining to sub-Saharan Africa was included, as the intention of the bigger study was to develop an intervention to support respectful maternity care in this context. The researcher was concerned with identifying existing interventions that had been designed to prevent disrespect and abuse in maternity care, in order to design an intervention that promoted respectful care. In order to answer the review questions, articles relating to the role of health care providers, and specifically midwives, as well as data on the extent and nature of D&A in maternity care were also sought and included.

6.4 Search Strategy

The data bases used were: Science Direct; Scopus; and PubMed.

The following search words/strings used were during the research:

“disrespect AND maternity care”

“intervention AND respectful maternity care AND Africa”

“respectful maternity care AND Africa”

“abuse AND midwife AND Africa”

The term ‘Africa’ was used, as when a preliminary search was done using the term ‘sub-Saharan Africa’, many articles were missed. The researcher therefore selected the articles relating to sub-Saharan Africa manually.

The term ‘intervention’ was only linked with the terms “respectful maternity care” and not the negative words, as interventions are only aimed at positive outcomes.

6.5 Screening and Selection of Articles

The PRISMA diagram that follows records the screening and selection of articles for the scoping review.

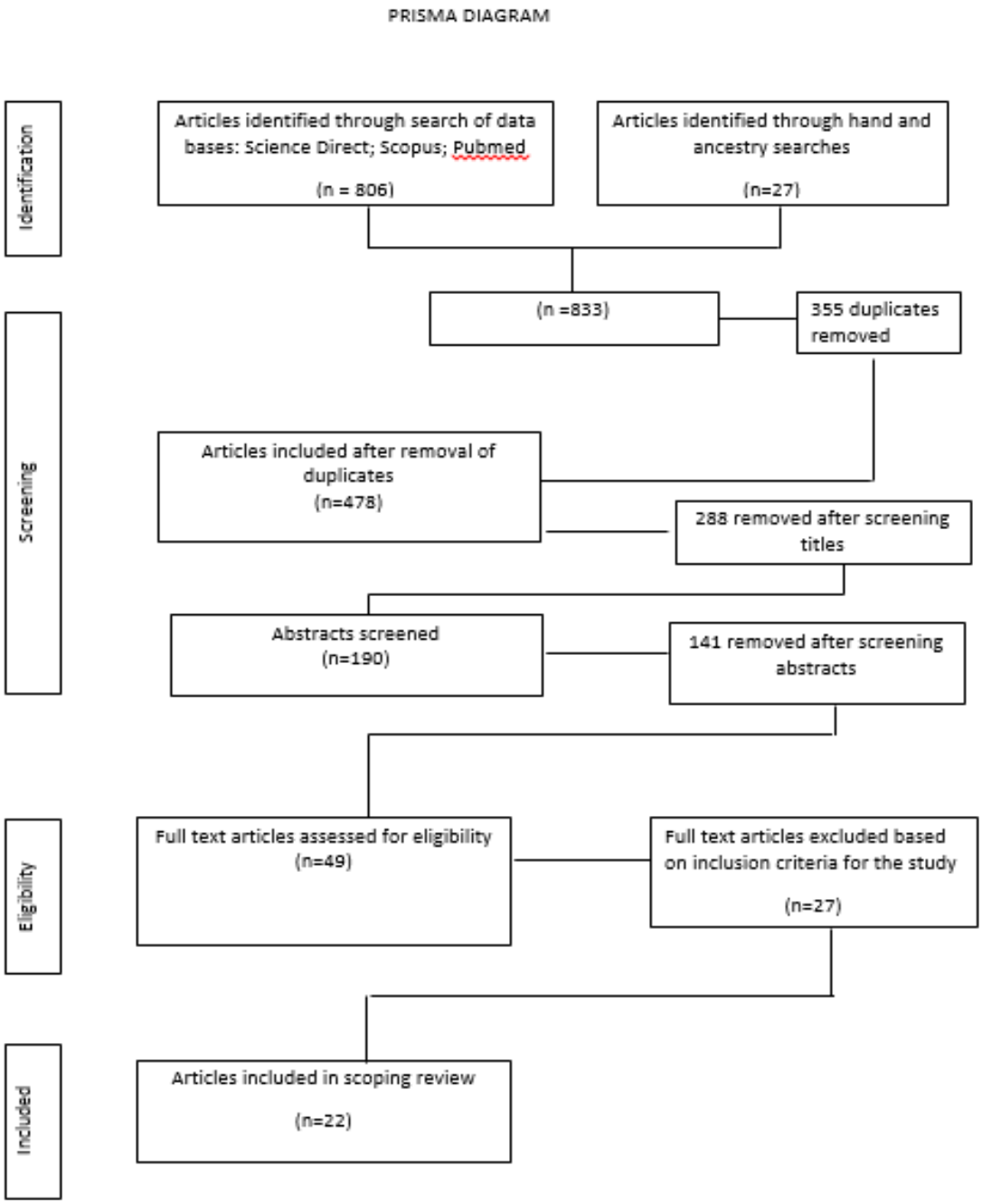


Figure 6.1 PRISMA Diagram: Search Process and Inclusion

6.6 The Scoping Review Matrix

Table 6. 6.1 Scoping Review Matrix

The current evidence on disrespect and abuse in maternity facilities, interventions and the midwife's role in changing practice. The matrix below shows a summary of the article reviews.

Note: As disrespect and abuse are used frequently in this scoping review, the abbreviation D&A will be used.

Code for each article: E = evidence of D&A; I = Intervention.

	Author, date and publication	Title and country	Study design: Aims, Population, Method.	Intervention: Outcomes, Key Findings
1 **I**	**Abuya, T., Ndwiga, C., Ritter, J., Kanya, L., Bellows, B., Binkin, B., Warren, C.E.** **BMC Pregnancy and Childbirth 2015 15:224**	**The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya**	**Aim** To lower the frequency of disrespectful and abusive behaviours towards women in facility-based childbirth. **Population** 641 women in 13 Kenyan health facilities. These were different types of facilities with 4 being rural and 9 urban or peri-urban under the *HESHIMA project*. **Methods** Before and after design to measure the effect of interventions on the reduction of disrespect and abuse during labour and birth. 1. Exit interviews with women after labour and birth 2. Structured observation of provider-patient interactions during labour and birth, measuring content and process. **3.** Client-Provider interaction observations measured against 7 indicator categories for D&A.	**Outcomes** 7% reduction in the prevalence of D&A during facility-based childbirth in Kenya. Women were less likely to report physical and verbal abuse, violations of confidentiality or detainments. **Key Findings** Disrespect and abuse decreased significantly. Night shift births were associated with a higher level of abuse. Greatest reduction was in the prevalence of physical abuse and detainment Detainment of the mother and baby dropped dramatically – partially due to the introduction of free maternal child health in 2013. A multi-component intervention may reduce the frequency of disrespect and abuse in childbirth.
2 **E**	**Bohren, M.A., Vogel, J.P., Hunter, E.C., plus 10 authors.**	**The mistreatment of women during childbirth in health facilities globally:**	**Aim** To synthesize evidence on the mistreatment of women during facility-based childbirth globally.	**Outcomes** Categorisation of disrespect and abuse during facility-based childbirth.

	PLOS Medicine 30 June 2015 12(6)	**mixed-methods systematic review.** (Across geographic and income levels)	To develop an evidence-based classification / categorization of disrespect and abuse during labour and birth in facility-based childbirth. **Population** 65 studies from 34 countries **Methods** Systematic review	**Key Findings** Categories of D&A: Physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, health systems conditions and constraints**.**
3 **E**	**Bradley, S., McCourt, C., Rayment, J., Parmar, D.** **Social Science and Medicine 169 (2016) 157-170**	**Disrespectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and thematic synthesis of women's perceptions and experiences.** **(Ethiopia, Kenya, South Africa, Ghana, Tanzania, The Gambia, Malawi and Zambia.)**	**Aim** To synthesize women's perceptions and experiences to explore the factors which define midwives' D&A behaviours in order to understand the dynamics that result in disrespectful care. **Population** 52 papers from 9 African countries (1990 – 2015). **Methods** Systematic review using the "Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines." Thomas and Harden's (2008) thematic synthesis method.	**Outcomes** Themes arising were "Power and Control" and "Maintaining Midwives status" as drivers of disrespectful care. Development of a conceptual framework for drivers of disrespectful care during facility-based childbirth by putting disrespectful care into a broader framework. **Key Findings** Current model of maternity care is institution centred not woman centred Midwives strive to maintain control and power by making birth a medical event and keeping their power by focusing on technical aspects of care, controlling women's bodies, and controlling knowledge (vs listening to women's embodied knowledge and empowering women). Changing the current model can only happen with the midwives' active participation in bringing about changing the model.
4 **I**	**Downe, S., Lawrie, T.A., Finlayson, K., Oladapo, O.T.** **BMC Reproductive Health 2018 15:23**	**Effectiveness of respectful care policies for women using routine intrapartum services: a systematic review.** **(**Africa.) (Kenya, Tanzania, Sudan, South Africa)	**Aim** To assess the effectiveness of respectful intrapartum care policies. **Population.** Five studies were included. – All from Africa. 7500 women. **Methods** A systematic review with the Preferred Reporting Items for systematic review and meta-analysis guidelines (PRISMA). The GRADE criteria were used to assess the certainty of the evidence from the 5 studies.	**Outcomes** Multi-component RMC policies could improve women's experiences of respectful quality care and lead to a reduction of D&A staff behaviours and physical abuse. This review of 5 African studies led to WHO Recommendations for Intrapartum Care towards a positive childbirth experience, which has been contextualised for use in South Africa. **Key Findings** Implementation of RMC policies leads to**:** Women are more likely to report receiving respectful care. Reduction in D&A care by two thirds. Reduction of physical abuse, non-dignified care.

				A low certainty that RMC policies will decrease non dignified care, neglect and abandonment or verbal abuse. Deficiencies in infrastructure leading to disrespectful care need to be addressed by the service providers and policy makers as a matter of urgency. Involvement of the community is essential.
5 **E**	**Dynes, M., Twentyman, E., Kelly, L., Maro, G., Msuya, A., Dominico, P., Chaote, P., Rusibamayila, R., and Serbanescu, F.,** **BMC Reproductive Health 2018 15:41**	**Patient and provider determinants for receipt of three dimensions of respectful maternity care in Kigoma Region, Tanzania-April-July, 2016**	**Aim** To describe both patient and provider characteristics and their association with receipt of RMC **Population** 189 Provider interviews 908 client interviews 30 facilities out of 163 facilities in Kigoma Region. **Methods** Cross-sectional surveys Client Post-Delivery Exit interview done in the facility Provider Interview Questionnaire and Self-administered Knowledge Test Matched client and provider were analysed, using Stata 14.1.	**Outcomes** Identified client and provider factors that predict the receipt of RMC Three dimensions of RMC identified. RMC-DC1 - *friendliness, comfort, and attention.* RMC-DC2 - *information and consent* RMC-DC3 - *non-abuse and kindness* **Key Findings** DC1 and DC2 - client age mattered. Teens were less likely to receive RMC. ● Women who had birth complications received a lower RMC score DC3 – companionship was a positive factor for receipt of RMC related to information and consent. Frequent attendance at religious services was a determinant of receiving lower level RMC! Nurses and midwives who attended a higher number of births provided lower levels of RMC than providers who attended less births per month. Job satisfaction did not correlate with RMC. Pay equity positively influences interpersonal interactions and care provision. Providers who worked more hours a week, provided significantly high levels of RMC than providers who worked less hours a week. Providers in their 20s provided higher levels of RMC related to information and consent. Providers who had access to two types of electronic foetal monitoring (e.g. CTG and emergency call line) gave significantly better non-abusive and kind RMC, than providers with no access to electronic monitoring.
6 **E**	**Freedman, L.P., Kujawski, S.A., Mbuyita, S., Kuwawenaruwa, A., Kruk, M.E., Ramsey, K., Mbaruku, G.**	**Eye of the Beholder? Observation versus self-report in the measurement of disrespect and abuse during facility-based childbirth.**	**Aim** To compare the prevalence of disrespect and abuse during childbirth – measured through observation by trained nurses and self-reporting by the same woman on discharge**.** **Population** Two hospitals in the Tanga region of Tanzania	**Outcomes** Observers reported more abuse than women did. The prevalence of D&A declined substantially - 50%, between baseline and end line. The incidence of D&A that observers reported were not the same ones that women self-reported. "**Human rights based respectful maternity care and the power to generate change, in any given setting cannot be assumed: it must be actively built."**

	Reproductive Health Matters (2018), 26:53, 107-122	**Tanzania**	At Baseline: 11 focus groups in community with men and women with a child under one year old. 3 focus groups with doctors, midwives and medical assistants working in facilities 60 key informant interviews with stakeholders from community to national level 232 women at baseline 237 women at end line participated in observation and the exit interview. **Methods** Mixed method study including focus groups, key informant interviews, observation and self-report exit interviews.	**Key findings** Most reported D&A was shouting or scolding, sometimes threatening to withhold treatment, often related to provider's annoyance with the women's behaviour – closing their legs, touching the provider which would trigger hitting, slapping, pushing, pinching. Increase of reporting any D&A over time. Three scenarios were common – privacy violations, shouting or scolding and ignoring a woman or negative comments, which had to do with the woman's low / poor status. Women might be ignored because of age and parity, or not bringing supplies or failing to pay her bill. Women's low self-reporting of D&A shows their powerlessness to prevent or challenge D&A, given that they will be subjected to D&A has been internalised and providers propensity to commit D&A despite knowing that are being observed shows that D&A has become normalised.(invisible power in the maternity ward).
7 **I**	**George, A., Branchini, C.** **BMC Pregnancy and Childbirth 2017 17:264**	**Principles and processes behind promoting awareness of rights of quality maternal care services: a synthesis of stakeholder experiences and implementation factors** **(**Central Europe, Asia, sub-Saharan Africa, and Latin America**)**	**Aim** Synthesize stakeholder experiences and implementation factors in promoting awareness of rights for maternal health. **Population** 26 documents **Method** Secondary analysis of documents identified whilst doing a previous systematic review which mapped literature of maternal health, which focused on health system and community based interventions aimed at improving the equity and quality of maternal health in middle and low income countries, published between 2000 – 2012.	**Outcomes** Women reported an increase in their sense of self-empowerment and self-esteem across the interventions documented. **Key Findings** Key to obtaining health rights is the involvement of leadership and collective organizing amongst women. Community involvement is critical in supporting women's rights to maternity care services. Interventions which improve awareness of RMC and quality care provide opportunities for providers to receive feedback which can be used to improve maternity care services. Provider resistance stems from a narrow interpretation of women's rights to RMC or to "poor working conditions". Changing provider attitudes and developing the midwives' interpersonal skills, requires time, training and capacity building and needs to have the active support from managers, administrators, and policymakers. This requires balancing power across all the stakeholders with active involvement of women and communities.

				It requires implementation in response to a situational analysis with good planning, adequate funding, strategic thinking, good management, political savvy, and strong leadership.
8 **E**	**Ishola F, Owolabi O, Filippi V** **PLOS ONE 2017, 12(3): e0174084.**	**Disrespect and abuse of women during childbirth in Nigeria: A systematic review.**	**Aim** A systematic review was conducted to synthesize current evidence on disrespect and abuse of women during childbirth in Nigeria, in order to understand its nature and extent, contributing factors and consequences, and propose solutions. **Population** Fourteen studies, 11 cross sectional, 1 qualitative and 2 mixed methods. **Method** Five electronic databases were searched for relevant published studies, and an additional five data sources for grey literature. A qualitative synthesis was conducted using the Bowser and Hill landscape framework on disrespect and abuse of women during facility-based childbirth.	**Outcomes** This systematic review documented a broad range of disrespectful and abusive behaviour experienced by women during childbirth in Nigeria, their contributing factors, and consequences. **Findings** The factors influencing disrespectful and abusive behaviour in childbirth in Nigeria, suggests: ● educating women on their rights ● strengthening health systems to respond to specific needs of women at childbirth ● improving providers' training to encompass interpersonal aspects of care ● implementing and enforcing policies on respectful maternity care ● more robust research is needed to explore disrespect and abuse of women during childbirth in Nigeria in order to develop interventions which would address D&A and promote RMC
9 **E**	**Mselle, L.T., Kohi, T.W., and Dol, J.** **BMC Pregnancy and Childbirth 2019 19:231**	**Humanizing birth in Tanzania: a qualitative study on the (mis) treatment of women during childbirth from the perspective of mothers and fathers.**	**Aim** To describe the experience of mothers and fathers in relation to mistreatment during childbirth in Tanzania. **Population** 12 semi-structured interviews and four focus group discussions were held with mothers and fathers who were attending a postnatal clinic in the Lake Zone region of Tanzania. **Method** Qualitative, descriptive design with data analysed using priori coding based on Bohren *et al* typology of mistreatment of women in childbirth.	**Outcomes** Mothers reported mistreatment and disrespectful maternity care through: ● verbal abuse (harsh or rude language and judgmental or accusatory comments), ● failure to meet professional standards of care (refused pain relief, unconsented surgical operations, neglect, abandonment or long delays, and skilled attendant absent at time of birth), ● poor rapport between women and providers (poor communication, lack of supportive care, ● denied companion of choice – husband's presence at birth, ● denied mobility, denied safe traditional practices, no respect for their preferred birth positions), ● health system conditions and constraints (poor physical condition of facilities, supply constraints, bribery and extortion, unclear fee structures) **Findings** "Humanizing birth care in Tanzania continues to have a long way to go, however, there is evidence that changes are occurring as mothers notice and report positive changes in delivery care practices."

10 **E**	**Mukamurigo, J., Dencker, A., Ntaganira, J., Berg, M.** **PLOS One 2017 Vol 12 (12)pp**	**The meaning of a poor childbirth experience – A qualitative phenomenological study with women in Rwanda.**	**Aim** To explore the meaning of a poor childbirth experience amongst women in Rwanda. **Population** 898 women **Method** A structured questionnaire in a cross-sectional household study. Seventeen women who rated their childbirth experience as bad participated in an individual in-depth interview. Texts were analysed with a reflective lifeworld approach.	**Outcomes** A poor childbirth experience was that the women had been exposed to neglect, verbal or physical abuse, disrespectful care, insufficient information, and denial of a birth companion. **Key Findings** The actions of the carers were: ● Abandonment ● Shaming and insulting ● Humiliation ● Creating fear and distrust ● Making women feel insecure Activities focusing on implementing RMC and evidence-based care are needed.
11 **I**	**Ndwiga, C., Warren, C.E., Ritter, J., Sripad, P., Abuya, T.** **Reproductive Health (2017) 14:99**	**Exploring provider perspectives on respectful maternity care in Kenya: "Work with what you have."**	**Aim** To assess the effects of a multi-component RMC intervention package at provider level. **Population** 13 Kenyan health facilities. 142 provider interviews. **Methods** A pre-post study assessing health providers' perspectives on a multi component intervention interview, using a two-part questionnaire – an interviewer guided section on knowledge and practice, and a self-administered part on value systems and perceptions. Composite scores created on client rights and care, provider emotional wellbeing and work environments.	**Outcomes** Data on the complexity of provider behaviour and maternal health care challenges. **Key Findings** More than half of the providers were exhausted and emotionally drained at the end of their shift. Improved knowledge and provider practice in respecting client's rights and providing client centred care – but these may be affected adversely by the work environment, including space constraints, low staffing, and heavy client loads. Provider emotional health has the potential to drive mistreatment and affect women's care. **The emotional well-being of providers** is needed to deliver quality RMC in high workload environments. This is strongly affected by management styles, communication structures, and availability of qualified counsellors. Little change was shown in **provider attitudes and behaviours** that would support rights based maternity care. Health system challenges limit the translation of providers' positive attitudes and behaviours in the implementation of a rights-based approach to RMC. Maternity settings with **poor work environments MUST be improved** in order to facilitate the **emotional well-being** of providers, with increased intensity in **emotional support** through better and more frequent access to counselling by a suitably trained person.

				Leadership and management styles affect work-based stress, which is then transferred to the client. Individual's behaviours are influenced by their peers and practices which have become the norm in the unit. There was improved supportive supervision and shared decision making between management and providers.
12 **E**	**Oosthuizen, S.J., Bergh, A., Pattinson R.C., Grimbeek, J.,** **BMC Reproductive Health 2017 14:151**	**It does matter where you come from: Mother's experiences of childbirth in midwife obstetric units, Tshwane, South Africa.**	**Aim** To determine women's experiences of childbirth in order to improve RMC in low risk MOUs. **Population** 653 new mothers **Method** Anonymous questionnaire administered to postnatal women. ANCOVA was performed to identify socio-demographic variables that predict disrespectful care. ANCOVA is a blend analysis of variance and regression analysis, which is used as a test in experimental research. It is a quantitative test that looks at the influence of an independent variable on an independent variable while removing the effect of co-variable effects.	**Outcomes** Age, language, education, and length of residence in the district were strongly associated with disrespectful care. ● 46% welcomed by name ● 47% asked for consent to do a physical examination ● 39% offered food and water during labour ● 48% treated with respect ● 55% completely satisfied with their experience **Key Findings** Need to improve respectful care through interventions integrated into routine care in labour wards. These interventions should include the most vulnerable and underserved women. Midwives support and clinical governance in maternity facilities also needed.
13 **I**	**Ratcliffe, H.L., Sando, D., Lyatuu, G.W., *et al*.** **BMC Reproductive Health 2016 13:79**	**Mitigating disrespect and abuse during childbirth in Tanzania: An exploratory study of the effects of two facility-based interventions**	**Aim** The selection and implementation of a package of RMC interventions, and to assess preliminary outcomes of the interventions for the facility, women and providers. **Population** **Methods** Two interventions were implemented: Health care provider RMC workshop utilising the Health Workers for Change curriculum and Open Birth Days – a birth education and preparedness program.	**Outcomes** Increased, empowerment of women regarding labour and birth. Increase in provider knowledge of user rights. Higher level of empathy amongst providers, with better interpersonal relationships. Improved patient satisfaction and improved perception of quality care. Improved job satisfaction amongst providers. **Key findings** Both interventions impacted on consumer and staff empowerment. The publication can be used as a guide to implement both interventions.

