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PRIVATE SECTOR HEALTH CARE USERS' CRITERIA FOR CHOOSING MATERNITY SERVICES IN A DISTRICT IN MPUMALANGA

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A Dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Master of Science in Nursing

Johannesburg, 2024

Declaration

I, Nadia Clay, declare that this Dissertation is my own, unaided work. It is being submitted for the Degree of Masters in Nursing Science at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



2 June 2024

For every Midwife, striving for the best possible care for women

Abstract

Currently, maternity care in the public sector in South Africa is differentiated according to the level of care required. There is also a substantial difference in resource availability between the public and private healthcare sectors. Urban area healthcare users with medical insurance have a choice of private or public sector facilities and even a choice between midwifery-led care and obstetrician led care. This will no longer be the case once the National Health Insurance (NHI) is introduced. Currently, private healthcare users in rural areas have fewer choices due to the lack of facilities. This group of healthcare users therefore has a unique understanding and experience of the quality and types of service offered in the public and private sector. Their perspective will be useful in determining the priorities for establishing equitable maternity services as envisaged by the NHI. By comparing their perspectives to those of healthcare users of the public sector maternity services, it will be possible to establish whether differences occur and, at a later stage, to start planning services that meet the needs of both the public and the private sector healthcare users.

This study sought to answer the research question, “Do private sector healthcare user’s criteria for choosing a maternity service differ from those of public sector users?” A multi-method qualitative study was used. Phase 1 included a scoping review which determined the criteria used to measure patient satisfaction in the public maternity services in sub-Saharan Africa. Phase 2 of the study included semi-structured interviews of nineteen (19) women of childbearing age to determine the criteria that private sector users use when choosing a maternity service to meet their needs and aspirations. The scoping review provided the a priori codes for phase 2 of the study. Using the a priori codes from the scoping review, a template analysis was conducted in phase 2.

The findings of this study indicated that all women, irrespective of social class, culture or socio-economic status have similar needs and preferences and would use those similar criteria for choosing a birthing facility, should they be given that choice. The study emphasised that women need caring, responsive midwives to be present at their birth together with a birth companion of their choice in an accessible, clean and comfortable environment.

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To my loving husband, you have been my rock, my constant source of encouragement, motivation, and financial support. Your belief in me has been my guiding light and has provided me with the strength to persevere through the tough times. I cannot express enough how much your love, support and gentle, yet stern pressure has helped me achieve this. You are my number one supporter, and I am endlessly grateful for everything you do. I love you more than words can convey.

To my God, my Saviour, I humbly acknowledge your guidance and presence in my life. May your divine guidance always lead me to fulfil your will.

With heartfelt appreciation,

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Chapter 1: ORIENTATION TO THE STUDY

1.1. Introduction

Childbirth is an important life event for parents and is a multifaceted experience, which may impact a woman's well-being and future health (Bélanger-Lévesque et al., 2014; Hildingsson et al., 2013). A positive birth experience is associated with an increased mother-child bond, where the mother is left feeling empowered, enriched, dignified with a sense of pride, accomplishment and self-esteem. In contrast, a traumatic birth experience may leave a mother disconnected, helpless and isolated during birth, with a fear of future childbirth (Reed, Sharman and Inglis, 2017). This may be accompanied by memory pain and increased risk of postpartum depression. Maternal health remains a global health issue, as quality care is known to save the lives of women of reproductive age (Bélanger-Lévesque et al., 2014).

Patient satisfaction is a concept which involves the correlation between what the patient expects and what the healthcare environment actually delivers. Patient satisfaction measures the healthcare quality by determining the provider's success at meeting the expectations of most relevance to the patient (Xesfingi and Vozikis, 2016). Women's satisfaction with maternity services is often associated with the quality of intrapartum care, as a positive birthing experience is influenced by the manner in which support is received during labour and childbirth. Patient satisfaction encompasses various dimensions, including structure, process and outcome of care. Evaluating patient satisfaction aids in delivering more adaptable and culturally sensitive services, thereby potentially increasing future utilisation rates, reducing malpractice litigations, and ultimately improving birthing outcomes (Kifle et al., 2017).

Previous studies indicate that patient satisfaction regarding care is influenced by various factors, including overall satisfaction with the healthcare service, attitudes and communication skills of healthcare workers and the quality of the hospital environment (Khumalo and Rwakaikara, 2020). All the studies conducted have however, measured patient satisfaction in the public sector. Patient satisfaction based on the experience of patients, or the perceptions they have developed from hearing of the experiences of

others, may influence a women's decision, where to seek care, if they have a choice. Currently, maternity care in South Africa is differentiated according to the level of care required.

The Competition Commission states that, in 2018, the vulnerable and poorly resourced public sector served approximately 83 percent of the population (Competition Commission, 2019). In contrast to public healthcare, South Africa also has a private healthcare sector, which serves the remaining 17 percent of the population (Competition Commission, 2019). Private health care practitioners and private hospitals serve individuals with medical aid (medical insurance), and individuals are able to pay the premium price for private health care services, compared to free maternity health care provided by the public healthcare system. In a private healthcare facility, maternity care is predominantly obstetrician-led. Upon admission, care is provided by the nurses and midwives on duty. The birth itself is generally attended by the obstetrician regardless of the risk of the pregnancy (Jordaan, 2015).

According to the Government of the Republic of South Africa, during the Presidential Health summit (2018), there is a substantial difference in resource availability between the public and private healthcare sectors. More than half of financial and human resources are allocated to the private sector. With the majority of the country utilising the public healthcare facilities, 70 percent of healthcare practitioners are employed in the private sector, leaving the public sector with a shortage.

It is in an attempt to address these inequities that the government of South Africa is introducing a National Health Insurance system. The intention is to achieve universal health coverage by providing access to quality health care for all South Africans regardless of socio-economic status.

Once the National Health Insurance scheme is fully implemented, the patients should, theoretically, have a wider choice in regard to the facility they choose to birth. To date, pregnant women in the rural areas, which is the setting for this study, have been obliged to use public maternity services for child birth. Now, healthcare users who are currently using private day clinics have aspirations to deliver in private facilities, and

have expressed a hope that, come the NHI, the services offered at the public hospitals will provide equitable quality services as promised by the NHI Bill.

It would be a mistake to assume that there will be one system of healthcare for all and that everyone will have the same level and quality of maternity services. By measuring the factors that women are currently using in the private sector for deciding on which maternity facility to use, it will be possible to predict the likely success or failure of the implementation of the NHI and to plan for the provision of services for prospective maternity patients.

1.2. Statement of the problem

Patient satisfaction is a concept, that is measured to gauge whether patients perceive a health service as quality care or not. This is done to improve services and to establish a baseline for future measurements to determine whether quality improvement strategies that are implemented are successful or not. Patient satisfaction can only be measured once a patient has used the facilities. With the planned introduction of the National Health Insurance system, it is important to determine what criteria prospective patients would use to make them satisfied with, or choose to access, a healthcare facility.

Maternity patients with medical aid cover in urban areas have a choice of private or public sector facilities and even a choice between midwife-led care and obstetrician-led care. However, in the rural areas these options are not all available and patients may be obliged to use the only facility in the area. This puts pressure on the health services to ensure that the patient's needs are met in the available facility. An understanding of needs and preferences of patients currently using private healthcare facilities who have aspirations of delivering in the private sector or equitable quality services in the public sector, will assist in forward planning for the time when both private and public sector patients are to use the same services according to the NHI guidelines. To date patient satisfaction of maternity services in South Africa has only been measured in the public sector. This study seeks to understand whether the private patients' needs and preferences are any different to those of the current public sector users of the maternity services.

1.3. Research question

Do private sector healthcare user's criteria for choosing a maternity service differ from those of public sector users?

1.4. Purpose of the study

The purpose of this study is to understand whether the private patients' needs and preferences are any different to those of the current public sector users of the maternity services. An understanding of private patient's needs and preferences will assist in forward planning for the time when both private and public sector patients are to use the same services according to the NHI guidelines.

1.5. Objectives of the study

- To determine the criteria used to measure patient satisfaction in the public maternity services.

- To determine the criteria that private sector users use when choosing a maternity service to meet their needs and aspirations.

- To compare the criteria that private sector users use when choosing a maternity service to meet their needs and aspirations

1.6. Operational definitions

1.6.1. Patient satisfaction

Patient satisfaction is the degree of measurement, which determines how happy and satisfied the patient is with the health care service provided. Patient satisfaction determines how an individual regards a service delivered as useful, effective, or beneficial. The level of patient satisfaction is completely subjective and may influence the patient's decision whether or not to utilise a service.