			Pre-Post design: pre-post questionnaires, structured interviews, and direct observation.	Women were not reporting D&A before the intervention phase. This shifted to 10% reporting D&A. This study showed that successful engagement with health facility staff, administrator and authorities can lead to identification, development and implementation of doable, cost efficient, low cost interventions that reduce D&A and promote RMC.
14 **I**	**Ratcliffe, H.L., Sando, D., Mwanyika-Sando, M., *et al*** **BMC Reproductive Health 2016 13:80**	**Applying a participatory approach to the promotion of a culture of respect during childbirth.** (Tanzania)	**Aim** Generate open dialogue on RMC between women, providers, and administrators, on D&A in the maternity care setting to foster collaboration. Strategic engagement with influential policy makers and stakeholders at national, district and facility levels. **Population** 362 women participated in Open Birth Days. 76 providers participated in RMC workshop (86% participation rate). **Method** Use of a participatory approach to engage health facility staff, administrators and multi-level health care authorities leading to the identification, development and implementation of feasible, cost efficient, low cost interventions that reduce D&A and promote RMC by providers.	**Outcomes** The participatory implementation process facilitated multilevel support which amplified the effects of the two interventions. Participatory dissemination process to generate collaboration, transparency, and institutional accountability. Development of a technical working group of researchers and representatives from local and international organisational partners, municipal health managers, hospital management and providers to work on the interventions (women were not included). Consensus on the interventions selected through dissemination of the results of the baseline study on D&A to national Ministry of Health and leaders in the field. Open birth days included a participatory health education session and tour of the maternity facility. RMC provider workshops led to an action plan for the facility to address improvements identified e.g. privacy curtains, staff structure changes. **Key Findings** Sensitization meetings (consultations) with influential policymakers created better awareness of D&A and generated support to investigate mitigating D&A in maternity settings.
15 **E**	**Rominski, S.D., Lori, L., Nakua, E., Dzomeku, V., Moyer, C.A**	**When the baby remains there for a long time, it is going to die so you have to hit her small for the baby to come out: justification of disrespectful and**	**Aim** To examine disrespectful and abusive treatment towards labouring women from the perspective of midwifery students who were within months of graduation. **Population** 83 final year midwifery students at 15 public midwifery training colleges in all 10 of Ghana's regions.	**Outcomes** Themes which emerged 1) rationalization of disrespectful and abusive care; 2) the culture of blame and 3) no alternative to disrespect and abuse. Without better quality care, including humanised care, the use of facility-based maternity services in Ghana is not likely to improve. **Findings**

	Health Policy and Planning, 32, 2017, 215-224	**abusive care during childbirth among midwifery students in Ghana**	**Method** Focus groups using a guide.	Midwifery students in Ghana's public midwifery schools report witnessing and participating in many forms of disrespect and abuse during births as part of their education. While they understand why respectful care is important and necessary, they are able to justify the reason for disrespectful and abusive care. "This poor treatment of labouring women was explicitly and tacitly supported by these students' teachers and preceptors."
16 **E**	**Sacks, E.** **BMC Reproductive Health 2017 14:66**	**Defining disrespect and abuse of newborns: a review of the evidence and an expanded typology of respectful maternity care**	**Aim** To review the evidence using an expanded typology of RMC, to define disrespect and abuse of the newborn. **Method** A literature review was conducted using the seven universal rights categories for RMC, on disrespect and abuse of the newborn.	**Outcomes** The literature review found substandard care, stigma, discrimination, health system constraints, neglect, non-consensual care PLUS legal accountability and bereavement care comprised the typology for disrespect and abuse of newborns. **Findings** Expand RMC research, policy, and programs to include newborns and infants.
17 **E**	**Sethi, R., Gupta, S., Oseni, L., Mtimuni, A., Rashidi, T., and Kachale, F.** **BMC Reproductive Health (2017) 14:111**	**The prevalence of disrespect and abuse during facility-based maternity care in Malawi: evidence from direct observations of labour and birth.**	**Aim** To describe the prevalence of disrespect and abuse during labour and birth through the secondary analysis of direct clinical observations, and to describe the association between the observation of D&A items with the place of the birth and client background characteristics. **Population** 2109 observations across 40 facilities. **Method** 20 clinical observers using a labour and birth observation checklist, observed an average of 5 births per day over 12 days. Data analysis used Stata statistical software	**Outcomes** The results showed that while women were frequently greeted respectfully (13.9% were not), they were often not encouraged to ask the health provider questions (73.1%), were not given privacy (58.2%) and were not encouraged to have a support person present with them (83.2%). **Findings** There was an inconsistent relationship between place of the birth and D&A items: ● where the odds of being shouted at was lower in a health centre when compared to a hospital (OR: 0.19; CI: 0.59–0.62) ● While there were higher odds of clients not being asked if they have any concerns if they were in a health centre when compared to a hospital (OR: 2. 40; CI: 1.06–5.44). ● Women who were HIV+ had significantly lower odds of not having audio and visual privacy (OR: 0.34, CI: 0.12–0.97), of not being asked about her preferred birthing position (OR: 0.17, CI: 0.05–0.65) and of not being asked if she had any other problems she was concerned about (OR 0.38, CI: 0.15–0.96).
18	**Sheferaw, E.D., Mengesha, T.Z., Wase, S.B.**	**Development of a tool to measure women's perceptions of respectful maternity**	**Aim** Construct and validate a scale measuring women's perceptions of RMC in health facilities.	**Outcome** RMC Scale with 15 items in four components Quantitative Validated tool

E	**BMC Pregnancy and Childbirth (2016) 16:67**	**care in public health facilities.** (Ethiopia)	**Population** 509 postnatal women visiting facility from childbirth to 7 weeks post birth, able to speak Amharic. **Method** Literature review, in-depth interviews with women about their intrapartum experiences. Expert review of the tool. Tool was pilot tested by 40 women.	**Key findings** Seven priori dimensions identified from literature. 5-12 items selected from items generated by the in-depth interviews 60-item draft tool, using a 5-point Likert Scale. Experts reviewed the 60-item draft tool: 4 items excluded, five items rephrased, and three new items added. Pilot tested on 40 women. Data collected was managed using a template prepared by Microsoft Access 2010. Data was analysed using IBM SPSS 20 statistical package for factor analysis and validity and reliability analysis. **Results** 1. Expert review of the tool improved content coverage and relevance 2. Validity and reliability were obtained from factor analysis **3.** Tool developed used quantitative methods
19 **E**	**Sheferaw, E., Bazant, E., Gibson, H., *et al*** **BMC Reproductive Health (2017) 14:60**	**Respectful maternity care in Ethiopian public health facilities.**	**Aim** To describe the prevalence of RMC and mistreatment of women. To identify the factors associated with mistreatment of women in labour in maternity facilities. **Population** 240 women in 28 maternity facilities **Method** Structured observations checklists used.	**Outcome** Providers RMC performance was measured by nine behavioural descriptors. Mistreatment was measured by four items. **Key findings** Women received 6 of the 9 RMC practices. RMC was higher at health centres than hospitals. **Results** A quality improvement program and having a birth companion were associated with RMC.
20 **E**	**Solnes Miltenburg, A., van Pelt, S., Meguid, T., Sundby, S.,** **Reproductive Health Matters, 26:53, 88-106,**	**Disrespect and abuse in maternity care: individual consequences of structural violence.** **Tanzania**	**Aim** To show such disrespect and abuse is enacted at an interpersonal level across the continuum of care in Tanzania. To describe how and why women's exposure to disrespect and abuse should be a symptom of structural violence ("*Social forces which create and maintain inequalities within and between social groups"*). **Population** 14 women were purposively selected and followed up during their pregnancies. Their interactions with health providers from their first antenatal visit until after birth were observed. Narratives were based on observation of 25 antenatal visits, 3 births and 92 in-depth interviews with the same women. **Method**	**Outcomes** All women were exposed to supportive and non-supportive care during pregnancy and birth including psychological abuse, physical abuse, and abandonment and privacy violations. Younger and less experienced women were more likely to experience D&A (more experienced, older women took precautions to avoid D&A by not attracting attention). Women revealed how they were exposed to D&A from one pregnancy to the next. **Findings** Systemic gender inequality renders women excessively vulnerable to abuse, and this abuse has become normalisation in society.

			The fourteen women's interactions with health providers from their first antenatal visit until after birth were observed, using observation guidelines. Detailed narratives were developed based on observation of 25 antenatal visits, 3 births and 92 in-depth interviews with the same 14 rural women. Narratives were analysed using deductive thematic analysis and then viewed through the lens of structural violence.	Normalisation of non-supportive care is symptomatic of an institutional culture of dehumanised care. Health providers may act disrespectfully because they hold power /authority over their patients, especially authoritative power. However, health care providers are also victims of continuous health system challenges and poor working conditions. Preventing disrespect and abuse during pregnancy and childbirth means paying attention to structural inequalities that foster conditions that make it possible to mistreat vulnerable women.
21 **I**	**Warren, C., Ndwiga, C., Sripad, P., *et al*** **BMC Women's Health 2017 17:69**	**Sowing the seeds of transformative practice to actualise women's rights to respectful maternity care: reflections from Kenya using the consolidated framework for implementation research (CFIR)**	**Aim** Use the consolidated framework for implementation research (CFIR) to understand complex interventions. **Methods** Before-and-after study. Data from project documents, reports and interviews collected during the HESHIMA PROJECT to generate categories for analysis across the intervention design and implementation stages.	**Outcomes** Improved knowledge of both the clients and the providers, of D&A, RMC, and health as a human right. Increased self-awareness of how labour and birth service delivery is affected by values, socio-norms and the attitudes and behaviours of providers. Cultivated mutual respect between the clients, providers, and communities. Increased individual and team accountability. Devised mechanisms for managing the drivers of mistreatment. **Key findings** "The CFIR is a useful tool for contextually understanding and adapting interventions to country needs." A participatory, consultative, iterative process is critical for designing, planning, and implementing multifaceted interventions. The implementation of the RMC package was meaningful within Kenyan politics and health care. Flexibility is fundamental in the participatory process. Social norms revealed how important men are in their households and communities, thus their involvement is essential to add momentum to RMC changes in facilities. Facility and staffing infrastructure continue to impact on the delivery of quality respectful maternity care. There remains a resistance amongst communities, clients, and providers to report D&A. A key element of success was providing providers with emotional support.

22 **I**	**Wilson-Mitchell, k., Robinson, M.A., Sharpe, M.** **Midwifery Vol60, May 2018 pg27-29**	**Teaching respectful maternity care using an intellectual partnership model in <u>Tanzania</u>**	**<u>Aim</u>** To develop and run a two-day RMC workshop for midwives using Intellectual partnership Model Principles. **<u>Population</u>** Midwives **<u>Method</u>** Co-creation of solutions using learners' challenges in the workplace.	**<u>Outcome</u>** A ten-item multiple choice test increased by 20% after completion of the interventions. **<u>Key findings</u>** The Intellectual Partnership model should be considered along with problem-based learning in the global South

Table 6.6.2 Geographic Distribution of Studies

Country	Number of Articles	Authors
Ethiopia	2	Sheferaw *et al* (2016, 2017)
Ghana	1	Rominiski *et al* (2017)
Kenya	3	Abuya *et al*, Ndwiga *et al* and Warren *et al* (2015)
Malawi	1	Sethi *et al* (2017)
Nigeria	1	Ishola *et al*, Bohren *et al* (2017)
Rwanda	1	Mukmurigo *et al* (2017)
South Africa	1	Oosthuizen *et al* (2017)
Tanzania	8	Dynes, Freedman, Msele, Ratcliffe (x2), Solnes Miltenburg, Wilson *et al* (2018)
Multiple countries	4	Bohren *et al*, Bradley *et al*, Downe *et al*, Sack E. (2015)

Systematic Reviews that Included Countries in sub-Saharan Africa:

1. Bohren *et al*: 2015: systematic review on the mistreatment of women in childbirth in health facilities globally: total of 34 countries – with 11 countries in sub-Saharan Africa: South Africa, Ghana, Kenya, Tanzania, Uganda, Benin, Malawi, Ethiopia, Zambia, Sierra Leone and Morocco.
2. Bradley *et al* 2016: systematic review and meta synthesis of women's experiences of facility-based delivery in sub-Saharan Africa to examine the drivers of disrespectful care: South Africa, Ghana, Tanzania, Ethiopia, Malawi, Zambia, Zimbabwe and the Gambia.
3. Downe *et al* 2018: systematic review (of 5 studies) of the effectiveness of respectful care policies in four African countries: Kenya, Tanzania, Sudan, and South Africa.
4. Sack, E., 2017: conducted a literature review on D&A of newborns to expand the RMC typology.

Figure 6.6.3 Distribution of Articles According to Journals

	BMC Pregnancy and Childbirth	George A & Branchini C, Msele *et al*; Sheferaw *et al* (2016); Abuya *et al*.
	BMC Reproductive Health	Downe *et al*; Dynes *et al*; Ndwiga *et al*; Ratcliffe *et al*: 1 and 2; Sacks; Sheferaw *et al* (2017); Oosthuizen *et al*; Sethi *et al*
	BMC Women's Health	Warren *et al*. (2017)
	Health Policy and Planning	Rominiski *et al* (2017)
	Midwifery	Wilson-Mitchell *et al* (2018)
	PLOS One	Mukamurigo *et al* (2017); Bohren *et al* (2015); Ishola *et al*.
	Reproductive Health Matters	Freedman *et al*; Solnes Miltenburg *et al* (2018)
	Social Science and Medicine	Bradley *et al* (2016)

6.7 Findings

In order to answer the scoping review questions i.e. what the evidence is of D&A in maternity care in sub-Saharan Africa; what interventions have been developed to promote respectful maternity care in sub-Saharan Africa and the role of the health care provider in these interventions, the review articles were coded as evidence (E) or intervention (I). The role of the health care provider was clear in all the studies.

The studies all looked at D&A in facility-based maternity care.

6.7.1 Evidence

There were 14 articles (coded as E in the matrix) reporting on D&A in maternity care from 11 different countries.

6.7.1.1 Evidence from Systematic Reviews

In their systematic review of mistreatment of women during childbirth, from 65 studies in 34 countries, Bohren *et al* (2015) typology provides evidence-based categories of mistreatment of women: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet

professional standards of care, poor communication between mother and provider, and health conditions and challenges. These categories are very specific and align with the charter of the 7 Universal Rights of Childbearing Women (WRA 2011). Bohren *et al* (2015) raised the terms that are being used to research or discuss disrespect and abuse, including "obstetric violence" and "dehumanised care", however the researchers proposed using the term "mistreatment of women". They go on to explain the mistreatment can be intentional (slapping) or unintentional (neglect due to understaffing) or related to health systems (insufficient space and beds).

Bradley *et al* (2016) conducted a systematic review of evidence of D&A in 7 countries in sub-Saharan Africa. Themes that arose from this study were "power and control" and "maintaining midwives' status" and drivers of D&A. George & Branchini (2017) conducted a secondary analysis on a previous systematic review which synthesised stakeholder experiences and factors influencing the implementation of rights-based RMC. One of their key findings was in order to work in a rights-based RMC approach, women and the community need to be equal partners with the health care providers. Ishola (2017) conducted a systematic review to look at the nature and extent, contributing factors, and consequences of D&A in Nigeria.

6.7.1.2 Evidence from Research Studies Conducted in Tanzania

Dyre *et al's* (2016) study in Tanzania identified client and provider factors which influenced RMC. These included age matters, women with complications receive more D&A, but RMC happens if the woman is accompanied by a companion during labour. Frequent attendance at religious services was a deterrent to receiving RMC. Freedman *et al* (2018) found that trained nurses observing births in Tanzania reported more D&A than the women self-reported. The most reported form of D&A was verbal abuse – shouting, scolding, threatening to withhold treatment often related to provider's annoyance with the woman for being non-compliant in some way, which then led to physical abuse. The authors concluded that the low self-reporting shows the women's powerlessness to prevent or challenge the D&A. Msele *et al* (2019), in their study in Tanzania, documented D&A from the perspective of mothers and fathers. The mistreatment of women in maternity care reflected similar D&A reported in other studies conducted in sub-Saharan Africa. The conclusion of the study was that "humanising birth care has a long way to go".

Solnes Miltenburg *et al* (2018) in Tanzania followed 14 pregnant women's interactions with health care providers. All the women received both supportive and non-supportive care during pregnancy and labour. Younger women were more at risk of D&A than older women – as they

took precautions not to attract negative attention. The researcher's specific approach was to discuss D&A in terms of "structural violence". Notably were systemic gender inequality makes women vulnerable to abuse; abuse has become normalised in society and as an institutional culture of dehumanised care; health care providers act disrespectfully because they hold power and authority over labouring and birthing women (providers themselves are victims of health system challenges and poor working conditions). They conclude that in order to prevent D&A in maternity care, attention needs to be paid to institutional culture and structural inequalities that create conditions in which women can be mistreated and abused.

6.7.1.3 Evidence from Other sub-Saharan Countries

Mukamurigo *et al* (2017) explored the meaning of a poor childbirth experience amongst women in Rwanda. From a cross-sectional household study 17 women who had reported a bad childbirth experience were interviewed. The key findings centred on the provider's actions: abandonment, shaming and insulting, humiliation, creating fear and distrust and making women feel insecure.

Oosthuizen *et al* (2017) in South Africa, determined women's experiences of childbirth in order to improve RMC and midwives obstetric care units, using an administered anonymous questionnaire with postpartum women. Age, language, level of education, and length of residence in the district were strongly associated with disrespectful care.

Rominiski *et al* (2017) in Ghana examined D&A from the perspective of midwifery students. Three themes emerged – rationalisation and normalisation of widespread D&A, the culture of blame (i.e. midwives were blamed for negative outcomes), and no alternatives to D&A (i.e. when a woman in labour is being uncooperative, the provider was forced to abuse her to gain cooperation). The mistreatment of women in labour and birth was "explicitly and tacitly" supported by the students, teachers, and preceptors.

Sethi's *et al* (2017) study in Malawi, documents the prevalence of D&A during labour and birth, using direct observations in hospitals and health centres. The study found that older women had a higher chance of singular occupation of a bed; and that the higher a woman's parity was, the more unlikely she would have a support person with her in labour; and HIV positive women had lower odds of receiving audio and visual privacy.

Sheferaw *et al* (2016) (2017) in Ethiopia, developed a quantitative validated tool to measure D&A from women's perceptions, followed by using this tool to determine the prevalence of

D&A in public health facilities, using trained observers and structured observation checklists. RMC was higher in health centres versus hospitals. At least one form of mistreatment of women occurred in 36% of the observations. Higher levels of RMC performance were found among male versus female providers, and amongst midwives versus other providers. Woman accompanied by a companion had less D&A and more RMC.

6.7.1.4 RMC Including the Mother Baby Dyad

One article included in the scoping review search and matrix, bears mention, as the mother and baby should be treated continuously as a dyad. This article was written by Sacks (2017) on the abuse of newborns. After birth, both the newborn and mother need maternity care. There has been very little research on respectful care or mistreatment of well, healthy newborns (versus compromised neonates). There has been very little research on the effects to the newborn, from the D&A of the mother in maternity care, other than the effect on newborns with mothers who suffer postnatal depression and PTSD. Withholding skin to skin contact between mother and baby immediately at birth significantly affects the mother-baby attachment process, and the baby is denied being exposed first to the mother's commensals, allowing these commensals to colonize the baby's body and create the newborn microbiome. The baby is commonly taken to a hospital warmer, with after birth procedures carried out that expose the baby to hospital organisms, which may well influence the child's immunity in the long term. These issues need to be considered in the continuing dialogue of D&A in maternity care in the future.

6.7.2 Interventions

Abuya *et al* (2015), Ndwiga *et al* (2017) and Warren *et al* (2018) all contributed to the Heshima Project in Kenya.

Abuya *et al* (2015) in Kenya, assessed the effects of a complex intervention, through observation and exit interviews. The researchers found that the interventions led to a 7% reduction in D&A, especially physical abuse and detainment. D&A was found to be highest during the night shift. Ndwiga *et al* (2017), in assessing the effects of the complex intervention the Heshima project carried out in Kenya, found that 50% of staff were exhausted and drained at the end of the shift. There was an increase in knowledge of RMC and respecting clients' rights, amongst providers. However, this is affected by the work environment, space constraints, low staffing, and heavy workloads. The provider's emotional health has the potential to drive D&A and affect women's care. The provider's emotional health is affected by the management style, communication structures and the availability of qualified

counsellors. Poor working environments must be improved to contribute to provider emotional health. Warren *et al* (2017) identified four themes in the data - prioritising the care provider's agenda; disregarding the women's embodied knowledge about labour and foetal well-being; lies and threats leading to coerce a woman into complying with procedures; provider's actions that were abusive and violent. Key findings included women describing similar experiences across different birth settings and cultural contexts; the relationship between the care provider and the woman is critical to the birth experience; actions and interactions that providers may see as routine may be experienced as traumatic by women; providers need to understand how practices and behaviours influence the psychological and emotional experience a woman has of birth.

Downe *et al's* (2018) review across five African countries assessed the effect of the implementation of RMC policies on decreasing D&A. Where RMC policies were implemented, more RMC was reported. D&A decreased by two thirds, especially physical abuse. Deficiencies in infrastructure leads to D&A and thus need to be addressed by the service providers and policymakers.

George and Branchini (2017) did a synthesis of stakeholder experiences and implementation factors in promoting awareness of rights for maternal health. This was a secondary analysis of documents identified whilst doing a previous systematic review, which mapped literature of maternal health which focused on health system and community-based interventions aimed at improving the equity and quality of maternal health in middle and low income countries. Women reported an increase in their sense of self-empowerment and self-esteem across the interventions documented. Key to obtaining health rights is the involvement of leadership and collective organizing amongst women/community involvement - critical in supporting women's rights to maternity care services. Provider resistance stems from a narrow interpretation of women's rights to RMC or to "poor working conditions." Changing provider attitudes and developing the midwives' interpersonal skills, requires time, training and capacity building and needs to have the active support from managers, administrators, and policymakers. This requires balancing power across all the stakeholders with active involvement of women and communities.

Ratcliffe *et al* (2017), in Tanzania, used a participatory approach to engage stakeholders in the planning and implementation of the two interventions - the Open Birth Days and provider RMC training, using the Health Workers for Change Curriculum (this work was part of a larger

implementation research project). With sufficient engagement with staff, administrators and policymakers, RMC interventions can be identified, developed and implemented. Low cost, doable, cost efficient interventions can decrease D&A and improve RMC.

Wilson-Mitchell *et al* (2018) conducted RMC workshops for providers using the intellectual partnership model, to co-create solutions to workplace challenges.

6.8 Discussion of Findings

Four themes arose during the analysis of the literature featured in the scoping review matrix. These were women, providers, and health care systems. In addition, the interventions and programmes identified have been discussed.

6.8.1 Theme 1: Women

Under this theme, the types of D&A, factors leading to, and consequences of D&A, and the measurement and prevalence of D&A are discussed.

Bohren *et al* (2015) typology provides evidence-based categories of mistreatment of women. These categories are very specific and align with the Charter of the 7 Universal Rights of Childbearing Women (WRA 2011), which was developed by global stakeholders in response to Bowser and Hill's (2010) landscape analysis of mistreatment of women in facility-based maternity care. The charter became the leading document internationally, in defining this mistreatment. Bohren *et al* (2015) raised some of the other terms that are being used to discuss disrespect and abuse, including "obstetric violence" and dehumanised care", however the researchers proposed using the term "mistreatment of women". They go on to explain the mistreatment can be intentional (slapping) or unintentional (neglect due to understaffing) or related to health systems (insufficient space and beds).

D&A causes not only immediate distress, but the effects are also long term. Mukamurigo *et al* (2017) showed that when a woman has been traumatised in facility-based childbirth, the woman is likely to withdraw from maternal childcare offered by the health system and in relating her childbirth experience, perpetuates negative community perceptions regarding providers in healthcare facilities. Reed *et al* (2017) looked at the long-term effects of a traumatic birth experience. They found that a traumatic birth experience influences mother baby attachment in the first year and beyond, influencing a child's social, emotional, and mental development. A negative birth experience can affect the way a woman views herself, potentially altering her development as a woman and a mother, and disrupting family

relationships. It is also associated with postpartum mental health problems including depression and post-traumatic stress disorder (PTSD).

Regarding measuring and categorizing mistreatment of women in facility-based labour and birth, the women's experiences and their perceptions thereof need to be identified and measured before any intervention can be developed.

Since 2010 validated tools for the measurement of disrespect and abuse are now available in the literature. For example: Sheferaw, Mengesha and Wase (2016); a 15-item RMC quantitative scale was used to measure women's perceptions of RMC. In Sheferaw *et al's* 2017 study, having used their validated tool, they describe the occurrence and factors associated with mistreatment of women in maternity facilities.

While, as stated, evidence that arises from these surveys provide a needed background for the development of intervention, participation in such surveys gives women a voice. Uwimana's (2020) very recent study indicates that women in Rwanda, where the study was undertaken, are reluctant to "complain" but were very keen to complete the survey she administered. This is undoubtedly due to the anonymity factor when completing a survey.

Together, these authors provide an up to date, sturdy base for reporting on D&A in facility-based childbirth and are further useful for identifying drivers of D&A, which is discussed in the next section.

6.8.2 Theme Two: Health Care Providers (health care workers, midwives, doctors, or nurses)

Drivers identified for D&A in maternity care are poor interpersonal relationships, the emotional health and wellbeing of the provider and the impact of unresolved work-based stress, such as a poor working environment, on the providers.

A key driver of disrespect is **poor interpersonal relationships** between provider and woman, with poor quality communication (Ratcliffe, 2016a). Some providers explained that they were focusing on the clinical care and didn't explain the procedures, decisions and care to the women. Other providers reported that this continual explanation during care was repetitive. Disrespect and abuse have consequences for the women who have been mistreated. Prior experiences of mistreatment significantly reduce the woman's will to use and trust maternity facilities (Austad 2017; Sheferaw 2017). This kind of poor reputation contributes to the negative public views of the health system. These women usually seek kinder, empowering

care for future births. In some countries this may mean birthing at home with an unskilled provider and the risk of life-threatening complications (Sheferaw 2017).

An interesting driver raised by Bohren *et al*, is that providers **blame women** for presenting at maternity facilities with complications. This creates stress for the provider especially when compounded by health systems issues e.g. poor transport to referral facilities. Thus, providers justified the disrespect and mistreatment of these women in a bid to facilitate a safe outcome for the mother and newborn – 'forced by circumstance'. Some providers reported that it was not all the providers, but some 'rotten apples.'

The health care providers' **emotional health is** also a key driver for disrespect and abuse (Ndwiga *et al*., 2017). As disrespect and abuse occurs under stressful conditions, it is important to aid health care providers with stress management tools and resources. The literature documents the value of having champions within the health facility. These champions can include champions from within the health care provider groups – doctors, midwives, other staff members. Champions are there to support staff and encourage the development of the respectful care programme (Warren *et al*., 2017). Mentorship has also been shown to reduce health care provider stress. Mentorship can be peer to peer, senior to junior or management to staff member. Mentorship can also be in groups. Some of the articles stated that health providers often felt they had poor or absent support from their managers. Mentorship would be a way to facilitate improving relationships between providers and managers.

There were strong, frequent messages about supporting staff emotionally with a call to provide a counselling service to staff. Debriefing with the team following an adverse event during the birth is strongly recommended in medical care, so that lessons can be learnt from the event. This is not the same as providing counselling services where a provider can work through work-based stress and develop coping mechanisms and skills. This however may be resource driven and not available within / to all maternal child health facilities.

It's clear from the significant mass of literature published on RMC since Bowser and Hill's (2010) landscape report on the widespread mistreatment of women in facility-based childbirth, that in most healthcare settings the power relationship between provider and client is weighted towards the provider's authority over the client. For women to become self-empowered and equal partners in their own healthcare, the existing power relationship needs to change.

Bohren *et al* (2015) referred to providers as being impatient, which the women attributed to staff being overworked and tired. Providers raised the belief that the hierarchical **authority** in

the facility and health system "legitimizers" the control the provider has over the labouring and birthing woman, and thus it was acceptable to coerce women to be compliant. Providers reported that some providers "enjoyed exerting control over" women they were caring for. When acceptance of this mistreatment was discussed, the providers cited lack of supervision, which in turn leads to frustration within the workplace and the development of negative attitudes in both the women and providers.

In George and Branchini's (2017) synthesis of health providers' experiences of initiatives that promote awareness of rights in maternity care, they report that in general, providers saw these initiatives in a positive light. However, some providers found it difficult to cope with issues that challenged their authority and manner of working. There were also providers who interpreted women's rights to quality maternity care, too narrowly with a lack of understanding about the challenges which may come when seeking care. Some providers viewed the promotion of women's rights to RMC as a much larger issue which they didn't think they had much influence over. Providers respond differently to difficult work environments. Those providers who co-operated recognized the need for a change in mind-set. George and Branchini (2017) call this "balancing power across stakeholders". This means individually with women, families and communities, providers, managers, administrators, and at the level of policy with high-level decision makers. An iterative, reflective approach is aimed at creating change that addresses the imbalance of power between parties and overcomes resistance at any level.

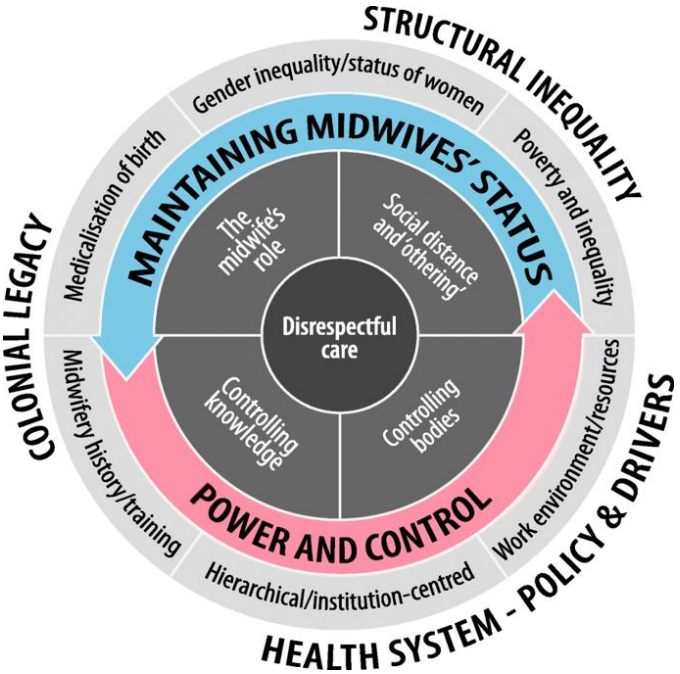
Bradley *et al* (2016) also found these two themes of "Power and Control" and "Maintaining Midwives Status". Bradley *et al* (2016) identifies "power and control" as a meso level driver of mistreatment and disrespectful care. Describing it as D&A arising from the midwives attempts to "assert their professional identity and take charge of women and the birth process," in particular women's physical behaviour during labour. Women experienced being shouted at when they "vocalised" pain, or the midwives told them to keep quiet often using words that trigger a sense of shame. Bradley *et al* (2016) highlights "trigger points" that spark a midwife's authority and control – such as not listening or paying heed to a woman's embodied knowledge of the need to push. Midwives hold authoritative knowledge and a technical approach to labour and birth which has been institutionalised. They often misuse their authoritative knowledge as a way of exercising power and control. Another way that midwives might misuse their authoritative knowledge is withholding information about the wellbeing of the baby and the progress in labour. Bradley at al uses the term "bystander, not participant" – where instead of women-centred practice, care is service delivery centred. Bradley at al's synthesis shows that

limited participation, lack of collaboration and poor interpersonal relationship with the provider prevents women from participating in decision making and disempowers them. This can translate by the mother as being emotionally traumatic (Reed *et al*., 2017).

Conversely two studies showed that some women are dependent on the midwives' authoritative knowledge and control. Power and control are also maintained by rules, compliance, and punitive behaviour by the midwives. The example is given of women being scolded for using traditional herbs or potions. Provider behaviours may be the way they maintain their "technical, professional and social" status, which often reflects as power relationships found in a wider society at meso and macro levels contexts as social dynamics in the labour ward, do not occur in isolation. Bradley *et al* (2016) uses the term social distance and "othering" which arises from social inequality between women and providers perpetuated by midwives controlling behaviours.

Nurses and midwives are themselves subject to an imbalance of power in their interactions and decision making with doctors, health professionals, managers, and administrators. Thus, in maternity care, some midwives may perpetuate the same power imbalance, with their clients, in order to retain some status in the healthcare setting. Overcoming this means bringing about a change in attitudes and behaviours at all levels of care within a facility and within the broader context of maternity care. It also means opening the dialogue with women and their communities, and the willingness to act upon the feedback they provide.

Unresolved, continuous workplace stress is another driver of D&A, where providers project their own frustrations on the women they are caring for. In order to level the power relationship between the midwives and women, maternity care needs to become client centred versus institutionally centred, de-medicalising birth and acknowledging women's embodied knowledge. Midwives need to be at the centre of bringing about this change (Bohren *et al*., 2017). Bradley *et al* (2016) recommended possible solutions to mitigating the drivers of mistreatment as shown in a "historical, social and health systems" context, making power dynamics visible. Nwiga *et al* (2017), Abuya *et al* (2015), and Warren *et al* (2018) also made recommendations to mitigate the drivers of mistreatment of women. Bradley *et al* (2016) developed a conceptual framework as shown in Figure 6.8.1 below:



(Bradley et al., 2016)

Figure 6.2 Bradley *et al's* conceptual framework of the drivers of mistreatment of women in sub-Saharan Africa, during facility-based maternity care in sub-Saharan Africa

Sheferaw's study in 2017, in Ethiopia found that male providers were more likely to perform at a high level of RMC vs. female providers. In the conclusion of the abstract, Sheferaw recommends research is needed to identify the reason for this phenomenon.

6.8.3 Theme 3: Programs and Interventions

In Kenya and Tanzania, maternity open days were one of the interventions used to mitigate D&A in labour and birth. These maternity open days were aimed at giving the community an opportunity to visit the maternity facility to see the labour and birth facilities, meet some staff and to attend a high impact training session on birth preparedness and emergency readiness (Ratcliffe *et al*., 2016). Women reported that they felt better prepared for labour and birth. They also reported feeling more empowered and confident during labour and birth. These opportunities were used to set up a facility-community team that would meet regularly, continuing the link between facility and community in the long term (Warren *et al*., 2018).

Debriefing staff becomes an important outlet in caring for the caregivers within a maternity unit. Formal debriefing of the team after an adverse outcome or near miss event, aimed at strengthening the team approach to future adverse events, is one way of debriefing the staff, however this form of debriefing only works through an adverse event. Debriefing the midwives peer to peer has shown to be very useful in resolving tensions and conflict in a unit. Debriefing midwives helps them to realise they are not alone. Sharing personal reactions and responses to

work stress also helps each midwife learn from others how to manage these reactions and responses. It leads to greater teamwork and improves the quality of care.

Methods that have been used to bring about attitude changes amongst providers include – self-reflection on their own experiences of being a patient seeking health care, strengthening interpersonal skills, refresher training to build a sense of teamwork and improve morale. Identifying a group of champions who will lead and sustain change is another useful strategy to elicit provider engagement. The change process needs to have high-level, widespread support and may require structural changes to create a broader enabling environment.

Three specific programmes have been described below. The first, the *HESHIMA* project (a large scale multi approach comprehensive project), the second and third used participation and intellectual partnership, which the researcher, based on the findings of the scoping review, believes provide a sound base for an intervention to promote RMC.

6.8.3.1 The *HESHIMA* Project in Kenya

HESHIMA was a comprehensive and complex intervention study that bridged policy, health systems, health care providers, women, and communities.

The interventions were a manager's two-day RMC orientation workshop – for policymakers, health managers, legal and health rights advocates and media; a three-day facility-based workshop for provider training in RMC; community-based one-day training focusing on the rights and responsibilities of both providers and women giving birth in facilities, as well as maternity open days.

Mitigating work-based stress was approached from policy, health systems, facilities, and the provider's emotional wellbeing. "Interventions that help change provider behaviour are essential and easy to implement to promote RMC. However there needs to be sustained engagement in the health systems where the providers work." (Warren *et al* 2017).

The figure below shows the *HESHIMA* theory of change.

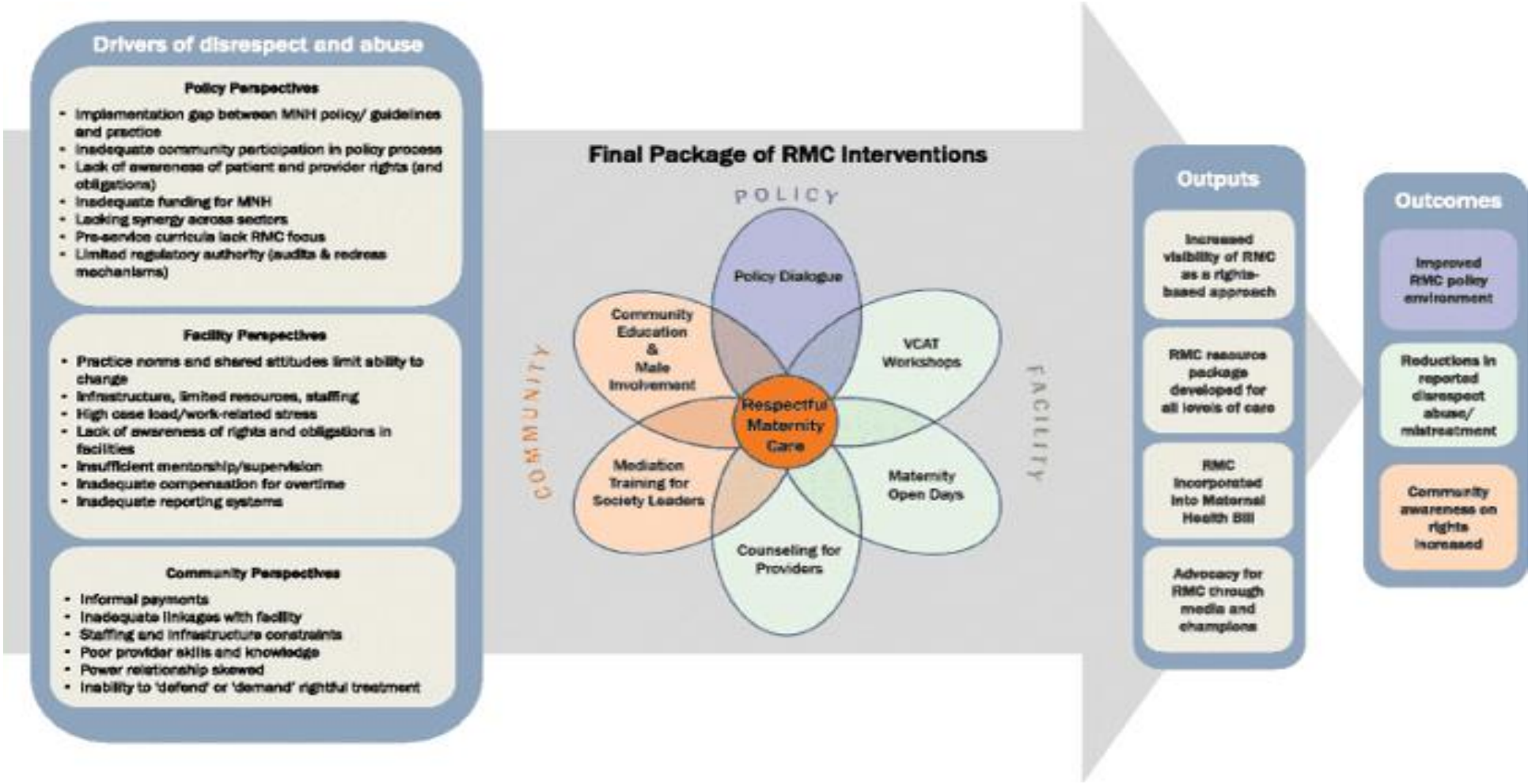


Figure 6.3 HESHIMA Theory of Change

Warren et al., 2017

6.8.3.2 The Participatory and Intellectual Partnership Models

Ratcliffe *et al* (2016) describe the participatory approach used to engage with key stakeholders through the process of selecting, implementing and evaluating interventions, in a large urban hospital in Tanzania, to reduce D&A and promote RMC: "The study team strategically engaged with key influences at facility, district and national levels throughout the course of the project." (Ratcliffe at al., 2016). They also engaged with midwives, nurses, and influential hospital staff. The study team puts forward the argument that by generating multiple levels of support, through using a participatory approach to the implementation of the study's interventions, it amplified the effect of the interventions and promoted respectful care which positively influenced the outcomes of the interventions.

In Wilson *et al's* (2018) study, also conducted in Tanzania, an intellectual partnership model (IPM) was used to teach respectful maternity care to experienced midwives. This means transforming the relationship between the teacher in a position of authority and the learners who are often passive and feel powerless. In the IPM model, the teacher becomes a facilitator and there is co-operative learning and co-creating amongst the learners. The IPM model was used to incorporate soft skills, shared decision making with the women, professional collaborations, problem solving skills and conflict resolution into humanising the midwives' clinical care.

It is clear from the literature reviewed that for interventions to lead to sustainable changes in RMC, they need to be developed, monitored and evaluated using a participatory approach (Ratcliffe *et al*., 2016), and be an intellectual partnership (Wilson *et al*., 2018) involving women, providers, managers, and the community. This means opening the dialogue where all parties are heard equally, develop, monitor, and evaluate interventions together. This is a very different approach from the prevailing medical model.

6.8.4 Theme 4: Health Systems

Health systems issues are cited by Bohren *et al* (2015) and other researchers as drivers of disrespect and abuse. Understaffing, long hours, poor salaries, interrupted supply of commodities, heavy patient loads, and poor infrastructure are cited as contributing to workplace stress and a hostile environment.

Two interventions – health professional training and open days for the community, have had an impact in both Tanzania (Ratcliffe *et al*., 2016) and Kenya (Abuya *et al*., 2015), but they

alone cannot lead to sustained behaviour changes by health professionals. All the health system issues raised above impact both the care providers and the women using the facility. Thus, interventions must include ways to improve the effectiveness of the facility/health system. This means strong management with the will to persist with addressing the inconsistent supply of daily commodities such as linen savers, gloves, obstetric drugs e.g. oxytocic drugs, enough linen etc. Managers are a very important part of an efficient facility. They are responsible for identifying impending problems and their efforts to avert or manage problems arising. It is very clear from the literature that there is often poor communication between managers and health care providers. This process needs to be addressed first. Health care providers feel valued when a manager listens and attempts to problem solve. Professional supervision is one of the core functions of a manager, and shows that the manager is conversant with the challenges that contribute to workplace stress in the staff. This supervision is aimed at setting professional standards for practice as well as addressing quality of care at the facility. An effective manager does not use this supervision as a punitive tool.

Staffing is an important factor in improving the work environment and health care provider's job satisfaction. It is a clear driver for incidents of disrespect and abuse of women in labour and birth (George and Branchini, 2017). If the staff to patient ratio is high, health care providers function in an unacceptably stressful work environment – overcrowding, lack of commodities, insufficient time to invest in each woman as an individual. Incidences of disrespect and abuse have been documented as more frequent during the night when the staff patient ratio is high (Abuya *et al*., 2015). Bohren *et al* (2015) report that both women and health care providers are affected by poor staff to patient ratios. This leads to poor quality of care. In their study, both mothers and health care providers said that inadequate staffing contributed to the health provider's negative attitudes and poor motivation.

Inadequate staffing also led to neglect of women during their time at a maternity facility (Bohren *et al*., 2015). This could be in the form of long waiting times for assessment in labour, women with complicated labours are attended to first, leaving women progressing in normal labour feeling neglected. Women reported waiting a long time when they were being referred to a higher level of care. Some women reported feeling that they were a "nuisance" or an "imposition" when they called for health care providers' attention.