1.6.2. Quality of care

Quality of care encompasses various dimensions of healthcare delivery, including safety, effectiveness, timeliness, efficiency, equality and patient-centeredness (Department of Health, Republic of South Africa, 2015). In this research study, the term quality of care is in reference to providing care that meets or exceeds established standards and guidelines, resulting in improved health outcomes and patient satisfaction.

Patient satisfaction often reflects the patient's perception of the quality of care received. For example, if the quality of care is high, and the patient feels disregarded, uninformed, or uncomfortable, their satisfaction with the care provided may be low. Therefore, patient satisfaction and quality of care are intertwined concepts.

1.6.3. National Health Insurance (NHI)

A health financing system designed to provide all South Africans with universal health service ensures access to quality and affordable personal health services based on individual' health needs, irrespective of socio-economic status. The NHI will allow access to comprehensive healthcare services free of charge at accredited facilities such as; clinics, hospitals and private health practitioners. The NHI is intended to ensure that healthcare is not a financial burden to any South African citizen. The National Health Insurance commenced with implementation steps in 2012 with full effect to take place in 2026 (National Health Insurance | South African Government, 2021).

1.6.4 Private sector

The private sector refers to healthcare services that are owned and operated by non-government entities. These include individual medical practitioners, group practices, clinics and hospitals that operate for profit and are independent of government control.

Users of the private sector typically pay for services through out-of-pocket expenses, private health insurance or employer-sponsored health plans.

1.7. Conclusion

In this chapter the background and purpose of the research study were introduced. The problem statement, research question, the purpose and objectives of the study as well as the operational definitions were given.

In the next chapter, the methodology used in the study will be described in detail followed by a chapter on phase one of the study which consisted of a scoping review. This explores and discusses published articles within Sub-Saharan Africa exposing the criteria used to measure patient satisfaction in a public maternity setting. Chapter 4 provides the findings and discussion of the second phase of the study and chapter 5 seeks to answer the research question by comparing the results of the two phases. The final chapter will provide the conclusions, summary, main findings, limitations and recommendations.

Chapter 2: METHODOLOGY

2.1 Introduction

Chapter one provided a brief overview and a background to this study. This chapter describes the research design and methods that were used in this study to answer the research question: Do private sector health care user's criteria for choosing a maternity service differ from those of public sector users? This chapter also provides an overview of the strategies that were used to ensure trustworthiness and adherence to the ethical principles of research.

2.2 Research design

A structured research design increases validity by following an organised approach to reduce threats to the study (Gray & Grove, 2020). The choice of design is dependent on the problem the researcher wishes to investigate. As this study intended to compare the perceptions of two different groups of participants, a qualitative design was chosen.

A two-phased study was conducted with the first phase aimed at collecting data from public sector participants by means of a scoping review and the second phase consisted of semi-structured interviews of patients currently using a private sector health establishment. The data of the two groups was analysed by means of a template analysis.

Qualitative research is useful for gaining a deeper understanding of the perceptions of people's experiences within the participants' own context (Polit and Beck, 2017).

By conducting a scoping review in phase one, it was possible to collect data from a large number of studies from sub-Saharan Africa where public sector participants were involved and to analyse that data to create a template, which was then used to analyse the data for phase two to facilitate a comparison.

2.3. Research setting

Phase one of this study is a scoping review which is discussed in detail in chapter three. The research setting only applies to phase two of the study.

According to Burns et al. (2013) the setting is the place where the study is conducted. The research setting for phase two of this study is a private day clinic located in Mashishing (Lydenburg), Mpumalanga. This clinic serves as a vital healthcare facility within the community, being one of only two private clinics available. The private day clinic serves an average of 110 patients per month. It caters primarily for women of childbearing age and their children. The clinic offers essential primary healthcare services for a fee. These services include minor ailments (colds and flu, minor cuts and bruises, sprains and strains, earaches, rashes and insect bites), HIV counselling, vital sign monitoring, and antenatal services, although it does not currently offer birthing facilities. Mashishing currently relies on a single government hospital for its maternity needs. In the absence of a private hospital, women in need of birthing services are required to use either the nearby government hospital or travel approximately 98 km to the nearest private hospital located in Mbombela (Nelspruit). This situation underscores the limited options available to women in Mashishing for childbirth within a private healthcare setting.