Where there are respectful maternity care policies in place at a maternity facility, they do appear to reduce disrespect and abuse (Downe *et al*., 2018). Especially when combined with staff

training, mentoring, and debriefing. These policies should be written in such a way that women will read and understand the policy, gaining some degree of empowerment through knowledge of a rights-based approach to caring for women in labour and birth.

Health provider training is the actual training programme and methods – which leads to improved job satisfaction (Radcliffe *et al*., 2016), behavioural changes and feeling valued, which in turn reduces disrespect and abuse. The depth of the training of the health care workers is important. The literature documenting the outcomes of the *HESHIMA* Project in Kenya showed that multiple component interventions may improve understanding disrespect and abuse – the many different forms of disrespect and abuse; identify and addressing the drivers of disrespect and abuse, promoting a human rights approach for all maternity care, improving professional ethics and mutual accountability, strengthening facility management, and increasing community engagement, all lead to the development of quality strengthened teams.

The maternity facilities need to acknowledge the value of community engagement, community sensitizing meetings (Warren *et al*., 2017), sensitizing women and their families to women's rights and responsibilities in maternity care (Ratcliffe *et al*., 2016); sustaining links with the community and the value of open days at the maternity facility (Abuya *et al*., 2015).

There is a very varied uptake, in Africa, of women being accompanied by a birth companion of her choice, in labour and birth. Sheferaw *et al* (2016) found that women accompanied by a companion experienced a higher level of RMC. In Sheferaw *et al's* (2016) study, four out of five women were allowed to have a companion present in labour and at the birth. As the companions could provide emotional and physical comfort during labour, it relieved some of the burden for the health workers. The obstetric care navigators for rural Maya women in Guatemala, transferred to a hospital, use the same philosophy as that of the inclusion of birth companions in maternity care. Austad *et al* (2017) addresses the fact that through passive education the care navigators contribute meaningfully to changing institutional culture.

6.9 Conclusion

Disrespectful behaviour may be part of the personality characteristics of an individual and surface in response to stress. Leape *et al* (2012) states that the "expression of disrespectful behaviour is a learnt behaviour". This becomes acceptable in an environment with a culture that tolerates (normalises) and supports (rationalises) disrespect. The beginning point of resolving problems related to RMC, needs to come with a change in organisational culture. These studies in the scoping review, have shown that a change in the organisational culture can

be achieved in a relatively short time. This process needs to be facilitated by several key champions and includes the facility manager, the unit manager for the labour ward, antenatal and postnatal clinics, the midwives and other nursing staff, head of the obstetric service, and doctors.

Humanising maternity care, through a number of ways, was a key theme that ran through this scoping review of RMC and interventions that promote RMC. Interventions are more effective if women, the community, providers, managers, administrators, and policy makers collaborate, with a sense of ownership in the project or programme.

Reed, Sharman, and Inglis (2017) in Australia, explored the relationship between care providers' actions and women's experiences of being traumatised during labour and birth. This helps sensitize providers to the behaviours that women find traumatic, and the effect that has on their perception and memory of the birth experience. Mukamurigo *et al* (2017) explored the meaning of a poor childbirth experience amongst women in Rwanda. International literature shows that when a woman has been traumatised in facility-based childbirth, it leads to avoiding postpartum follow ups, not attending well baby monitoring, delayed/missed newborn immunisations, avoiding care in health facilities for future maternity care and childbirth, and perpetuates negative community perceptions regarding providers in healthcare facilities.

Midwives have a professional, ethical, and legal responsibility to provide safe and respectful care to all women during pregnancy, labour, birth and postpartum. About one third of women experience emotional trauma during labour and birth (Reed, Sharman, and Inglis, 2017). This in turn contributes to postnatal depression and post-traumatic stress disorder (PTSD). This may lead to ongoing difficulties for mother, baby, and the family in the long term.

The strongest predictor of developing birth related PTSD is interpersonal difficulties with the health provider and lack of support during labour and birth. Disrespect and abuse prevents women from receiving the best quality maternity care. In addition, disrespect and abuse of women when they are most vulnerable, especially during labour and birth, is an ethical and human rights issue.

In addressing D&A, women need to be educated on their rights in childbirth, providers should receive interpersonal skills training, utilization of RMC policies, and strengthening health systems to respond to specific needs of childbearing women.

This chapter documented the outcomes of the scoping review and discussed the findings and the interventions which lead to reducing and redressing the mistreatment of women in facility-based maternity care. In the next chapter, the researcher triangulates the three sources of data, women, midwives and literature in the design of an intervention to address RMC in maternity care.

CHAPTER 7

SPECIFYING THE PROGRAMME STRUCTURES AND PROCESSES

7.1 Introduction

The previous four chapters have addressed the research findings in each of the four data sets. This chapter provides an integration of these findings leading to the development of Meta inferences. The Meta inferences will then guide the development of an intervention nurturing respectful maternity care, or as stated by Fraser and Galinsky (2010), the specification of programme structures and processes. This was done in order to meet the final objective: to develop an intervention to nurture respectful maternity care by midwives in the MOUs.

7.2 Findings

The findings from the four sets of data originating from women, midwives' naïve sketches, nominal group discussions, and the literature, have been summarized in the matrix below (see Table 7.1). The recommendations are reflected under the themes that arose during the analysis phase of the data from each method, that is, women, midwives, the health system, and the scoping review indicating the evidence relating to the theme or recommendation.

Table 7.1 Recommendations to Improve Respectful Maternity Care: Findings Matrix

The text in purple represents malleable factors.

The text in red represents non-malleable factors.

Theme	Subtheme	Recommendation	Women	Midwives	Literature
Women	**Expectations and preparation**	**Reduce negative preconceptions about midwives**	P4, P7, P8	M6, M9, M43, M73 NG2:5	Warren *et al* (2017)
		Midwives to empower women with knowledge about labour and how to prepare for labour versus allowing authoritative control. Women should take responsibility for their own health	P8, P12,	M1, M4, M9, M7, M27, M29, M71 NG2:4, NG1:5, NG3:2	Bohren *et al* (2016) Bradley *et al* (2016) George and Branchini (2017) Oosthuizen *et al* 2917 Ratcliffe *et al* (2016a) Sheferaw *et al* (2016) Wilson-Mitchell *et al* (2018) Reed *et al* (2017)
		Midwives to provide a positive presence, including giving women arriving in labour immediate attention.	P4, P7, P10, P30, P35, P38, P52, P73	NG1:4	Oosthuizen *et al* (2017) Sheferaw *et al* (2016) Reed *et al* (2017)
		Provide women with personal privacy	P4, P7, P8, P42	M6 NG1:6	
Midwives	**Actions**	**Provide a constant positive presence for women in labour**	P30, P35, P52, P73	NG1:4	Mukamurigo *et al* (2017) Oosthuizen *et al* (2017) Warren *et al* (2017) Reed *et al* (2017)
		Desist from verbal and physical abuse	P7, P9, P11, P12, P24, P26, P42, P46, P52, P65	NG3:4	Bohren *et al* (2016) Bradley *et al* (2016) Downe *et al* (2018) Mukamurigo *et al* (2017) Ratcliffe *et al* (2017) Oosthuizen *et al* (2017) Sheferaw *et al* (2016,2017) Warren *et al* (2017) Wilson-Mitchell *et al* (2018) Reed *et al* (2017)

Theme	Subtheme	Recommendation	Women	Midwives	Literature
		Desist from non-consensual care with no feedback	P4, P8, P9, P11, P30, P52	NG1:3	Downe *et al* (2018) Ndwiga *et al* (2017) Mukamurigo *et al* (2017) Oosthuizen *et al* (2017) Sheferaw *et al* (2016) Warren *et al* (2017) Reed *et al* (2017)
		Active listening to the women in labour	P7, P9, P31, P73	M11	Bradley *et al* (2016) Mukamurigo *et al* (2017) Reed *et al* (2017)
		Provide physical and psychological support	P12, P31, P32, P47, P73		Bradley *et al* (2016) Oosthuizen *et al* (2017) Ratcliffe *et al* (2016) Reed *et al* (2017)
		Improved communication with women in labour		NG3:4, NG3:5	Oosthuizen *et al* (2017) Ratcliffe *et al* (2017) Warren *et al* (2017) Reed *et al* (2017)
	Personal attributes	**Treat women with professionalism and respect**	P27, P28, P41, P42, P52	M18 NG1:1, NG1:2, NG1:4, NG2:5, NG3:1, NG3:2, NG3:6	Ndwiga *et al* (2017) Ratcliffe *et al* (2017) Reed *et al* (2017)
		Have good interpersonal relationships	P26, P27, P41	M12 NG1:3, NG1:4	George and Branchini (2017) Ndwiga *et al* (2017) Ratcliffe *et al* (2017) Warren *et al* (2016) Reed *et al* (2017)
		Show empathy and kindness	P4, P42, P49, P50		Mukamurigo *et al* (2017) Oosthuizen *et al* (2017) Sheferaw *et al* (2016) Reed *et al* (2017)
		Support staff who feel demoralised and demotivated		M6, M22, M19	George and Branchini (2017) Ndwiga *et al* (2017) Warren *et al* (2017)
Health Systems	**Resources**	**Provide adequate and appropriate space, sufficient beds, stock management**	P26, P32, P42, P51	M3, M6, M7, M35, M45 NG1, NG1:2, NG1:6, NG2:1, NG2:6, NG3:4, NG3:6	(Downe *et al* (2018) George and Branchini (2017) Oosthuizen *et al* (2017)

	(Non-malleable risk factors)				
Theme	**Subtheme**	**Recommendation**	**Women**	**Midwives**	**Literature**
		Provide human resources		M3, M7, M19, M20, M25, M32, M36, M42 NG 1:2, NG1:4, NG1:5, NG2:3, NG2:5, NG3:6	Ndwiga *et al* (2017) Ratcliffe *et al* (2016) Reed *et al* (2017)
		Provide translators/interpreters		M6, M7, M33, M45 NG1:3, NG1:5, NG2:3, NG2:5	
		Provide Quick response ambulance services for transfers to hospital		M4, M25, M27, M32, M45 NG1:3	
	Policies and institutional practices Malleable risk factors	**Develop a positive organisational culture** **Encourage supportive managers**		NG1:1, NG1:2, NG1:5, NG2 :3	Bradley *et al* (2016) Downe *et al* (2018) George and Branchini (2017) Ndwiga *et al* (2017) Oosthuizen *et al* (2017) Ratcliffe *et al* (2017) Warren *et al* (2017)
		Develop a positive policy and practice environment (put RMC policy in place, reduce fear of litigation, desist from staff rotation)		M7, M17, M18, M38, M25, M5 NG1:1; NG1:3, NG1:4,	Bradley *et al* (2016) Downe *et al* (2018) George and Branchini (2017) Ndwiga *et al* (2017) Ratcliffe (2016) Sheferaw *et al* (2017) Warren *et al* (2017) Reed *et al* (2017)
		Adopt an active institutional policy on permitting birth companions	P4, P7, P8, P9, P10, P11, P12, P26, P28, P30, P32, P35, P41, P48, P50, P51, P73	M11, NG1:1	Mukamurigo *et al* (2017) Oosthuizen *et al* (2017) Sheferaw *et al* (2016,2017)

		Provide debriefing serious adverse events BUT also work-related stressors /emotional wellbeing		M7 NG1:1, NG1:2, NG1:3, NG1:6, NG2:1, NG2:2,	Ndwiga *et al* (2017) Warren *et al* (2017) Wilson-Mitchell *et al* (2018)

The greatest contradiction can be identified between the women's and midwives' experiences of respectful maternity care in the facilities that were part of this study. The women in this study described their experiences of respectful maternity care in terms of the quality of interpersonal relationships with midwives and the personal attributes of the midwives. They did not report on the impact of the lack of consumables and poorly maintained facilities that were in disrepair. Their experience of respectful maternity care was entirely influenced by the nature of the relationship between the mother and the midwife, including positive and negative experiences with the midwives.

The majority of the midwives described their experiences of respectful maternity care (or lack of it) as being driven by the lack of resources and other forms of work-based stress. However, the findings from the midwives can also be categorized under both the midwives' interpersonal relationship with women and the midwifery team and work-based stress. The interpersonal skills of the midwives were raised by midwives themselves, either in the naïve sketches or nominal groups. These were mostly reported as observed negative behaviour amongst their fellow midwives. The midwives' perceptions of work-based stress relate to the findings that emerged under the theme 'health systems.' The emotional well-being of the health care provider is one of the greatest drivers of respectful maternity care (Ndwiga *et al*., 2017). The midwives linked their discussions regarding their emotional wellbeing with the facility-based challenges of providing RMC, which in turn relates findings under the theme of the health system.

7.3 Meta Inferences

Inferences are made from the interrelationship the researcher sees between people, events, and variables, and how the respondents' perceive these relate to each other in a logical and systematic way (Tashakkori and Teddie, 2003). Inferences in qualitative research are usually made through inductive reasoning – when a conclusion is derived from multiple observations (Miller, 2003). 'Good' inferences need to be plausible, provide a credible explanation, and there needs to be congruence between the evidence and explanation (Krathwohl, 2004).

Drawing a Meta inference is developing a conclusion based on research findings. The conclusion may be appropriate to specific settings, people, and context. For example, the conclusions to be drawn from this study relate to midwife obstetric units in Gauteng province.

Meta inferences are made by integrating strands of research in order to provide a more comprehensive understanding of the research problem, usually from the integration of findings

from mixed method/quantitative and qualitative data (Tashakkori, 2008). In this multi method qualitative study, inferences were made from the findings of each of the four data sets under the themes of women, midwives, health system, and literature, as shown in table 7.2 below under section 7.3.1.

7.3.1 Findings and Inferences Generated from the Data Sets and Under the Themes of Women, Midwives, and Health Systems

Table 7.2 Tabulation of Findings and Meta Inferences under the Themes of Women, Midwives, and Health Systems

Theme	Finding	Meta Inferences
Women	All the findings from the women relate exclusively to the relationship between a woman and the midwife.	A woman's perception of RMC in childbirth is derived from the relationship between mother and midwife. Humanizing midwifery care will improve a woman's childbirth experience.
Midwives	The findings from the midwives' naïve sketches and nominal groups relate to both the relationship between women and midwives as, well as to health system challenges.	There is value in improving midwives' interpersonal skills in order to apply RMC care to women in childbirth. The midwives need support in managing work-based stress.
Health systems	The findings draw attention to health system challenges that midwives in MOUs face in providing RMC in labour and birth.	Health system challenges impact on the midwives' ability to provide RMC in labour and birth, in the MOUs. Debriefing work-based stress is one way to support midwives working within these health system challenges. Health system challenges need to be addressed in order to provide quality of maternity care in MOUs.

The Meta inferences made from the study are humanizing maternity care including individualized labour support by a companion of choice; improving midwives' interpersonal skills through provider training, and debriefing midwives work-based stress arising from health system challenges will lead to the promotion of respectful maternity care by midwives during labour and birth. The Meta inferences will be used to guide the development of an intervention to nurture RMC in the MOUs.

7.4 Designing an Intervention

The ADDIE Model (see Chapter 2) was used to design an intervention to nurture respectful maternity care by midwives at the MOUs in the metro health district. Based on the collective findings of the study and the meta-inferences, the researcher decided to build the intervention around the communication problems that clearly exist, and not to include the resource issues as they were not malleable risks. Malleable risks are those aspects of an intervention that can be influenced, changed, or adjusted to meet a particular need (Fong and McCabe, 1999).

It is acknowledged that the health system's resource issues influence respectful maternity care to a considerable degree, but as resolving these problems would require multi-stakeholder involvement, changes in governance, budget scrutiny, and policy, the researcher felt that this was a non-malleable risk and would therefore not be addressed in this study.

Of all the findings, the one the researcher considered to be a malleable risk was that of addressing the interpersonal relationships between mothers and midwives, and between midwives and managers.

The alpha version of the intervention described below, was therefore developed and taken to the expert group who required an additional aspect to be added, which will be discussed in the next chapter under refining the intervention. Literature pertinent to this issue was accessed in order to build the intervention.

7.4.1 Strengthening the Interpersonal Relationships and Communication between Midwives and Mothers

In their study titled 'The Woman's Birth Experience –The Effect of Interpersonal Relationships and Continuity of Care' (2013), Dahlberg and Aune reiterated the importance of the quality of relationships between the midwife and the mother. They refer to women's experiences of "presence and emotional support" (Dahlberg, 2013) from the midwife, and state that women expressed the "feeling of interdependency" (Dahlberg, 2013) within their

relationship with the midwife, which led to a sense of personal growth and contributed to a positive birth experience.

Lewis, Jones, and Hunter (2017) wrote that the initial trust a woman has in a midwife originates from an expectation that the midwife is professionally competent. Trust is also influenced by the interpersonal relationship between mother and midwife, with a two-way trust that meant the midwife also trusted the mother.

Effective communication creates a more positive experience for the women in labour and birth. The midwives have a higher self-esteem and sense of professional status when women respond to their explanations and coaching. This, in turn, improves job satisfaction and reduces stress, especially in the challenging environment which the midwives work in, in the Gauteng MOUs.

The interpersonal communication skills that are important in healthcare are talking to people clearly so one is understood, recognising non-verbal cues (body language), creating an environment where the other person feels safe, the awareness of the impact of emotions, feelings, values and perceptions that influence communication, active listening and understanding what others say, understanding barriers to communication and, conflict resolution (GE Foundation, 2019).

In an interpersonal relationship there may well be barriers that affect effective communication between the midwife and a woman in labour and birth. Figure 7.1 summarizes the possible barriers to effective communication between the nurse (midwife) and patient.

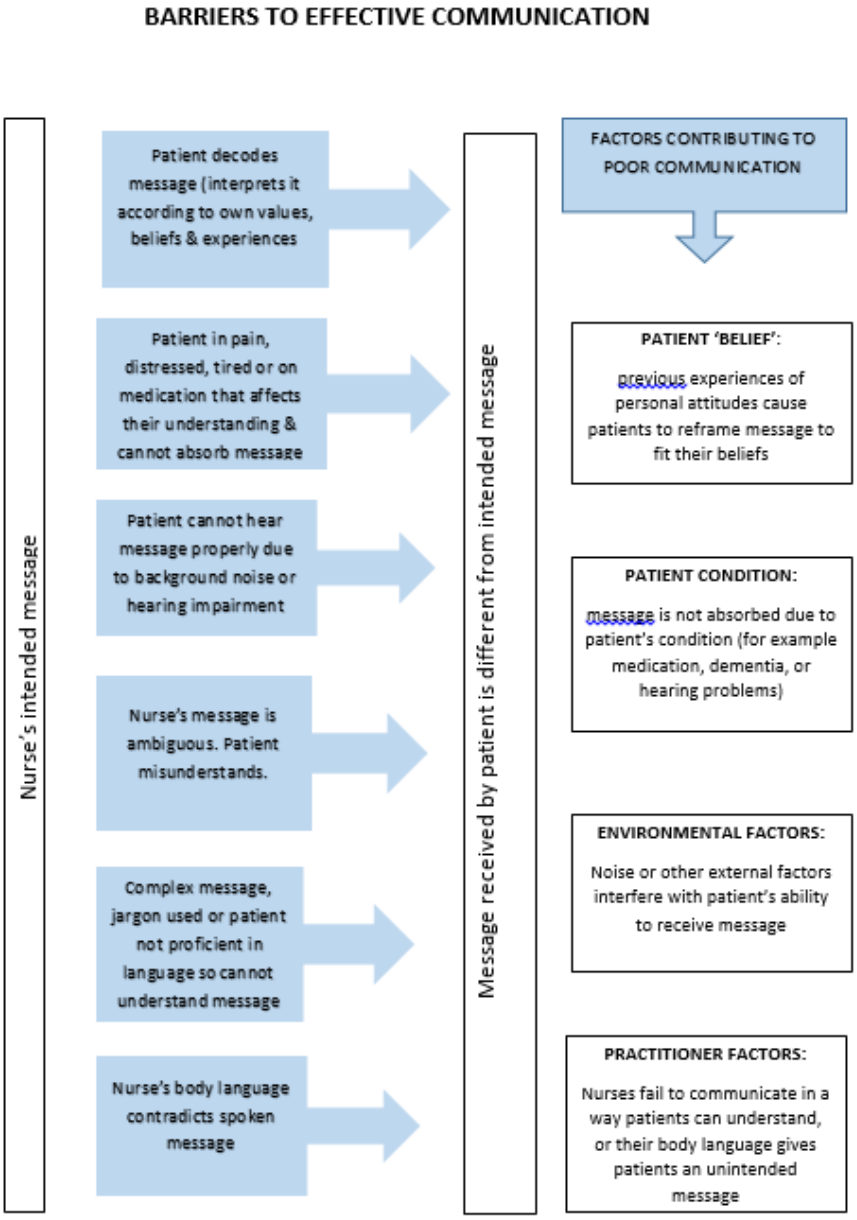


Figure 7.1. Possible Barriers to Effective Communication (Ali, 2017). Used with permission from EMAP Publishing.

Women feel demeaned and dehumanised when the midwife shouts or speaks harshly to them. Midwives may misinterpret the woman's lack of a positive response as the woman being 'unco-operative'. This, in turn, contributes to stress and poor job satisfaction for the midwife.

Ali (2017) lists ways a midwife could be more effective in communicating with the women they care for, which flow from her model shown above. These methods could also improve communication with managers and colleagues:

Do you:
Use appropriate language for your audience?
Listen actively and concentrate on what is being said?
Ask open questions to gain information?
Demonstrate you are listening?
Use appropriate body language?
Respond appropriately to other people's body language?
Check you have understood and have been understood?
Seek clarification where necessary?
Correct misunderstandings?
Reflect on your performance?

(Ali, 2017)

Numerous barriers to effective communication with patients have been identified: time constraints, lack of privacy, pain, anxiety, use of jargon (medical words) and insufficient plain language explanations regarding procedures such as an internal examination, both parties' values, beliefs and assumptions, appearance, language, non-verbal communication, disapproval or judgemental phrases, embarrassment with bodily functions and fluids, and the effects of the environment on both the midwives and patient (Ali, 2018). Ali further (2018) points out that active listening is important in building a therapeutic relationship. Active listening consists of several steps and is not always easy to implement in a labour ward situation. However, awareness that it involves listening skills, a listening attitude, and the provision of opportunities to have a conversation, will assist in encouraging active listening. Jahromi *et al* (2018) suggest there are subscales of active listening which include avoiding interruption, maintaining interest, postponing evaluation, organizing information, and showing interest. A midwife's lack of listening skills can lead to incorrect assumptions being drawn about a woman in labour and her birth needs. It is important for midwives to respond to the woman's cues.

Effective communication skills will help to defuse difficult situations. Resolving conflict is a very necessary skill for midwives to develop (Neades, 2013). Establishing a clear boundary when patients use abusive behaviour is also part of conflict management. Conflict resolution skills should assist the midwives in reducing their work-based stress.

7.4.2 Strengthening Interpersonal Relationships and Communication between Midwives and Managers

Chipeta, Bradley, Chimwaza-Manda and McAuliffe (2016) found that obstetric care staff in Malawi were dissatisfied with the interpersonal relationship between the staff and their managers. Staff felt that there was a lack of support from managers regarding staff welfare, performance, supervision, mentorship, lack of feedback, and exclusion, and evidenced by poor leadership. Improved nurse-manager relationships should lead to improved job satisfaction and improved motivation for the nurses

Findings from the midwives' naïve sketches and the nominal groups (numbers) showed that some midwives found the lack of support and action from their managers demotivating. Midwives also utilise their interpersonal skills to build a good working relationship with their managers, such as the shift leader, unit manager, facility manager, as well as the district health team. Positivity and mutual respect are a very important part of these relationships. In order to feel supported, midwives need to feel that the challenges that they discuss with their managers are heard, some action is taken, and that there is a cycle of feedback that takes place continually. This means that both the midwives and the managers utilise their interpersonal skills to create a meaningful two-way relationship. Essentially, this will assist in addressing the midwives' frustrations with lack of resources, notably functional equipment, the sustained supply of consumables and drugs, and maintenance of the work environment and facility.

7.4.3 Analysis

The ADDIE model requires an analysis to be carried out of the characteristics of the group and the needs of the learner. The latter is based on the previous stages of the research and as explained above, the researcher initially thought the needs centred on communication. With respect to the characteristics of the group, the following was established:

The intervention was designed for Registered Midwives who are professional (registered) nurses, working in the maternity facilities at the MOUs, in the metro health district. The

midwives' range in experience from a new midwifery graduate (1-3years) to medium term midwifery experience (4 – 15 years), and longer term midwifery experience (>16 years).

The participants' age range is from 22 years to 60 years.

In line with the constructivist approach, which was used in designing the intervention, it was designed as a participatory workshop.

All the participants are registered nurse midwives working in labour ward of an MOU. The intervention was designed to improve the midwives' interpersonal communication skills.

While the characteristics of the group and the needs of the learner are important to establish in order to write training material of any sort, the intention was to ask participants to communicate their expectations for the workshop and to allow sufficient flexibility in offering the intervention. Where and when the training was offered was a big consideration, as MOUs mostly schedule two midwives per shift, divided into teams: team 1 – on duty, team 2 off duty, team 3 and 4 on night duty. In order to make the workshop more accessible, it was planned so as to cluster MOUs into groups of threes – three MOUs closest together. The intervention would be run at one of the MOUs with midwives from the 2 other MOUs all participating.

7.4.4 The Planned Intervention Programme

Using all the information from the research findings and inferences, as well as the considerations discussed in the analysis above, and by integrating constructivist learning theory (Chaves, 2008), the researcher designed the RMC Interpersonal Communication Workshop (alpha version) entitled 'Listening to Mothers'.

The content of the workshop was broken up into manageable tasks, all participant-centred, and involves experiential learning using a range of learning techniques.

7.4.4.1 Creating the Intervention Programme

The key issue raised in the interviews with third day postpartum women was the quality of the interpersonal relations the woman experienced with the midwife(s). The most frequent form of D&A reported in this study was verbal abuse, being shouted at, and being insulted, which is linked to the midwives ignoring the woman's embodied knowledge (especially when the woman feels the baby is about to be born e.g. statements like "no it's too soon", "long time still", or "keep quiet" are made).

As a means to address the importance of the interpersonal relationship between mothers and midwives, and to address poor interpersonal communication skills, a workshop was designed called ‘Listening to Mothers’. The main objective of the programme was to sensitize midwives to ways in which to improve a midwife’s interpersonal skills, by focusing on values clarification, what mothers said in the interviews, a role play to highlight poor communication and meaningful communication between mothers and midwives, a quick in-the-moment stress relief technique, individual self-reflection on issues raised in the programme, a fishbowl exercise that pulls respectful inter personal communication together, and the wrap-up of activities. The table below is the alpha version of the programme with activities that were created to nurture respectful maternity care.

Table 7.3 RMC Interpersonal Communication Skills 'Listening to Mothers' Workshop Programme (Alpha Version)

RMC INTERPERSONAL COMMUNICATION SKILLS TRAINING: LISTENING TO MOTHERS

An intervention programme to nurture respectful maternity care by midwives in labour wards of the MOUs.

	ACTIVITY		RESOURCES	TIME
1	**Introduction**	Every participant states their name and where they work. Participants are asked to write down ways in which Respectful Maternity Care (RMC) could be nurtured in the MOU for the women in labour in the MOUs. Index card and pen are provided for recording their response. After 5 minutes, each person has a chance to contribute two ideas. Keep going until ideas pooled. Participant discussion takes place after all the ideas are pooled. These ideas are written on a flip chart page for referral. Researcher gives a short summary of the findings of the study. Discussion about group opinions and study findings. .	Summary provided / PPT of Poster of the Universal Rights of Childbearing Women	08h30 – 08h45
2	**Values Clarification**	Each participant examines their personal and professional values and how these impact on the relationship with the women they care for: ● Participant generates a list of personal values. ● They then match their personal values with a list of professional values.	Generate a 'list' of professional values	08h45 – 09h30

		• Group discussion on the exercise around the role values play in promoting RMC.		
3	**Communication skills Q-sort**	Using a Q-sort template and a standard set of communication skills cards, each participant assesses their own communication skills, and identifies skills that are important to them as an individual in their professional interactions with women in labour. ● Participants do the Q- sort. ● Feedback identifying common communication priorities between midwives and mothers.	Create a Q-sort template and cards in a set (multiplied by anticipated number of participants).	09h30 – 10h00
4		TEA		10h00 – 10h20
5	Interpersonal skills role play	A semi-scripted role play to mirror an interaction in maternity care with a range of interpersonal skills: ● A likely scenario is provided to the group with core roles identified. ● Participants act out the role play. ● Facilitator debriefs the actors regarding their role. ● Discussion and feedback.	Role play scenario and story props. **Pocket cards:** Barriers to effective communication, Tips for nonverbal communication, Unintentional messages. ACCA Communication: Tips to improve active listening + Sage and Thyme Model.	10h20 -11h45
6	3 Minute breathing space exercise	A breathing technique for disrupting negative thinking. A direct way of coping with the present experience.	Positive Psychology Programme.	11h45-12h00
7	Communication Self-Reflection	Reflection on lessons learnt: ● Reflection sheet for personal self-reflection.	GE Foundation self-reflection sheet.	12h00 – 12h10

8	Final Question	Do you think RMC interpersonal communication 'Listening to Mothers' will improve respectful maternity care in MOUs?	Fishbowl feedback.	12h10 – 12h30
9	Wrap up	Evaluate workshop – form provided. Write 2 affirmation cards on improving interpersonal communication with mothers. One affirmation card for communication with your professional colleagues to be displayed in the work environment.	Evaluation form. Cards and markers. Affirmation card sample.	12h30 – 13h00

Resources: Cards, marker pens, pen and paper, refreshments, flip chart, projector, laptop, AVG cable, Q-sort template, worksheets, sample of pocket cards, workshop materials. Reflection notebook.

To supplement the workshop activities, which were limited by time, a set of pocket cards with communication skills was developed, and will be given to all the participants who attend this workshop (Annexure 7.10). These cards are held together with a metal ring; the size fits the average nursing uniform pocket. By becoming familiar with the content of the cards, the midwives should be more aware of the value and process of interpersonal communication skills in their relationships with the women they care for.

The evaluation of the workshop by participants should provide insight into the ways in which this programme needs to be revised, as an ongoing development of the intervention.

7. 5. Conclusion

This chapter presented the findings from the four data sets, identifying the need for midwives to improve interpersonal communication skills and using the ADDIE model, described the development of an RMC interpersonal communication workshop named 'Listening to Mothers' (Alpha version).

The next chapter addresses confirming and refining the intervention programme components using an expert panel review and a Delphi technique to gain consensus and feedback from the midwives on the revised intervention programme.

CHAPTER EIGHT

CONFIRMING AND REFINING THE COMPONENTS OF THE INTERVENTION PROGRAMME

8.1 Introduction

In the last chapter the development of an intervention programme using the ADDIE Model was discussed. The alpha version of the intervention programme used the ADDIE model to design an RMC interpersonal communication skills workshop for midwives called 'Listening to Mothers'. This intervention programme was reviewed by an expert panel of midwives and a researcher. Expert panels synthesize knowledge, provide valuable discussion and make recommendations (Waltz *et al*., 2015). As explained in chapter two, purposive sampling was used to recruit the members of the expert panel - six midwifery experts and one midwife / researcher (refer to 2.9.1). The experts initially participated in a nominal group where the alpha version of the intervention programme was presented. An expert facilitator was used to moderate the process of the nominal group. This freed the researcher to listen to the discussion and answer any questions that arose. Notes were taken by the supervisor and the proceedings were recorded digitally.

After the expert group had reviewed the alpha version of the intervention programme, they asked for additional aspects to be added to the intervention programme, thus a Delphi panel process was done on the augmented intervention programme (referred to as the Beta version) – this time as an on-line exercise. The researcher provided evaluation criteria for reviewing the intervention programme (See Table 8.1).

8.2 An Expert Panel Review of the Alpha Version of the Intervention Programme: RMC Interpersonal Skills Training: Listening to Mothers

The alpha version of the RMC Interpersonal Communications Training intervention programme: Listening to Mothers, was reviewed by a panel of expert midwives for acceptability, appropriateness, and feasibility including constraints and challenges (See Table 8.1).

The format of the review was a nominal group led by an experienced facilitator. Experts were given cards on which they were asked to each write down ways in which Respectful Maternity Care (RMC) could be nurtured in MOUs in caring for women in labour. Each expert then shared with the group the ideas she had written on the card (this is the value of using a nominal

group vs a focus group. i.e. every person has a chance to speak and this decreases the dominant voices input, which often happens in a focus group). Following which, the discussion was open to all the experts.

The researcher gave a brief overview of the findings of the study after which she presented each aspect of the alpha version of the intervention programme which can be found as Table 7.3. A summary of each activity is given here, followed by the reaction and discussion by the group.

The alpha version of the intervention programme consisted of:

- An introduction
- A values clarifications exercise
- A ranking of various communication skills
- A role play of positive and negative communication
- A role play debriefing exercise
- Development of a personal plan for enhancing communication skills.

As explained in Chapter 2, a constructivist approach was chosen for the intervention programme and a participatory workshop was therefore developed. The following questions, listed in Table 8.1, were put to the experts who were asked to score each activity.

Table 8.1 Evaluation Questions given to the Expert Panel

	Review criteria
1	Will the intervention be *acceptable* to the midwives?
2	Is the intervention *feasible*?
3	Is the *length* of the workshop appropriate?
4.	What are the *practical constraints and challenges* to implementing the intervention?
5	What *monitoring and evaluation* is required in the short and long term to assess change in midwives' communication with the mothers?
6	Will the intervention foster RMC?
7	Will the intervention contribute to positive childbirth experiences amongst women whom the participating midwives care for?

(Baltussen and Niessen, 2006)

RMC Interpersonal Communication Skills Training: Listening to Mothers (Alpha Version of the Intervention Programme) (See Table 7.3 in the previous chapter for the format of this workshop)

8.2.1 Introduction

The **objective** of this activity is to provide quotes, both positive and negative, from the mother participants in the study that reflect on the communication skills and personal attributes of the midwives, and explain the purpose of the 'Listening to Mothers' (alpha version of the intervention programme) workshop.

Procedure: The quotes from the mothers were captured on PowerPoint and these slides were shown to the experts, followed by a brief overview of the programme.

Discussion: The experts accepted this introduction and made no further suggestions.

8.2.2 Activity One - A Values Clarification Exercise

The **objective** of this activity was to enable the midwife participants to examine their own personal and professional values and how these may enhance interpersonal relationships with the women they care for in labour (Dewing, 2014).

Procedure: The midwife participants were asked to write down a list of personal values, and then they were given a set of cards on which professional value statements are stated. The midwife participants were then asked to match these with their personal values. The midwife participants would then discuss their choices.

Discussion: The experts found this to be a difficult exercise and it generated a great deal of discussion based on the activity, even before they attempted to do it. The discussion centred on how to define a personal and a professional value. One suggestion was that midwife participants should be provided with a list with the explanation or definition of each of the professional values so that all participants interpreted the value in the same way.

Expert 6 suggested that the experts do the actual activity and then provide feedback. When asked what their experience of doing the exercise was, experts said it was quite complicated. The values identified might have different meaning to different midwife participants. The experts also found that the values were similar to one another. Expert 1 found that the list of values provided was restrictive. She said that a wider choice of values should be provided. It was also suggested that examples for each value be given to midwife participants before

starting to do the exercise. The experts recommended that this be an individual exercise versus a group exercise. They liked the concept because it related to professional values assessed in performance management done in the public sector. In the end, the group agreed it would be better for midwife participants to generate their own list of values. Expert 1 pointed out that it is the individual midwife who cares for the mother in labour, so her own list of values is of greater relevance to her.

8.2.3. Activity Two - A Communication Skills Q-sort

The **objective** for this activity was for each midwife participant to assess their own communication skills and identify skills that are important to them personally.

Procedure: The Q-sort template (16 squares) and 16 communication skills cards (Annexure 8.1) fitting the squares were provided. Midwife participants then sorted these skills in order of their individual priorities.

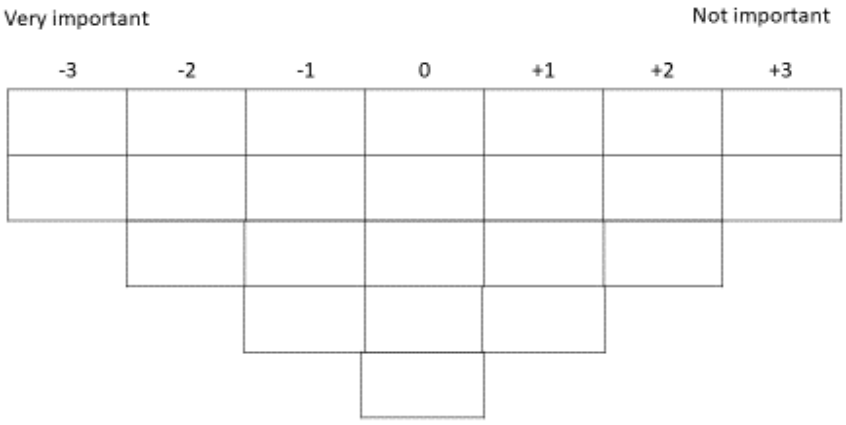


Figure 8.1 An example of a Q-sort template

In the Q-sort template used for this study, 23 squares were provided. Midwife participants were requested to prioritise the communication skill cards provided, from most important to least important. The most important would be placed in the top right-hand square, and the least in the top left-hand square.

Discussion: Using Q-sort allows for self-discovery and can be used to engage the midwives in sorting out preferences, analysing their thinking patterns, undertake comparative analysis with others, structure subjective interpersonal processes, and transform thinking into a concrete "map" (Shinebourne, 2011). Sorting the cards out and placing them on the grid shows the relationship between statements (Aitken, 1989). Q-sort can be used to characterize how people think about a particular issue in a systematic way (Webler *et al*., 2012).

The experts were comfortable completing the Q-sort communication skills exercise. They discussed the advantages of doing this exercise individually and/or in small groups. Clarification was given that the value of the exercise to the individual is in identifying the communication skills that are important to each midwife, rather than giving co-workers feedback on their communication styles. There was discussion about different issues relating to communication, with one expert expressing the opinion that if the midwife is not happy with the patient, it is better to say nothing. The experts needed clarification on whether this session could be used to correct colleagues who were not using positive communication skills. The researcher explained that discussion about negative communication traits in general could be part of the group's discussion, but the discussion should not focus on negative attributes at an individual level. Constructive silence and how this might be interpreted by the mother was raised in the discussion on this exercise. The experts found that this exercise was acceptable, appropriate and feasible.

Experts suggested that listening skills are a valuable part of communication skills. The researcher explained that, as part of the workshop material, each midwife would receive a set of pocket cards featuring different aspects of communication. These would serve as a reminder to midwives of the importance of using listening in communication with the women they care for.

Experts raised the issue of how culturally related requests were, or should be, received and responded to. They felt it is important that an explanation be given to the mother explaining the midwife's response to this request, especially if it cannot be accommodated.

The experts discussed the importance of non-verbal communication, especially when there is a language barrier between the midwife and woman in labour. There was concern raised as to how honestly this exercise would be done by individuals. In summary, this exercise gives midwife participants an opportunity to identify communication skills that are important to the

individual midwife, and to stimulate active thinking about the way or ways in which midwives communicate with women in labour.

Experts raised the issue, that in the clinical area, mothers make culturally specific requests that sometimes cannot be accommodated. The experts emphasized the importance of the midwife explaining why this could not be done rather than saying 'no'.

8.2.4 Activity Three - A Role Play

The **objective** for this activity was to simulate a likely interaction in a maternity facility and have the midwife participants act out a scenario leading to discussion and feedback on the value of the exercise.

Procedure: There were two parts to this exercise viz. the role play and the debriefing. The role play featured an issue which could be conflicting, particularly in a labour ward, between the midwife and the mother. A semi-scripted role play designed according to the principles suggested by Bambini in 'Writing a Simulation Scenario: A Step-by-Step Guide' (2016), with a scenario and identified roles were provided (See Annexure 8.3). The scenario featured an unbooked patient presenting in second stage at the MOU. During the role play negative and positive communication was depicted.

Discussion: The experts supported the value of a role play but questioned the need to script the role play. It was recommended that the people who are involved in the role play develop the role play using the scenario provided. This is more likely to reflect an experience the midwives have faced in the care of women in labour and allows the midwives' creativity. The experts advised against using the example of an unbooked patient as it results in immediate conflict between midwife and mother. They recognised the need for a scenario that simulates a role play, and mimics possible communication styles between the mother and the midwife. Expert six suggested that the workshop facilitators act out a negative role play and the participants act out a return role play, managing the same situation differently. Expert one suggested that the role players come up with some alternative endings. Expert six suggested videoing the role play for debriefing purposes. A concern was raised about getting the midwives to understand the implications of the role play. Expert six suggested that by making clear what the motivation of each character in the role play is, it will lead to a better understanding of the scenario being

enacted. The experts agreed that role play is a useful tool to identify gaps in communication and offers participants an opportunity to discuss solutions.

The **debriefing of the role play** dealt with discussion of the roles the midwife participants had played and facilitated a discussion on lessons learnt from the role play (Bambini, 2016). This is an essential step, and each midwife participant can give feedback on how their character in the role play felt in the scenario presented. Once the actors have been debriefed, comments from other workshop participants can be heard and this will contribute to the onlookers' perceptions of the experience.

8.2.5 Activity Four - A Breathing Technique to Disrupt Negative Thoughts

Objective: To disrupt the negative thoughts a midwife may have in a challenging moment with a woman during childbirth.

Procedure: The 'Three Minute Breathing Space' is a technique that helps shift the midwife's attention away from the negative thinking (e.g. frustration), focusing on her breath and being in the present moment (Robinson, Smith and Segal. 2019). The midwife sits or stands, straightening her spine, and takes a moment to acknowledge the negative thought. She then takes a deep breath and slowly lets the air out, mentally releasing the negative thought. She does this twice. The third breath is a refreshing breathe and with the outbreath she releases the tension in her jaw and core muscles. She then resumes the task she was busy with.

Discussion: The experts could see the value of the exercise but expressed concern as to whether the midwives would use the technique in their busy clinical practice.

8.2.6 Activity Five - A Personal Action Plan for Improving Communication Skills

Objective: to provide the midwife participants with a way to reflect on lessons learnt and set three goals arising from the workshop that the midwife participant would like to achieve in a personal time frame.

Procedure: The midwife participants are provided with a personal action plan template with three instructions to use for self-reflection (See Annexure 8.4). Time will be given for the midwife participants to do self-reflection using the personal action plan. The personal action plan has three questions which guide the self-reflection. A workshop evaluation will be given

to the midwife participants to complete at the end of the programme. The workshop will be brought to a close.

Discussion: The experts agreed that this exercise was appropriate.

8.2.7 Overall Evaluation by the Experts of the Alpha Version of the Intervention Programme

The greatest concern raised by the expert panel was that in order to understand the value of the 'Listening to Mothers' workshop, midwives need an opportunity to talk about why negative communication happens in the current work setting in the MOUs. Expert six said that the workshop in its original format may address communication skills, but there is a need to address why the staff were abusing patients. Expert four agreed that midwives need help with appropriate communication skills, but even if the contributing factors such as staff shortages cannot be fixed with this programme, stressful contributing factors to poor interpersonal communication cannot be ignored.

Expert five thought it might be useful to identify the midwives' work life stressors. These may help the midwife understand the way she behaves and the way(s) this may affect the outcomes for mother and baby. Expert two cautioned that as the experts were all operational managers, and therefore very focused on evaluating quality, they may be thinking very differently to the midwives for whom the workshop is targeted.