A significant development in healthcare is the initiation of the National Health Insurance (NHI), which aims to provide accessible and equitable healthcare for all citizens. In alignment with this initiative, there are plans to establish a private maternity facility to address the existing gap in this community by offering women a choice regarding childbirth services.

2.4. The sampling process

2.4.1. Population

Gray et al. (2017) define a study population as all elements that meet the sample criteria for inclusion in a study, which could also be described as a target population (Gray, Grove and Sutherland, 2017). The target population in this study included women of childbearing age who utilise the private clinic services.

According to the Statistics Department of South Africa (statsSA, 2022), the municipality of Mashishing is Thaba Chweu which has an overall population of 109 223 residents. The working age population (15-64 years) constitutes 68.8 % of the population. The predominant demographic in the area is characterised by a significant majority of black African residents (87.6%), followed by white residents (10%), coloured residents (1.8%), Indian/Asian residents (0.6%) and others (0%) (Statistica, 2022). This is demonstrated in the Figure 2.1. Population distribution in Mashishing. By utilising the national data Statistica (2022) and Stats South Africa (2021) it is possible to extrapolate that there are approximately 55 922 women living in Mashishing and that 30 478 are of childbearing age.

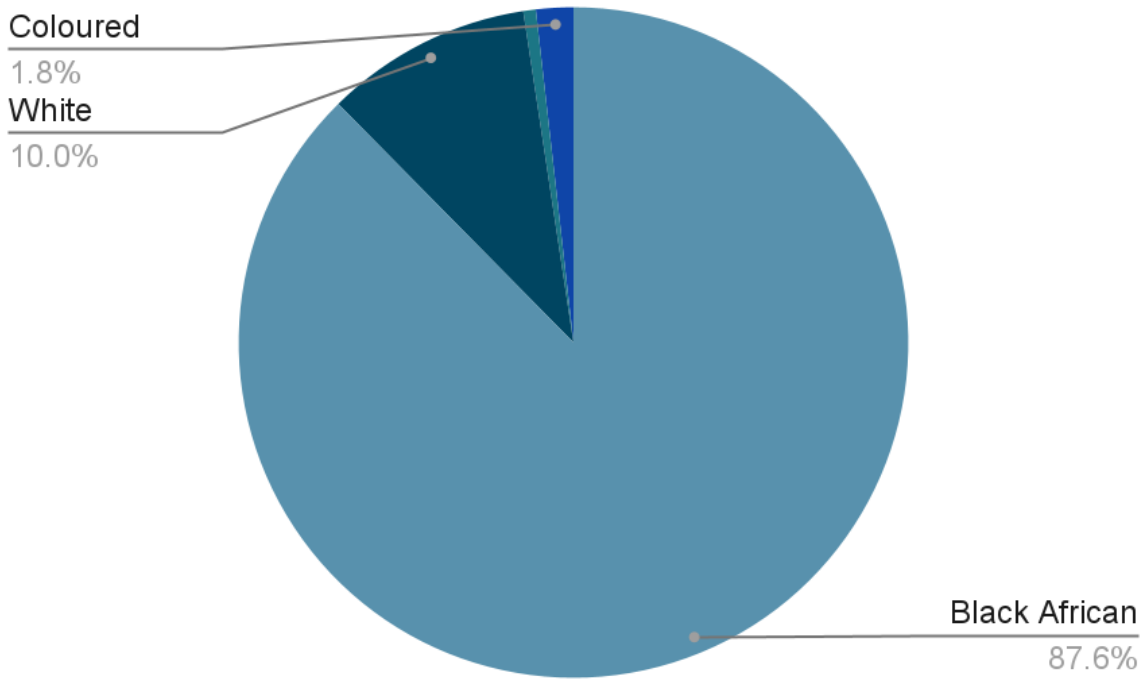


Figure 2.1. Population distribution in Mashishing

2.4.2. Sample

A research sample refers to the process of selecting a smaller group that is from the specified population, thus indicating a selected portion (Brink, 2018). As indicated by the World Health Organization (WHO), women between the ages of fifteen (15) and

forty-nine (49) are considered to be of reproductive age (WHO, 2023). Nineteen (19) women of childbearing age were included in this study. Data saturation determined the sample size and was considered to have been reached when no new information was extracted during data collection (Gray, Grove and Sutherland, 2017). The point of data saturation was reached by 15 interviews. Subsequently, four (4) additional participants were purposefully selected to display the population's demographics and enhance diversity within the sample. The decision to include these extra participants was driven by the desire to capture a more comprehensive range of perspectives.