In the overall feedback several issues were raised. Expert four was concerned about the space and time the midwives would need to participate in this programme. If this workshop were to be at the MOU, then the midwives would be constantly interrupted and, thus, suggested that this workshop be offered away from the clinic and MOU. Expert two suggested managers and support staff attend the training too. Expert four disagreed and said this workshop needs to be focused on the midwives.

The experts were invited to write down their overall feedback on the cards provided. With regard to acceptability they said the 'Listening to Mothers' was an acceptable programme. With regard appropriateness, they said that with changes incorporated from the discussion on each activity, the 'Listening to Mothers' programme was appropriate and they thought it would help improve the midwives' communication skills. With regard to feasibility, they expressed their concerns about the proposed venue. They did not believe it could be offered at the MOUs, and

that staff challenges might mean only a couple of midwives from the MOU would attend at a time. The overriding concern, however, was the lack of an opportunity for midwives to debrief work-based stress.

The researcher suggested that in order to address this problem, a second part to the intervention programme – 'listening to midwives' – be added. This suggestion was met with enthusiasm by the experts.

Table 8.3 Expert Panel Survey: Part 1 Listening to Midwives

An intervention programme to nurture respectful maternity care by midwives in labour wards of the MOUs

		Expert number and response: Y= Yes; M=Maybe; N= No																			
		E1	E2	E3	E4	E5	E 6	E 1	E 2	E 3	E 4	E 5	E 6	E1	E2	E3	E4	E5	E6	%	
ACTIVITY	EXPLANATION	Acceptable						Appropriate						Feasible							COMMENTS
1	**Introduction:** Participants share their expectations about the workshop. • Graffiti sheet and Parking Lot.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	E2: Include scenarios of different situations E3: Does the title of the workshop make it's focus clear? If so, then I think both ideas are great
2	**Values Clarification:** enables each participant to think about personal and professional values and to examine the connection between these values. • Definitions. Worksheet. • Feedback from the group.	Y	Y	Y	Y	M	Y	Y	Y	Y	Y	Y	Y	M	Y	Y	M	M	Y	78%	E2: Very useful E3: Nice exercise. With assistance. Share in a pair, then move to four - a pair and a pair
3	**Work-life stressors:** provides participants with the opportunity to share their personal and professional **work-life stressors.** To discuss ways of coping with these stressors. • Modelling a peer support and debriefing circle. • Effective Events Theory: how work-life stressors affect the midwife's emotion and behaviour in providing RMC.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	M	M	Y	89%	E2: It promotes team spirit and collaboration E3: The initial facilitator is key to normalising this practice and making it appear so easy and effective that they would want to practice it at home.
4	**Caring for Midwives:** provides participants with the opportunity to discuss the nature of a supportive work environment. •Identifying what midwives realistically need in order to cope with work-related stress and to function effectively in the maternity facility, providing quality respectful care. • Joint letter to the facility manager.	M	Y	Y	Y	M	Y	Y	Y	Y	Y	Y	Y	Y	M	M	M	M	M	61%	E2: It's ideal, but in the busy unit, may not be Realistic E3: Requires buy in of unit manager E5: Staff establishment may limit role play
5	**3 Minute quick stress relief:** demonstrate 3 techniques that can be used to cope with stress in a particular moment: Movement and music, vocal toning, sense of smell.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	M	M	Y	Y	M	Y	83%	E3: Maybe share ideas that they know work for them plus new ideas

Table 8.3 continued… Expert Panel Survey: Part 1 Listening to Midwives

An intervention programme to nurture respectful maternity care by midwives in labour wards of the MOUs

		Expert number and response: Y=Yes; M=Maybe; N=No																			
		E 1	E 2	E3	E4	E5	E6	E1	E2	E3	E4	E5	E6	E1	E2	E3	E4	E5	E6	%	
ACTIVITY	**EXPLANATION**	**Acceptable**						**Appropriate**						**Feasible**							**COMMENTS**
6	**Review of research findings on respectful maternity care:** to provide an overview to mistreatment of women in childbirth. To provide an orientation of the purpose of Part 2: Listening to Mothers: Interpersonal Communication Skills Workshop. • Bohren et al typology of mistreatment • Findings from the current study on RMC (SA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	M	Y	94%	E3: Very powerful information. Evidence-based practice
7	**Wrap up:** • Quick review of expectations graffitti sheet • Acknowledgement of parking lot issues • Action Plan • Affirmations: 2 personal, 1 for colleagues	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	M	M	Y	89%	E3: How frequently will they revisit it?

Table 8.4 Expert Panel Survey: Part 2 Listening to Mothers

An intervention programme to nurture respectful maternity care by midwives in labour wards of the MOUs

		Expert number and response: Y= Yes; M=Maybe; N=No																			
		E1	E 2	E3	E 4	E5	E 6	E 1	E 2	E3	E 4	E 5	E 6	E1	E2	E3	E4	E5	E 6	%	
ACTIVITY	EXPLANATION	Acceptable						Appropriate						Feasible							COMMENTS
1	**Introduction:** To review some of the quotes from mothers in the current study, in order to highlight the need for inter-personal communication skills. Bridges part 1 to part 2.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100 %	E3: Valuable as it adds balance to the picture. Provides the mother's reality which the HCP may not have seen.
2	**Communication Skills Q Sort:** A sorting template and a number of communication skills are provided to each participant. • Each participant assesses their own communication skills and identifies skills that are important to them as an individual. • Feedback identifying common communication priorities between midwives and mothers.	M	Y	Y	Y	M	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	89%	E3: Sounds really useful. Communication is such a key part of therapeutic care. Understand request for general feedback rather than public but agree they should see their own results.
3	**Interpersonal Skills Role Play:** to mirror a likely interaction in maternity care: • A likely scenario is provided to the group with some core roles identified. • The group enacting the role play then develops the role play, adding their own details. • Participants act out the role play. • Facilitators debrief the actors regarding their roles. • Group discussion and feedback.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	M	Y	Y	Y	Y	94%	E2: Staff establishment may limit the role play as it needs more than 2 people E3: The importance/value from this hinges on the skill of the facilitator. But a good opportunity for expression of events and feelings. Provides for freedom for expression.
4	**3 Minute Breathing Space Exercise:** a breathing technique for disrupting negative thoughts. A direct way to cope with a current difficult experience.	Y	Y	M	Y	Y	Y	Y	Y	M	Y	Y	Y	M	Y	M	M	M	Y	67%	E3: Some people may not find this acceptable/ feasible.
5	**Self-reflection:** reflection on lessons learnt. • Reflection sheet for 5 minutes personal self-reflection	Y	Y	M	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	M	Y	Y	Y	Y	89%	E3: Is this guided reflection?

Table 8.4 continued… Expert Panel Survey: Part 2 Listening to Mothers

An intervention programme to nurture respectful maternity care by midwives in labour wards of the MOUs

		Expert number and response: Y= Yes; M=Maybe; N=No																			
		E 1	E 2	E 3	E 4	E 5	E 6	E 1	E 2	E 3	E 4	E 5	E 6	E 1	E 2	E 3	E4	E 5	E 6	%	
ACTIVITY	EXPLANATION	Acceptable						Appropriate						Feasible							COMMENTS
6	**Wrap Up:** • Workshop evaluation form • Affirmations: 2 personal affirmations and 1 affirmation for colleagues on improving interpersonal communication.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	M	Y	Y	94%	E3: So important but not apart of our nursing culture.

8.3 Refining the Alpha Version of the Intervention Programme: 'Listening to Mothers'

Based on the expert panels' evaluation of the alpha version of the intervention programme, 'Listening to Mothers,' the researcher made the following changes: the values clarification exercise was removed, revised, and placed in the Beta version of the programme in the new 'Listening to Midwives' workshop (Table 8.2). The interpersonal role play was modified, removing the semi scripted action sheet, and providing a broader scenario and a few story props. Annexure 8.5 presents the revised intervention programme (Beta version) which now presents 'Listening to Midwives' first and 'Listening to Mothers' second. The workshop is now titled 'The RMC Interpersonal Communication Skills Training Intervention Programme (Beta version).'

8.4 Developing the Beta Version of the RMC Interpersonal Communication Skills Intervention Programme

An entirely new and additional workshop was added to the alpha version and is explained below:

8.4.1 RMC Interpersonal Skills Training: Part One – 'Listening to Midwives' Intervention Programme (Beta Version)

Table 8.2 RMC Interpersonal Skills Training: Part One – Listening to Midwives Intervention Programme (Beta Version)

An intervention programme to nurture respectful maternity care by midwives in labour wards of the MOUs.

	ACTIVITY	**PURPOSE and Activity**	**RESOURCES**	**TIME**
1	Introduction	Participants share their expectations for the workshop. ● Display a graffiti sheet headed 'Expectations' and leave coloured markers next to it. ● Read over the expectations with participants. Clarify anything that's not clear and ask for comments. ● Create a sheet with 'Parking Lot' title. ● Write down participants' ideas which are significant but beyond the scope of the workshop. (Look at the Parking Lot list together with participants at the end of Part 1 workshop).	A Graffiti sheet – displayed so that participants can write their expectations on the sheet.	08h30 – 08h45
2	Values Clarification	To enable participants to examine their own values and how these may enhance or detract from the interpersonal relationships they have with women in their care. ● Define 'values' 'attitudes', 'beliefs' "values clarification. ● Participants generate their own list of personal and professional values using the values clarification worksheet. ● Following, lines are drawn connecting professional values to match personal values ● Feedback: ask for some examples	Values Clarification worksheet and definitions.	08h45 – 09h20
3		TEA AND SANDWICHES		09h20– 09h40

4	Work-life stressors	Provide participants with the opportunity to share their personal and professional work-life stressors and discuss ways of coping with these stressors Demonstrate a peer support and debriefing circle for coping with everyday work-life stressors. Participant-led approach: Personal stressors in the workplace. Professional stressors in the workplace. Each person gets 2 different coloured packs of sticky notes – they write one personal stressor in the workplace per pink sticky note and write one professional stressor per yellow sticky note. The facilitator groups similar stressors together on the wall or board to create a participlan. Review the collection, move around the sticky notes as may be needed to make sense of the emerging stressors. Explain the Affective Events Theory and how these stressors affect the participants' emotions and behaviour in providing RMC.	A standardized "Peer to Peer debriefing" group facilitation card which guides the person facilitating the exercise. Affective Events theory hand-out.	09h40 – 11h20
		COMFORT BREAK		
5	Caring for Midwives Coping with stress	Provides the participants with the opportunity to explore and discuss the nature of a supportive environment in a midwifery unit. Identifying what midwives need in order to cope with work related stress and to function effectively in maternity facilities, providing respectful quality of care. <u>Opening the dialogue and Driving Change</u> Write a letter to the facility manager regarding the midwives' need to function efficiently and effectively in the maternity services.	Record the midwives' needs on a flipchart or whiteboard. Template for letter to the facility manager.	11h40 12h20

		The participant takes this to her manager and the facility manager – putting a date and time in the following week to meet with midwives for feedback from facility managers		
6	3 Minute quick stress relief	A technique that uses the senses for coping with stress in a difficult moment. Three techniques involving the senses are demonstrated: using the vibrations of one's voice (humming), sense of taste which is meaningful for the individual, and movement and music for 60 seconds.	A track of popular music, choc squares to pass around.	12h20 – 12h30
7	Review of Respectful Maternity Care	Objective: To provide an orientation to the purpose of the RMC Interpersonal Skills programme. To leave a lasting message. Give a brief overview for Universal rights, disrespect and abuse – Bohren's Typology of mistreatment of women in childbirth. Include drivers of abuse and disrespect from the study.	Handout a copy the article with Bohren's typology. PPT (PowerPoint presentation).	12h30 – 12h45
	Wrap up	Review graffiti sheets 5 minute brainstorm on parking lot issues. Personal Action plan is used for self-reflection on lessons learnt. Participants write 3 affirmation cards on coping with work life stressors. Workshop closed.	Graffiti sheet. Parking Lot sheet Personal Action plan. Cards and pens for affirmation cards.	12h45 – 13h00

Resources: Cards, marker pens, pen and paper, refreshments, flip chart, projector, laptop, AVG cable, 10 set Q-sort templates and communication cards, worksheets, workshop materials, affirmation cards; Pocket cards.

8.4.2 Activity One: Introduction to the Workshop

The **objective** is to have participants share their expectations for Part 1: Listening to Midwives.

Procedure: The participants are asked to write their expectations on a graffiti sheet placed on a whiteboard or wall. As part of the introduction, read the participants' expectations and clarify anything remaining unclear. A second graffiti sheet is put up with the heading 'Parking Lot'. This is for recording important issues which may arise during the workshop but do not relate directly to the workshop (to be reviewed at the end of the workshop).

8.4.3 Activity Two: Revised Values Clarification Exercise

Activity two (Annexure 8.6) is a revised values clarification exercise.

The **objective** is to enable each participant to identify and examine their own personal and professional values.

Procedure: The participants are given a sheet with three columns. In the left-hand column, the participant generates a list of their own personal values and in the right-hand column, the participant generates a list of their own professional values. Following, in the middle column, the participant connects personal and appropriate professional values with a line.

If asked to assist by the participants, the facilitator will provide a list of professional values, such as accountability, competence, excellence, personal commitment, respect. The reason for this is that the experts thought some midwives might struggle with the concept of professional values.

This is conducted as an individual exercise versus a group exercise based on the experts' feedback that midwives may find this intimidating in a group. One of the experts suggested that after individuals have completed this exercise, they engage in a 'think, pair, and share' exercise, which will extend the learning, but make it more anonymous and therefore less intimidating. This will be suggested to participants. The midwives would first think about their own values clarification, by writing down their professional and personal values. The midwife participants would then pair up and share their values, and how each person's professional values cross over and link with their personal values – this is to eliminate feeling intimidated by feeding back to a bigger picture.

Amendments made to Alpha Version of the Workshop:

This activity was previously part of the 'Listening to Mothers' workshop. It has been moved into this new workshop and the matching system changed with a new template.

8.4.4 Activity Three: A Role Play

The **objective** for this activity was to simulate a likely interaction in a maternity facility and have participants act out a scenario leading to discussion and feedback on the value of the exercise.

Procedure: There were two parts to this exercise viz. the role play and the debriefing. The role play featured an issue which could be conflicting, in a labour ward, between the midwife and the mother. A scenario providing the setting and characters is provided for the role play designed according to the principles suggested by Bambini (2016) (see Table 8.2). The participants develop the 'scripting' for the role play and then act out the scenario. Positive and negative communication is part of the role play.

Amendments made to Alpha Version of the Workshop:

The role play debriefing deals with the discussion of the roles the participants had played and facilitated a discussion on lessons learnt from the role play (Bambini, 2016). This is an essential step, and each participant can give feedback on how their character in the role play felt in the scenario presented. Once the actors have been debriefed, comments from other workshop participants can be heard, and this will contribute to the participants' perceptions of the experience.

8.4.5 Activity Four: Debriefing Work Life Stressors

The **objective** is to give the participants the opportunity to share their professional work-life stressors and to discuss ways of coping with these stressors.

Procedure: This exercise is structured as a peer to peer debriefing circle, simulating how to use this technique in weekly peer debriefing sessions in the labour ward amongst the staff. The staff decide how long this session should be e.g. 30 minutes for sharing and 15 minutes for problem solving.

A standard peer to peer debriefing group facilitation card (Annexure 8.8) is used to guide the group's activity. Staff takes turns in facilitating using the facilitation guide. This task needs to

be rotated between the midwives in the labour unit, excluding the unit manager. The facilitation guide provides the facilitator a step by step plan.

Participants are given two different coloured packs of sticky notes e.g. on the pink sticky note the participant writes one personal stressor in the workplace, and on the yellow sticky note writes one professional stressor in the workplace. Each participant shares briefly on the two issues she has identified. The facilitator puts these up on a wall or board. Once everyone has shared, the facilitator, taking direction from the group, moves the sticky notes around to create a meaningful 'picture'. The group then participates in a discussion on how these stressors could be approached.

After this exercise, the workshop facilitator then shares Weiss and Cropanzano's (1996) Affective Events Theory (See Annexure 8.7). Their theory suggests that specific events in the workplace cause different emotions in people. If people experience negative feelings, the limbic system is triggered causing anger, fear, and jealousy. These, in turn, lead to negative behaviours such as verbal and physical abuse – "affect driven behaviour" (lashing out at mothers). If these negative feelings and thoughts are put into words and shared, it will lead to "normalising" these feelings, and the person is better able to cope with the situation or stressor. Positive feelings resulting from work experience can inspire you to do something you had not planned before. Alternatively, if you have a negative work experience, you may withdraw or be mean to a co-worker. These are examples of affect driven behaviour.

8.4.6 Activity Five: Caring for the Caregiver

The **objective** is to give the participants an opportunity to explore and discuss the nature of a supportive working environment in the labour unit.

Procedure: The facilitator encourages a discussion on what the midwives feel would create a more supportive, yet still realistic and possible, environment in the labour ward for the staff. Midwives are asked to identify what they require to cope with work-related stress and to function effectively in the labour ward and providing respectful quality maternity care.

At the end of the discussion, with the aim of improving communication with the facility manager, the participants are given a template letter to the facility manager, which they can use to record their needs. This assists the midwives in having a voice, recording their needs, and a way of communicating these needs as a group to their managers. It provides a way of following up with the facility manager in the future. The letter ends with a suggested time and date to

meet with the facility manager to receive feedback on these issues. Staff buy-in and comfort in sharing is important for the peer to peer debriefing to be of value.

8.4.7 Activity Six: A Sensory-based Stress Relief Exercise

The **objective** is to provide participants with a quick stress relief technique that can be done at any time during and after working hours, that reduces the fight or flight stress response.

Procedure: There are three stress relief exercises that participants can choose from.

Firstly, music and movement: dancing for 3 minutes using the participant's own play list on the participants' cell phone. Using earphones, the participant finds a quiet corner, and moves to the music being listened to for 3 minutes.

Secondly, using humming which reduces stress hormones like adrenaline and cortisol. The participant sits up straight and makes the *hmm* sounds. The participant can experiment with pitch and volume until they experience a pleasant vibration in their face and eventually in their stomach.

Lastly, taste: the participant savours a favourite treat, indulging in the sense of taste mindfully. A treat could be chewing gum for 3 minutes and then throwing it away, indulging in a small square of chocolate, slowly, steadily sipping a refreshing, calming drink, or eating a piece of fruit, consciously savouring texture and taste.

To use the senses to quickly relieve stress, the participant needs to identify the sensory experience that works for them as an individual. Participants are encouraged to practice their choice of stress release exercise so that it becomes second nature and easy to draw on in a difficult situation.

8.4.8 Activity Seven: A Review of Respectful Maternity Care

The **objective** is to provide a review of respectful maternity care, using Bohren *et al's* (2015) typology (Annexure 8.8) of the mistreatment of women in facility-based childbirth, and the drivers of disrespect and abuse from the current study. This is to provide a bridge between this workshop: Part 1 Listening to Midwives and Part 2: Listening to Mothers.

Procedure: Provide participants with the article on Bohren *et al's* (2015) typology, titled, 'The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review.'

8.4.9 Activity Eight: A Wrap-up Session.

The **objective** is to bring closure to the workshop.

Procedure: Review the graffiti sheet of expectations for the workshop. Move expectations which were not covered by the workshop activities to the 'Parking Lot'. Participants then brainstorm how the parking lot issues could be taken forward.

This is a short and concise wrap-up session. Participants are then given fifteen minutes to reflect on the questions on the personal action plan (Appendix 7.4), and to create three personal affirmations for coping with work-life stressors to take away with them (cards and pens provided).

8.5 Evaluation of the Revised Beta Version of the RMC Interpersonal Communication Skills Intervention Programme by the Expert Panel

The experts reviewed the beta version, which includes the amendments to the alpha version, during an on-line Delphi session (See Annexures 2.12 and 2.14). The activities were listed, and experts were asked to indicate whether each was acceptable, appropriate, and feasible. The questionnaires were sent out by email and received back either by email or collected from the place of employment by the researcher. Of the six experts who received the beta version, five (5) responded. Repeated attempts were made to ask the sixth expert to respond, which were unsuccessful.

8.5.1 Data Analysis

The Delphi was analysed by calculating the mean score the experts assigned to each of the activities for all three criteria i.e. acceptability, appropriateness, and feasibility. Annexure 8.10 and 8.11 reflect the scores for individual activities in the programme.

8.5.1.1 Expert Panel Survey: Part 1 'Listening to Midwives' (Intervention Programme Alpha Version)

The Delphi results (Annexure 8.9) showed that the experts rated activities as 94.3% acceptable, 100% appropriate, and 77.1% feasible. Expert 6 cautioned that in relation to the peer to peer debriefing, the buy-in of the Unit Manager would be needed. Expert 3 felt that the peer to peer caring for the midwives would promote team spirit and collaboration amongst staff.

Whilst the experts felt strongly that the activities were acceptable and appropriate, they still showed some reservation about the feasibility of carrying some of these activities through in busy MOUs.

8.5.1.2 Expert Panel Survey: Part 2 'Listening to Mothers' (Intervention Programme Beta version)

The Delphi results (Annexure 8.10) showed that the experts rated activities in the beta version of the intervention programme, as 90% acceptable, 96.7% appropriate, and 93.3% feasible. There was a concern from one expert that due to the limited staff establishment (too few midwives), the role play might be limited. Expert 5 was enthusiastic about the communication activity using a Q-sort method. She stated that "communication is such a key part of therapeutic care." The interpersonal skills required for role play was endorsed by expert 4 as "a good opportunity for the freedom of speech and the expression of feelings." There was a comment from expert 6 on creating affirmation cards – 2 personal and 1 affirmation for colleagues on improving interpersonal communication – "so important but just not a part of our nursing culture."

8.6 Conclusion

This chapter has discussed how the components of the intervention programme were confirmed and refined. As a result of this process and based on the recommendations of the experts, the final version of the RMC Interpersonal Communication Intervention Programme consists of two parts – 'Listening to Midwives' followed by 'Listening to Mothers'. The results reflect that the intervention programme's activities are both acceptable and appropriate. However, experts were concerned that there may be factors which will influence the feasibility of some of the activities in the programme when they are implemented in busy MOUs.

The next chapter concludes this thesis and will include limitations and recommendations for post-doctoral research and the improvement of respectful maternity care in midwifery practice.

CHAPTER 9

CONCLUSION

9.1 Introduction

This chapter addresses the main findings from the study and limitations of the study, as well as recommendations for future research, education, and the development and implementation of respectful maternity care in the clinical practice of midwifery.

Chapter one provided the background and introduction to respectful maternity care and the disrespect and abuse women may experience in childbirth. Chapter two focused on recording and discussing the methodology used in this multi-method, qualitative study. Chapters three, four, and five recorded and analysed the findings of the three data collection methods used – semi- structured interviews with women on their intrapartum experiences, naïve sketches written by midwives from the MOUs included in the study, and the nominal group discussions held with midwives at three MOUs. Chapter six presented a scoping review conducted using the JBI method and the discussion of the findings from this scoping review. Chapter seven detailed the development of an intervention programme aimed at nurturing RMC amongst midwives at the public MOUs in a district in Gauteng. Chapter eight addressed the confirmation and refinement of the program contents, using a modified nominal group of experts and a modified Delphi technique.

9.2 The Main Findings

The research question posed at the beginning of this study states "how can respectful maternity care be improved in the Midwives Obstetric Units (MOUs) in Gauteng?" Through addressing each of the 5 research objectives, the researcher established the midwives' notion of RMC, as well as the opportunities and constraints in the provision of RMC by the midwives in the MOUs participating in this study; determined the experiences of RMC in childbirth by interviewing women about their intrapartum experiences; reviewed the literature on RMC, and intervention programmes in sub-Saharan Africa through a scoping review, and designed an intervention programme to nurture RMC by midwives in the MOUs.

The three themes that emerged from the data collected were 'mothers', 'midwives', and 'health systems'. The mothers, interviewed on the third day postpartum, had fresh recall of their childbirth experiences. Not all of the women gave negative reports, however the women reported most on the poor quality of their interpersonal relationships and communication with

the midwives. They spoke of verbal abuse, particularly related to the midwives shouting or insulting them, being ignored when calling for a midwife, or being told to keep quiet. They also reported on the sense of being left alone during labour with the midwives ignoring them or disputing the women's contention that "*the baby is coming*".

The midwives reported on the significant and very stressful impact which the lack of resources had on their ability to provide quality, respectful maternity care. This includes a lack of consumables, medication stock out, broken equipment, and other health system challenges.

The midwives also reported the community's negative perception of the midwives and women's lack of knowledge about labour and birth. The midwives raised the stressful situation of having to care for unbooked women who had no antenatal care or records, did not speak a local language, and resided out of the district or were migrants from outside South Africa. The language barrier is very stressful for the midwives during the labour and birth. Having to counsel, test, and initiate treatment for unbooked women who tested HIV positive on admission, was very time consuming, but had to be done to try and protect the baby during labour and delivery.

The scoping review aimed at looking at the evidence of disrespect and abuse in sub-Saharan Africa, and reviewed interventions to improve RMC used in 22 African countries. The impact of disrespect and abuse has long term effects on women's perception of their childbirth experience. One article (Sacks, 2017) expanded the typology for the mistreatment of women in facility-based childbirth to include the healthy newborn. This reminded readers that mother and baby are a dyad, and care should be care of the dyad versus caring focused on the mother. It was clear from the scoping review that the care providers' emotional wellbeing is a strong driver of disrespect and abuse.

Multicomponent and inter-professional interventions contribute to impact the change from an environment of disrespect and abuse, to one of respectful maternity care. Intellectual partnership and participatory methods that involve the care providers in finding solutions also have a major impact in nurturing respectful maternity care.

Using the ADDIE model, the researcher developed an intervention titled 'The RMC Interpersonal Communication Intervention Programme: 'Listening to Mothers' (alpha version).' This intervention programme aims at improving the midwives' communication skills, including a stress reduction technique, to disperse negative thoughts and reduce disrespect and abuse in difficult moments between mothers and midwives. It is an interactive

and experiential intervention programme involving the participating midwives throughout the intervention programme.

The alpha version of the intervention programme was reviewed by a panel of expert midwives in a facilitated modified nominal group. This led to developing a Beta version of the intervention programme, in two parts, that is, Part 1: Listening to Midwives, and Part 2: Listening to Mothers (which included the changes suggested by the expert panel). The Beta version of the intervention programme was reviewed online by the expert panel using a modified Delphi technique. The Delphi results showed that Part 1: Listening to Midwives was rated as 94.3% acceptable, 100% appropriate, and 77.1% feasible. Midwives rated feasibility against the likelihood of the training being completed in busy MOUs. For Part 2: Listening to mothers, the Delphi results were 90% acceptable, 96.7% appropriate, and 93.3% feasible.

9.3 Limitations of the Study

9.3.1 Data Collection

The semi-structured interview guide used to interview the women on their intrapartum experiences may have been too directed. The questions could have been phrased in a more open-ended manner, although the researcher was concerned, at the outset, that the communicative language skills of the mothers may be limited, and therefore tried to simplify the interview guide. Prior to its use in the study, the semi-structured interview guide was pretested to check for content and face validity on three women who had recently delivered. It was important to ensure that the language was easily understood and did not include medical jargon.

Whilst the midwives enjoyed the opportunity to write freely when completing the naïve sketches, the instruction was interpreted in two ways – what RMC is (the theory of RMC) or the challenges to RMC from the midwives' professional perspective. In replicating this research, it would be advantageous to re-word the instruction, so that it is more clearly understood by all the participants.

Difficulties in setting up nominal groups with the midwives and running it following an existing meeting, placed a time constraint on the length of the nominal group, making it difficult to complete the final step, that is, voting. However, the information obtained from the nominal groups contributed to the body of knowledge collected during the study. If the study were to be replicated, the researcher recommends careful and sufficient time to gain the full

benefits of the nominal group technique, as well as an agreement with the expert panel to participate in the Delphi technique at least three (3) times.

The scoping review search could have been strengthened by using different combinations of words in the search strings and enlarging the search to include additional data bases (such as Cumulative Index of Nursing and Allied Health Literature (CINAHL), Scopus and Mendeley's Repository.

In Chapter eight, which relates to confirming and refining the components of the intervention programme, only one round of the modified Delphi was done with the expert panel. This was due largely to the difficulties of raising a response and to time constraints. Although the composite scores for both programmes were high for acceptability and appropriateness, the experts did have some concerns about the feasibility of running the training at busy MOUs, which all have staff shortages. It will be important to do a follow up round of the Delphi as a post-doctoral activity, to remedy this deficiency once the feasibility issues have been addressed.

The expert working group took place in the November, and the experts then moved in December / January – period of leave. Not all of the experts had equal access to the internet in the December / January period. The researcher took the Delphi voting to two of the experts at their place of employment. The fifth expert was on leave and could not be contacted.

9.3.2 Sample Size

While saturation was reached when collecting data with both the mothers and the midwives, the data collection was restricted to three MOUs. It is possible that midwives and mothers at the remaining MOUs may have had different views and challenges. It is also likely that MOUs outside the Gauteng province may have different challenges, but these were not included.

9.3.3 Lack of Previous Studies in the Research Area

By limiting the scoping review to sub-Saharan Africa, the researcher sought to understand the concept of RMC within the African context. There is still a paucity of publications that address RMC and the rights of childbearing women in the South African setting, as well as some other Southern African countries e.g. Angola, Zimbabwe, Botswana, and Mozambique. Collaboration in research with Universities in these countries could lead to an increased understanding and implementation of RMC within the Southern African setting.

9.3.4 Language Fluency

While the *lingua franca* of the country is English, not all participants spoke the language fluently and the researcher was unable to translate into local languages. Few were considered insufficiently fluent to be included in the study, and the interaction was terminated, but it is possible that these women, who may have provided different insights, were excluded in this process. The use of a multi-lingual research assistant was considered but decided against as this too may have influenced the results of the study. The scoping review was limited to articles published in English. This was not considered to be a serious limitation as most of the literature from sub-Saharan Africa is published in English.

9.3.5 The Delphi Technique

The Delphi technique was not a full delphi design and did not use multiple rounds to achieve consensus amongst the expert panel. The review technique for confirming components of the final version of the intervention programme could be strengthened in future research.

9.4 Recommendations

9.4.1 Recommendations for Research

The intervention developed in this study needs to be implemented, and it is recommended that a longitudinal study be done to track the changes with regard to RMC that follow the implementation of the intervention.

In order to develop the implementation of RMC more in-depth in South Africa, collaboration should occur with other researchers and stakeholders in the field of RMC.

Master's students could continue to do research into aspects of RMC, for example, implementing the birth companion of the mother's choice; continuing to interview women in the early postpartum about their childbirth experience; ways in which the MOU midwives could engage with the community around them; empowering women about labour and birth; and, empowering women in attaining their rights in facility-based childbirth. Research into these issues has the potential to influence and strengthen RMC within South Africa and Southern Africa.

The researcher will roll-out the intervention as post-doctoral work and will monitor and evaluate the impact of the intervention on mothers and midwives. Invitations have been

received from Pretoria and Rwanda to implement the intervention in those two sites and monitor the impact thereafter. A comparative study could therefore be conducted.

9.4.2 Recommendations for Education and Training

Nursing and midwifery students should be taught the theory of respectful maternity care in an integrative and practical manner, and evaluations conducted on their competence in this regard. This could be achieved by having the students do one comprehensive clinical assessment per year which includes testing the "soft" skills – communication skills, verbal and non-verbal messages. Women's responses could be integrated into the comprehensive clinical assessments. The long-term plan when rolling out the intervention programme would be for each MOU to receive a Women's Feedback Box, to be installed outside the door of the MOU. A three-point question slip would be given to each mother on discharge, which she could then fill in and post into the box anonymously. The researcher is proposing that on a set day of the week, the box would be unlocked and a small team reviews the feedback. The team must include a postbirth client in the review team (e.g. a mother, labour ward manager, and a labour ward midwife). Following the meeting and discussion, the labour ward midwife gives feedback on RMC at the unit's weekly meeting.

Mothers who have given birth could be invited to share their experiences of birth with students in order to create an awareness among students of the potential long term impact their care (or lack of it) could have on women.

All midwives in the MOUs should be given an opportunity to attend the RMC Interpersonal Communication Skills training and thus improve their communication and interpersonal relationships with women in labour and birth, leading to positive childbirth experiences.

9.4.3 Recommendations for Clinical Midwifery Practice

This study addressed the two most important malleable risks arising from the findings of the study – the interpersonal skills of the midwives, and the need for midwives to debrief and support each other through work-life stressors including the lack of resources. This study did not seek to influence specific changes in the health system (non-malleable risks), such as environmental changes and management of resources such as seen in other research studies in the sub-Saharan region, referring to the Heshima project in Kenya. There remains a need to implement specific changes within the health system and maternity facilities in South Africa, in order to provide quality, respectful maternity care.

The MOUs need to be encouraged and assisted to engage with the community around the maternity/CHC facility, and empower the community with information about pregnancy, labour, birth, and postnatal care of mothers and babies, as well as the rights of childbearing women and their families.

Implementing the peer to peer debriefing, as opposed to critical incident debriefing, should be encouraged to help midwives manage work-based stress in challenging environments.

9.5 Conclusion

Disrespect and abuse in childbirth is a global phenomenon, especially where women are devalued in society, including in South Africa. Respectful Maternity Care, which promotes dignity and positive childbirth experiences for women, is an essential component of quality midwifery care. The long-term value of a positive childbirth experience for both mother and baby has been well documented.

The research question for this study was, "How can the respectful maternity care be improved in the Midwives Obstetric Units (MOUs) in Gauteng?"

Some of the challenges midwives face in the delivery of RMC will be addressed through the use of the intervention programme designed in this study. This, if effective, will in turn, have a positive effect on the quality of respectful maternity care. The intervention programme was built from the various components of the study, which started with determining women's intrapartum experiences of respectful care received during labour and birth. This was done in order to understand their perspectives, after which midwives' notions of respectful maternity care were established, as well as the constraints and opportunities which they believe exist in terms of providing RMC. These latter steps of the research assisted the researcher to understand the context in which the midwives work, in order to develop an intervention programme that was workable. A scoping review was then carried out to establish what interventions had worked in other parts of sub-Saharan Africa to address the issue of RMC. Finally, an intervention programme was developed, based on the findings of the first steps of the research, which were then subject to expert review to contribute to developing and confirming the components of the intervention programme. It will be important to implement the intervention programme and then to establish whether the intervention programme does have an impact on the quality of RMC in the MOUs in Gauteng.

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ETHICS CLEARANCE CERTIFICATE

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M130803

NAME: (Principal Investigator)	Mrs Barbara A Hanrahan
DEPARTMENT:	Department of Nursing Education CM Johannesburg Academic Hospital
PROJECT TITLE:	An Intervention to Enhance Respectful Maternity in Care in Labour by Midwives in the Public Midwives Obstetrics Units in Gauteng
DATE CONSIDERED:	30/08/3013
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr Sue Armstrong
APPROVED BY:	Professor PE Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 02/10/2013

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.

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 resubmit the application to the Committee. **I agree to submit a yearly progress report.**

B. Hanrahan. 25/10/2013.

Principal Investigator Signature M130803Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

ANNEXURE 1.1

CHARTER: THE SEVEN UNIVERSAL RIGHTS OF CHILDBEARING WOMEN



Source: The White Ribbon Alliance for Safe Motherhood.

ANNEXURE 2.1

AN INTERVENTION PROGRAMMETO ENHANCE RESPECTFUL MATERNITY CARE BY MIDWIVES TOWARDS WOMEN IN MIDWIFE OBSTSETRIC UNITS IN A DISTRICT IN GAUTENG

SEMI STRUCTURED INTERVIEW GUIDE: WOMEN'S INTRAPARTUM EXPERIENCE

1. **Please tell me about your experience of respectful care and dignity during labour and birth.**

Probes: What aspects of care made you happy or unhappy?

What aspects of maternity care were you satisfied and dissatisfied with when you gave birth to your baby?

2. **Please tell me what you think the midwives can do to help women during labour and birth?**

Probes: What did the midwife do to care for you when you were in labour and giving birth?

Were you ill - treated any time in your maternity care?

How were you ill-treated?

How did this make you feel?

3. **Please tell me about the information you were given when you arrived at the maternity unit in labour?**

Probes: Were you told clearly what was happening during labour and birth?

Did the midwife tell you what she was doing during the labour and birth?

4. **Please tell me what you think about having a companion during labour and birth?**

Probes: What did the midwives tell you about bringing a birth partner with you?

How did your companion support and help you during your labour and birth?

5. **Please tell me whether you were provided with confidentiality, privacy and dignity during labour and birth.**

Probes: Were you screened off during labour and birth?

What did you wear during labour and birth?

What was used to cover you during labour and birth?

What did the midwives call you during labour?

Were you confident that the midwives would not share your info with other women?

6. **Please tell me if you felt you were discriminated at all during your maternity care**.

Probes: Were there any problems getting care at the clinic?

How quickly were you attended to on arrival in the MOU?

Did you feel that you received the same care as other women?

7. **Did you give the midwife permission for doing any procedures or making choices about your care during labour and birth?**

8. **Is there anything else you would like to tell me about the care you received in labour and birth?**

Thank you for your contribution to this research.

ANNEXURE 2.2

AN INTERVENTION TO ENHANCE RESPECTFUL MATERNITY CARE BY MIDWIVES TOWARDS WOMEN IN MIDWIFE OBSTSETRIC UNITS IN GAUTENG

INFORMATION SHEET FOR WOMEN REGARDING THEIR INTRAPARTUM EXPERIENCES

Good day, my name is Barbara Hanrahan. I am doing research towards a Doctorate Degree at the University of the Witwatersrand.

I am researching respectful maternity care. Part of the research will be engaging with midwives, and the other part of this research is to interview women about their experience of maternity care, after they have had their babies. I am interested in how both midwives and women perceive respectful care during labour and birth.

I would like to interview you please. The interview will be done using a guided interview schedule. Your responses to the questions will be audio recorded on a small hand-held tape recorder. The interview will then be transcribed into writing on my computer. The interview will take about 20 minutes. You may stop the interview and opt out of the study at any time. You will be asked questions in English by the researcher.

In order to interview you I need to ask you to sign two consent forms. One consent form gives your consent to be interviewed. The other consent form asks for your permission to record the interview and use quotes from your feedback anonymously in the research report. No names of individuals or maternity facilities will be used during the research and in the research report. You will not receive reimbursement for participating in the interview.

Your participation will not benefit you personally, but the intervention designed to enhance respectful maternity care, as a result of this research, may improve care for women in labour in the future. The purpose of this study is to develop an intervention to enhance respectful maternity care by midwives at midwife obstetric units in Gauteng.

If at any stage you wish to contact me, please sms or call me on 083 500 0062 or my work phone 011 488 4275. If you have questions about your rights as a study participant, or concerns about any aspect of this study, please call the Ethics Department of the University of the Witwatersrand on 011 717 1234.

Thank you

Barbara Hanrahan.

ANNEXURE 2.3

AN INTERVENTION TO ENHANCE RESPECTFUL MATERNITY CARE BY MIDWIVES TOWARDS WOMEN IN MIDWIFE OBSTSETRIC UNITS IN GAUTENG

INFORMED CONSENT TO BE INTERVIEWED USING AN AUDIOTAPE--RECORDER

The research concept and the approach to conducting the interview have been explained by the researcher to me. She has used language and terms that I understand.

I have received, read and understand the written information sheet regarding the study.

I understand that this interview will be guided by the researcher, but that I am also free to raise aspects of maternity care that are from my experience of the labour and birth of my baby. The interview will be recorded using a hand-held voice recorder.

I acknowledge that my participation in this research is voluntary. I am aware that there is no reimbursement for participating in this study.

The researcher has explained that I can opt out of the interview at any time.

I accept that my participation will be confidential, and no names will be used when the research is published. I consent to the use of quotes using my words used anonymously in the research report.

I hereby give my consent to participate in a guided, recorded interview.

Participant's full name: _____

Place: _____

Date: _____

Field worker/researcher: _____

ANNEXURE 2.4

AN INTERVENTION TO ENHANCE RESPECTFUL MATERNITY CARE BY MIDWIVES TOWARDS WOMEN IN MIDWIFE OBSTSETRIC UNITS IN GAUTENG

INFORMATION SHEET FOR MIDWIVES

Good day, my name is Barbara Hanrahan. I am doing this research at the University of the Witwatersrand for a doctorate degree.

I am researching respectful maternity care. Part of the research will be engaging midwives, through the use of naïve sketches and nominal group technique. The other part of this research will be to interview women after they have had their babies. I am interested in both, the midwives and women's perception of respectful care during labour and birth.

This study will be done at the ten (10) midwives' obstetric units in the Johannesburg Metro Health District. All the midwives at the midwives' obstetric unit will be invited to participate in this research on respectful maternity care.

Midwives will be approached to write a naïve sketch (free style writing) of their experience of respectful maternity care. This means that the midwife will be asked to write on her experience, as a midwife, of respectful care in labour and birth. There is no set structure guiding the writer. The midwife will be asked to write freely. It is anticipated that the naïve sketch will take twenty minutes to write.

Midwives will also be invited to participate in a nominal group exploring the constraints and opportunities for respectful care of labouring women. The researcher will start the discussion with a trigger statement. A field worker will take written notes of the interaction and discussion. The group will be audio recorded. And this will then be transcribed verbatim and analysed. The nominal group discussion will take an hour at each of the maternity units.

Midwives will be asked to sign consent indicating their willingness to participate in writing a naïve sketch of their own experience of respectful maternity care.

Midwives will be asked to sign consent indicating their willingness to be in the nominal group examining the constraints and opportunities midwives have for providing respectful maternity care. This consent will also ask for the midwife's permission to have the discussion voice recorded

The participant's names and the name of the midwives' obstetric units will be kept in the strictest confidence. No names will be used when the research results are published.

No reimbursement will be given to the participant.

Participants have the right to opt out at any stage of this study.

If at any stage you wish to contact me, please sms or call me on 083 500 0062 or at work 011 488 4275. Should you have any questions about your rights as a study participant or any concerns about this study, please call the Ethics Department of the University of the Witwatersrand 011 717 1234.

Thank you.

Barbara Hanrahan.

ANNEXURE 2. 5

AN INTERVENTION TO ENHANCE RESPECTFUL MATERNITY CARE BY MIDWIVES TOWARDS WOMEN IN MIDWIFE OBSTSETRIC UNITS IN GAUTENG

MIDWIVES CONSENT TO WRITING ON THEIR EXPERIENCE OF RESPECTFUL MATERNITY CARE

The research concept and the explanation of the value of naïve sketches written by each midwife in contributing significantly to this research has been explained by the researcher to me.

I acknowledge that my participation in this research is voluntary. I am aware that there is no reimbursement for participating in this study.

The researcher has explained that I can opt out of writing the naïve sketch at any time.

I accept that my participation will be confidential, and no names will be used when the research is published.

I hereby give my consent to participate in this study by writing a naïve sketch on my experience, as a midwife, with respectful maternity care. And that quotes using my words may be used anonymously in the research report.

Participant's full name : _____

Place : _____

Date : _____

Researcher : _____

ANNEXURE 2.6

NAIVE SKETCH INSTRUCTION: MIDWIVES WRITE FREELY ON THEIR EXPERIENCE OF RESPECTFUL MATERNITY CARE

Instruction:

Please write down your experience of respectful maternity care. The form of writing is unstructured and free style. Write as your thoughts flow.

ANNEXURE 2. 7

AN INTERVENTION TO ENHANCE RESPECTFUL MATERNITY CARE BY MIDWIVES TOWARDS WOMEN IN MIDWIFE OBSTSETRIC UNITS IN GAUTENG

MIDWIFE'S CONSENT TO PARTICIPATE IN A NOMINAL GROUP AND FOR THIS DISCUSSION TO BE AUDIOTAPED.

The research concept and the nominal group technique have been explained to me by the researcher.

I acknowledge that my participation in this research is voluntary. I am aware that there is no reimbursement for participating in this study.

The researcher has explained that I can opt out of the nominal group at any time.