The inclusion criteria for this research study were women of childbearing age who utilised the private clinic, and gave consent to participate in the research and were able to communicate in English.

2.5. Data collection

2.5.1 Phase one: Scoping review

A scoping review is a 'form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in the research related to a defined area or field by systematically searching, selecting, and synthesising existing knowledge' (Colquhoun et al., 2014). The scoping review methodology outlined by the Joanna Briggs Institute (JBI) for scoping reviews was adapted to capture a wide range of study designs. The JBI approach is to date the most rigorous and defined methodology (Pollock et al., 2021).

A preliminary review on the literature examining the criteria used to measure patient satisfaction in the public maternity service in sub-Saharan Africa indicated there was limited primary research, therefore the scoping review was considered ideal to establish the current understanding of the topic. The JBI approach expands on the work of Arksey and O'Malley (2005) and Levac et al. (2010). The stages in this scoping review consist of:

1. Defining and aligning the objectives and research question;
2. Developing and aligning the inclusion criteria with the objectives and research question;

3. Searching for the evidence;
4. Selecting the evidence;
5. Extracting the evidence;
6. Analysis of the evidence;
7. Summarising the evidence. (Pollock et al., 2021).

Details of the methodology of the scoping review are given in chapter three, which has been included to provide a coherent and comprehensive description of the scoping review. A summary of the data collection for the scoping review is provided here:

The specific question that directed the scoping review was: What criteria do patients in sub-Saharan Africa use to measure patient satisfaction as reported in international literature.

The following electronic databases were searched to identify relevant studies: CINAHL, Proquest and Science Direct.

Boolean operators and medical subject headings were applied in the search strategy when applicable. Boolean operators are defined as simple words (AND, OR, NOT) used as conjunctions to combine or exclude keywords in a search, this allows the search to be more focused, by eliminating inappropriate articles. In this scoping review the Boolean operator “OR” was used. This broadens the search by allowing either or both search terms to be included in the article (Alliant International Universal Library. No date).

Search strings chosen in the search included:

Patient satisfaction OR Maternity care
Satisfaction OR Maternity care
Midwifery care OR Maternity care
Midwifery services OR Quality care

The search strategies were tailored for each database's thesaurus terms to ensure the inclusion criteria were respected. Articles were evaluated on the following inclusion criteria:

- Articles published between the years 2010-2021.
- Articles published in English available in full text.
- Primary study designs of all types (quantitative, qualitative and mixed methods study) and cross-sectional studies.
- Research setting was in the public sector within sub-Saharan Africa.

A total of 1057 articles were identified (CINAHL=61: Proquest=612: ScienceDirect =384). Eliminating all non-English articles and removing duplicates as well as reading the titles, reduced the number to 104 relevant articles. From these, 49 articles were deemed relevant after reading the abstracts. A further 13 articles were removed at this point as they did not meet the inclusion criteria, leaving 36 articles to be included in the scoping review.

The database search and the title screening were conducted by the primary reviewer (the student) together with a second person who was, at that stage, a co-supervisor.

Duplicates were removed. Abstracts followed by full articles were independently screened by the primary reviewer.

Data from the 36 articles were extracted to include key criteria such as author and publication year, study location, purpose/aim of the study, methodology, and factors associated with patient satisfaction/dissatisfaction.

2.5.2 Phase two: Semi-structured interviews

A semi-structured interview was conducted using the interview guide (Annexure 1) for data collection. A semi-structured interview consists of a few predetermined open-ended questions, which enables the interviewer to explore a participant's thoughts, feelings and beliefs about a particular topic. Kumar (2019) describes an interview guide as a list of questions, open-ended or closed, prepared for use by an interviewer in a person-to-person interaction.