I accept that my participation will be confidential, and no names will be used when the research is published.

I hereby give my consent to participate in a nominal group exploring the constraints and opportunities for respectful maternity care. I also consent to having this discussion audiotaped.

Participant's full name : _____

Place : _____

Date : _____

Researcher : _____

ANNEXURE 2.8

THE NOMINAL GROUP DISCUSSION WITH MIDWIVES

The discussion will be started by researcher asking midwives to describe respectful and disrespectful maternity care.

In the nominal group technique, every participant has the opportunity to be heard.

The midwives are asked to discuss the opportunities and constraints midwives have in providing respectful maternity care.

Then the midwives are asked to develop a consensus agreement on what respectful maternity care should be and if it is possible in clinical practice.

ANNEXURE 2.9

An intervention to enhance respectful maternity care by midwives in labour ward of Midwives Obstetric Units

Name of researcher: **Barbara Hanrahan: 8285063 PhD Candidate**

Supervisor: Dr Sue Armstrong: Department of Nursing Education, Witwatersrand University

PARTICIPANT's INFORMATION

You have been invited to participate in an **Expert Panel Review of an Intervention to Promote Respectful Maternity Care: RMC Interpersonal Communication Skills workshop for midwives.**

A panel of subject experts have been invited to review the intervention which was developed to address the relationship between the mothers and the midwives during labour and birth, with the aim of nurturing respectful maternity care.

A modified focus group will be used to conduct the review.

The panel of experts will review the intervention for context suitability, feasibility, addressing challenges in implementation, and acceptability by midwives in midwives' obstetric units.

The review will be audio recorded, transcribed and analysed.

The review will be facilitated by an expert who has successfully moderated groups of this nature in the past.

The panel of experts will be given a set of evaluation criteria at the beginning of the focus group.

The researcher will provide an objective and explanation of each activity in the intervention. Then the expert panel will discuss the value of the activity and make comments and suggestions.

A consent form for participation and the audio recording of the review is attached.

Should you have any concerns during the Expert Panel Review, please let the moderator know so that the researcher can address your concern/s.

A participant may withdraw for this research activity at any time.

Participants' names, position and employer will remain anonymous after the review has been completed, including in the researcher's dissertation and post study activities which arise from this study.

Thank you, Barbara Hanrahan 083 500 0062, barbara.hanrahan@wits.ac.za

…… (signature)

…… (name of participant)

…… (date)

ANNEXURE 2.10

An intervention to enhance respectful maternity care by midwives in labour ward of Midwives Obstetric Units

Name of researcher: **Barbara Hanrahan: 8285063**

Supervisor: Dr Sue Armstrong: Department of Nursing Education,

Witwatersrand University

CONSENT FORM

I …….. agree to participate in this research project: **Expert Panel Review of an intervention to promote respectful maternity care.**

The research has been explained to me and I understand what my participation will involve.

I agree that my participation will remain anonymous YES NO (please circle)

I agree that the researcher may use anonymous quotes in her research report
YES NO

I agree that the interview may be audio recorded YES NO

I agree that the researcher may take photos of me for use in her dissertation, but not in any media or publication YES NO

…… (signature)

…… (name of participant)

…… (date)

……. (Researcher)

ANNEXURE 2.11

Table 7.3 RMC interpersonal communication skills "Listening to Mothers"

RMC INTERPERSONAL COMMUNICATION SKILLS TRAINING: LISTENING TO MOTHERS

An intervention to enhance respectful maternity care by midwives in labour wards of the MOUs.

	ACTIVITY		RESOURCES	TIME
1	**Introduction**	Every participant states their name and where they work. Participants are asked to write down ways in which Respectful Maternity Care (RMC) could be nurtured in the MOU for the women in labour in the MOUs. Index card and pen are provided for recording their response. After 5 minutes, each person has a chance to contribute two ideas. Keep going until ideas pooled. Participant discussion takes place after all the ideas are pooled. These ideas are written on a flip chart page for referral. Researcher gives a short summary of the findings of the study. Discussion about group opinions and study findings. .	Summary provided / PPT of Poster of the Universal Rights of Childbearing Women	08h30 – 08h45
2	Values Clarification	Each participant examines their personal and professional values and how these impact on the relationship with the women they care for: ● Participant generates a list of personal values. ● They then match their personal values with a	Generate a 'list' of professional values	08h45 – 09h30

		list of professional values. • Group discussion on the exercise around the role values play in promoting RMC.		
2	Communication skills Q sort	Using a Q-sort template and a standard set of communication skills cards, each participant assesses their own communication skills and identifies skills that are important to them as an individual in their professional interactions with women in labour. • Participants do the Q Sort. • Feedback identifying common communication priorities between midwives and mothers.	Create a Q Sort template and cards in a set (multiplied by anticipated number of participants.)	09h30 – 10h00
3		TEA		10h00 – 10h20
4	Interpersonal skills role play	A semi-scripted role play to mirror an interaction in maternity care with a range of interpersonal skills: • A likely scenario is provided to the group with core roles identified. • Participants act out the role play. • Facilitator debriefs the actors regarding their role. • Discussion and feedback.	Role play scenario and story props. **Pocket cards:** Barriers to effective communication, Tips nonverbal communication, Unintentional messages ACCA Communication: Tips to improve active listening + Sage and Thyme Model.	10h20 - 11h45
5	3 Minute breathing space exercise	A breathing technique for disrupting negative thinking. A direct way of coping with the present experience.	Positive Psychology Programme	11h45-12h00

8	Communication Self-Reflection	Reflection on lessons learnt: ● Reflection sheet for personal self-reflection.	GE Foundation self-reflection sheet.	12h00 – 12h10
9	Final Question	Do you think RMC interpersonal communication 'Listening to Mothers' will improve respectful maternity care in MOUs?	Fishbowl feedback.	12h10 – 12h30
10	Wrap up	Evaluate workshop – form provided. Write 2 affirmation cards on improving interpersonal communication with mothers. One affirmation card for communication with your professional colleagues to be displayed in the work environment.	Evaluation form Cards and markers Affirmation card sample.	12h30 – 13h00

Resources: Cards, marker pens, pen and paper, refreshments, flip chart, projector, laptop, AVG cable, Q sort template, worksheets, sample of pocket cards, workshop materials. Reflection notebook.

ANNEXURE 2.12

EXPERT PANEL SURVEY: PART 2: LISTENING TO MOTHERS (Beta Version)

An intervention to enhance respectful maternity care by midwives in labour wards of the MOUs

The development of a workshop to address the midwives' needs was strongly recommended by the panel after the Interpersonal Communication Skills workshop was appraised. To this end a new part (workshop) called **Part 1**: **Listening to Midwives** has been designed.

A brief video explains:

1. The **changes made to Part 2: Listening to Mothers**.
2. The video then goes on to explain the workshop: **Part 1: Listening to Midwives.**
   The experts will have copies of the workshop programme to refer to.

The panel are asked to complete the **Survey (survey for each workshops is provided)** attached and return it to: Barbara.hanrahan@wits.ac.za by **6 December** please.

Please answer **Y** = Yes, **N** = No, **M** = Maybe. If you answer NO or Maybe, please comment to assist the revision of the activity.

Acceptability is the perception among implementation stakeholders that the programme is agreeable or satisfactory.

Appropriateness is the relevance and suitability of the programme to address the issue or problem. (Providing respectful quality maternity care)

Feasibility is the extent to which the programme can be used successfully to address the issue or problem.

(Weiner, Lewis, Stanick, *et al* 2017)

Expert Panel Survey: Part 2: Listening to Mothers

An intervention to enhance respectful maternity care by midwives in labour wards of the MOUs

ACTIVITY	EXPLANATION	Acceptable	Appropriate	Feasible	COMMENTS
1	**Introduction**: To review some of the quotes from mothers in the current study, in order to highlight the need for interpersonal communication skills. Bridges Part 1 to Part 2.				
2.	**Communication skills Q Sort**: A sorting template and a number of communication skills are provided to each participant. ● Each participant assesses their own communication skills and identifies skills that are important to them as an individual. ● Feedback identifying common communication priorities between midwives and mothers.	.			
3.	**Interpersonal skills role play:** to mirror a likely interaction in maternity care: ● A likely scenario is provided to the group with some core roles identified. ● The group enacting the role play then develops the role play, adding their own details ● Participants act out role play ● Facilitators debriefing the actors regarding their roles				

	● Group discussion and feedback.				
4.	**3 Minute breathing space exercise:** a breathing technique for disrupting negative thoughts. A direct way to cope with a current difficult experience.				
5	**Self-reflection:** reflection on lessons learnt, ● Reflection sheet for 5 minutes personal self-reflection.				
6	**Wrap up**: ● Workshop evaluation form ● Affirmations: 2 personal affirmations and 1 affirmation for colleagues on improving interpersonal communication.				

Additional Comments:

Thank you for your time and input.

ANNEXURE 2.13

RMC Interpersonal Skills Training: Part One – Listening to Midwives (Beta version)

An intervention to enhance respectful maternity care by midwives in labour wards of the MOUs

	ACTIVITY	PURPOSE and Activity	RESOURCES	TIME
1	Introduction	Participants share their expectations for the workshop. ● Display a graffiti sheet headed 'Expectations' and leave coloured markers next to it. ● Read over the expectations with participants. Clarify anything that's not clear and ask for comments. ● Create a sheet with 'Parking Lot' title: for Write down participants' ideas which are significant but beyond the scope of the workshop. (Look at the Parking Lot list together with participants at the end of Part 1 workshop).	A Graffiti sheet– displayed so that participants can write their expectations on the sheet.	8.30 – 08.45
2	Values Clarification	To enable participants to examine their own values and how these may enhance or detract in the interpersonal relationships they have with women in their care. ● Define 'values' 'attitudes', 'Beliefs' "values clarification. ● Participants generate their own list of personal and professional values using the values clarification worksheet. ● Following, lines are drawn connecting	Values Clarification worksheet and definitions.	08H45 – 09h20

		professional values to match personal values ● Feedback: ask for some examples		
		TEA AND SANDWICHES		09h20–09h40
3	Work life stressors	Provide participants with the opportunity to share their personal and professional work-life stressors and discuss ways of coping with these stressors Demonstrate a peer support and debriefing circle for coping with everyday work-life stressors. Participant-led approach: Personal stressors in the workplace. Professional stressors in the workplace. Each person gets 2 different coloured packs of sticky notes – they write one personal stressor in the workplace per pink sticky note and write one professional stressor per yellow sticky note. The facilitator groups similar stressors together on the wall or board to create a participlan. Review the collection, move around the sticky note as may be needed to make sense of the emerging stressors. Explain the Affective Events Theory and how these stressors affect the participants' emotions and behaviour in providing RMC.	A standardized "Peer to Peer debriefing" group facilitation card which guides the person facilitating the exercise. Affective Events theory hand-out.	09h40 – 11h20
		COMFORT BREAK		
	Caring for Midwives Coping with stress	Provides the participants with the opportunity to explore and discuss the nature of a supportive environment in a midwifery unit.	Record the midwives needs on a flipchart or whiteboard.	11h40 12h20

		Identifying what midwives need in order to cope with work related stress and to function effectively in maternity facilities, providing respectful quality of care. <u>Opening the dialogue and Driving Change</u> Write a letter to the facility manager regarding the midwives need to function efficiently and effectively in the maternity services. The participant takes this to her manager and the facility manager – putting a date and time in the following week to meet with midwives for feedback from facility managers	Template for letter to the facility manager.	
	3 Minute quick stress relief	A technique that uses the senses for coping with stress in a difficult moment. Three techniques involving the senses are demonstrated: using the vibrations of one's voice (humming), sense of taste which is meaningful for the individual, and movement and music for 60 seconds.	A track of popular music, choc squares to pass around.	12h20 – 12h30
	Review of Respectful maternity Care	Objective: To provide an orientation to the purpose of the RMC Interpersonal Skills programme. To leave a lasting message. Give a brief overview for Universal rights, disrespect and abuse – Bohren's Typology of mistreatment of women in childbirth. Include drivers of abuse and disrespect from the study.	Handout a copy the article with Bohren's typology PPT (PowerPoint presentation)	12h30 – 12h45
	Wrap up	Review graffiti sheets 5 minute brainstorm on parking lot issues. Personal Action plan is used for self-reflection on lessons learnt.	Graffiti sheet Parking Lot sheet Personal Action plan	12h45 – 13h00

		Participants write 3 affirmation cards on coping with work life stressors. Workshop closed.	Cards and pens for affirmation cards.	

Resources: Cards, marker pens, pen and paper, refreshments, flip chart, projector, laptop, AVG cable, Q sort template, worksheets, sample of pocket cards, workshop materials. Reflection notebook.

ANNEXURE 2.14

EXPERT PANEL SURVEY: PART 1: LISTENING TO MIDWIVES (beta version)

An intervention to enhance respectful maternity care by midwives in labour wards of the MOUs.

The development of a workshop to address the midwives' needs was strongly recommended by the panel after the Interpersonal Communication Skills workshop was appraised. To this end a new part (workshop) called **Part 1**: **Listening to Midwives** has been designed.

A brief video explains:

1. The changes made to Part 2: Listening to Mothers
2. The video goes on to explain the workshop: Listening to Midwives.
   The experts will have copies of the workshop programme to refer to.

The panel are asked to complete the **Survey** attached (Survey for each workshop is provided) and return it to: Barbara.hanrahan@wits.ac.za by **6 December** please.

Please answer **Y** = Yes, **N** = No, **M** = Maybe. If you answer NO or Maybe, please comment to assist the revision of the activity.

Acceptability is the perception among implementation stakeholders that the programme is agreeable or satisfactory.

Appropriateness is the relevance and suitability of the programme to address the issue or problem. (Providing respectful quality maternity care)

Feasibility is the extent to which the programme can be used successfully to address the issue or problem.

(Weiner, Lewis, Stanick, *et al* 2017)

Expert Panel Survey: Part 1 Listening to Midwives

An intervention to enhance respectful maternity care by midwives in labour wards of the MOUs.

ACTIVITY	EXPLANATION	Acceptable	Appropriate	Feasible	COMMENTS
1	**Introduction**: Participants share their expectations about the workshop. ● Graffiti sheet and Parking Lot				
2.	**Values Clarification:** enables each participant to think about personal and professional values and to examine the connection between these values. ● Definitions. Work sheet. ● Feedback from the group.				
3.	**Work life stressors;** provides participants with the opportunity to share their personal and professional **worklife stressors.** To discuss ways of coping with these stressors. ● Modelling a peer support and debriefing circle. ● Effective Events Theory: how worklife stressors affect the midwife's emotion and behaviour in providing				
4.	**Caring for Midwives:** provides participants with the opportunity to discuss the nature of a supportive work environment.				

	● Identifying what midwives realistically need in order to cope with work related stress and to function effectively in the maternity facility, providing quality respectful care. ● Joint letter to the facility manager.				
5.	**3 Minute quick stress relief:** demonstrate 3 techniques that can be used to cope with stress in a particular moment: Movement and music, vocal toning, sense of smell.				
6	**Review of research findings on respectful maternity care;** to provide an overview to mistreatment of women in childbirth. To provide an orientation to the purpose of Part 2: Listening to Mothers: Interpersonal Communication Skills workshop. ● Bohren *et al* typology of mistreatment ● Findings from the current study on RMC(SA)				
7.	**Wrap up**: ● Quick review of expectations graffiti sheet ● Acknowledgement of parking lot issues ● Action Plan ● Affirmations: 2 personal, 1 for colleagues				

Additional Comments:

Thank you for your time and input.

ANNEXURE 7.1

Values Clarification

Value: ideas about what is important to you in life – what you want to live by and live for. What is right, good and just.

Values clarification: values influence our lives. Values clarification is a process of becoming aware of, considering, affirming or rejecting our own values.

By clarifying our values, we acknowledge their influence in our lives. A person can be more self-directed and effective if you know which values will get priority over others.

Involves using rational thinking and emotional awareness to examine behaviours and attitudes.

Attitude: values affect our attitudes and behaviour. Beliefs shape our attitudes. How we communicate our beliefs and attitudes is an important aspect of our interactions with clients.

Beliefs: is a thought we hold and trust about something. Beliefs tend to be buried within the subconscious and they can trigger automatic reactions and behaviours.

Motivation for change: Values clarification is a process that helps the individual / team to examine the current behaviour and be open to change.

ANNEXURE 7.2

Communication skills for Q-sort exercise

Communication skills

- Active listening/ mindful listening
- Clarify
- Summarising as a form of reflecting back to another person
- Non-verbal communication
- Notice patient cues
- Create privacy
- Engage patient
- Avoid interrupting
- Hold back own advice
- Showing empathy
- Supportive comments
- Explain in terms patient understands
- Reflect back to patient
- Responding in a way that encourages patient to talk about feelings and concerns
- Asking what help the patient would like
- Giving information
- Reassurance
- Initiating a discussion
- Appropriate language
- Cultural sensitivity
- Asking questions
- Managing difficult situations
- Acknowledge patient's feelings and emotions
- Calm communication
- Affirming the other person.

ANNEXURE 7.3

RMC Interpersonal skills Training

Personal Action Plan

1. Identify the areas in which your skill level has improved as a result of the RMC workshops.

2. Identify one area where you will use your enhanced awareness and apply your improved skills in working with women in labour.

3. Write 3 brief goals on interpersonal communication skills, that you would like to pursue following these workshops and the ways in which you achieve these goals (include time frame.).

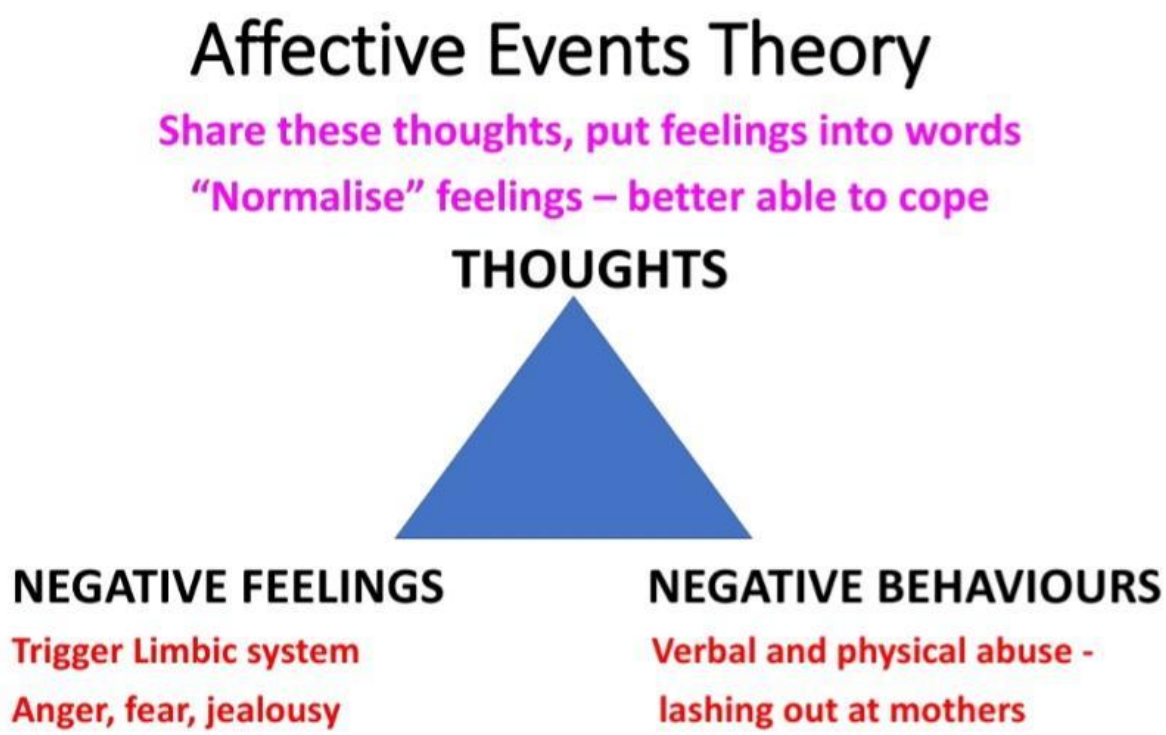
	Goal	Time required	Completed
1			
2			
3			

ANNEXURE 8.1

CHILDBIRTH EXPERIENCE CARD

1	***How do you feel about your labour and birth experience?***
2.	***Would you rate your labour and birth experience as positive or negative?*** **POSITIVE** **NEGATIVE**
3.	***Can you explain the reasons for your answer above please?***
4.	***What do you feel could be done to improve a woman's experience at the MOU ?***

ANNEXURE 8.2


Affective Events Theory
Share these thoughts, put feelings into words
"Normalise" feelings – better able to cope
THOUGHTS
NEGATIVE FEELINGS
Trigger Limbic system
Anger, fear, jealousy
NEGATIVE BEHAVIOURS
Verbal and physical abuse -
lashing out at mothers

ANNEXURE 8.3

Group Facilitation Guidelines for Peer to Peer debriefing in a group.

1. Start the meeting on time.

2. Welcome everyone

3. Explain the purpose of the meeting:

   This meeting is so that we can talk about the stressors we are experiencing which result from our work.

   This may include talking about individual stressors and coping skills, or common work based stressors.

   The purpose of this meeting is to listen to each other, share the stress you are feeling and possibly finds ways to reduce work based stress.

4. Group rules :
   - The debriefing session lasts 45 minutes.
   - The facilitator keeps the group on track without any judgement.
   - Each member of staff takes a turn at being the facilitator at these weekly debriefing sessions.
   - One person speaks at a time
   - Contributions, questions and additional information is offered in an orderly manner.
   - No minutes are written.
   - Please leave quietly if you don't stay for the whole session.

5. The group has the option to summarise difficulties related to the working environment in a letter to the facility manager (template provided).
   This gives the group a voice and a means of alerting the facility manager to problems that affect the quality of care the staff need to provide.
   It also gives the group a way of obtaining feedback from the facility manger – possibly at the next debriefing session.

   A problem shared defeats feeling alone and improves your health and wellbeing.

6. Bring the meeting to a close with an indication to wrap up five minutes before the actual group closes.
7. Thank everyone for coming.