Only once ethical approval was obtained from the ethics committee and permission obtained from the clinic manager, did the researcher approach women waiting to be assisted at the private clinic. Participants were approached while waiting in the queue, the purpose of the interview was explained verbally and they were given an invitation

to participate, providing information of the research study (Annexure 2). They were provided with an opportunity to read it. Interviews were only conducted after participants had seen the nurse at the private clinic to avoid losing their place in the queue.

Women who agreed to participate were asked to complete the consent form for both the interview and the recording of the interview (Annexure 3 & Annexure 4). The interview was conducted in a private room to allow open communication while maintaining confidentiality and privacy. The interviews were recorded and transcribed verbatim at a later date.

The semi-structured interview consisted of four (4) main questions, followed by probing questions (Annexure 1). The questions are as follows:

1. If you had a choice of where to receive care when pregnant, and for your delivery, what criteria or factors would influence your choice? Probes: ● Why is that important to you? (for each criteria mentioned) ● Of all the criteria and factors you have mentioned, which would be the deciding factor? ● Can you tell me why that one is so important?
2. I want to explore some specific issues with you. If you had to choose the facility you give birth in, what is it about **the people**, such as the doctors and the midwives that would be important to you? Probes: ● Can you tell me why that is so important? ● How about communication and information? Do they matter? ● What about respectful care? Is this important? ● And the relationship with the carer? What would matter in relation to that?
3. If you had to choose the facility you give birth in, what is it about **the place, or the environment**, that would be important to you? Probes: ● Can you tell me why that is so important? ● How about privacy, meals, cleanliness, equipment? Are any of those important? Why or why not?

● Is proximity of the facility important? For example, would you consider convenience an issue?
4. If you had to choose the facility you give birth in, what is it about the **policies, or rules and regulations,** that would be important to you? Probes: ● Can you tell me why that is so important? ● Would you consider policies regarding breastfeeding important? Why, or why not? ● What about policies regarding pain relief? Are they important? Why or why not? ● And waiting times, policies regarding birth companions? ● Does it matter what the cost of care would be? Are you willing to pay for the service in the hope of getting better quality care?

As explained earlier in the sampling section, data saturation determined the sample size and was considered to have been reached when no new information was extracted during data collection (Gray, Grove and Sutherland, 2017). Data saturation was reached at fifteen (15) participants. Four (4) additional participants were purposefully selected to accurately display Mashishing population demographics.

The researcher selected women who stated they were able to communicate in English. However, during the interviews it became clear that several of the participants had difficulty understanding the questions which needed to be rephrased and explained. Even then, many answered superficially and constantly reverted to speaking about past experiences, which were largely negative, in the public sector.

2.6. Data analysis

2.6.1 Phase one: Scoping review

Once the 36 articles were selected for the scoping review, the full articles were read. Factors associated with patient satisfaction and dissatisfaction were highlighted. This assisted in the objective of the scoping review, which was: To determine the criteria used to measure patient satisfaction in the public maternity services in sub-Saharan Africa. The highlighted findings were organised into categories, subsequently forming a set of a priori codes which were utilised during the second phase of the research study.

The primary categories identified were the following;

1. Relationships
2. Support
3. Service provision

2.6.2 Phase two: Semi-structured interviews

In Phase two of the research study, the a priori codes determined in phase one of the research study were used for a template analysis in phase two of the research study.

Brooks et al (2015) describe a template analysis as a form of thematic analysis which emphasises the use of hierarchical coding but balances a relatively high degree of structure in the process of analysing textual data with the flexibility to adapt it to the needs of a particular study. This was used to form a comparison between the factors used by the public sector healthcare users (from the scoping review) and the private healthcare users (Semi-structured interviews).

The researcher transcribed the interviews verbatim so was familiar with the data but, once they were all transcribed, she reread each transcript to refresh her memory and listened to the recordings while reading the transcripts. This also enabled her to “clean” the data as any errors of transcription were noted and corrected. This process assisted the researcher to gain a full understanding of the content. The researcher made notes of thoughts and ideas to be used at a later date. It was often necessary to re-read sections to understand what the participants were really saying due to the language difficulties encountered.

Brooks et al (2015) suggest that, when using a template analysis, although it is not obligatory to start with a priori codes, it is often helpful which proved the case with the analysis of the interviews. Brooks et al (2015) further note that coding using the a prior codes should be considered tentative until analysis is complete. As the researcher was using a priori codes, she went through each transcript manually highlighting sections of the text that “talked” to one or more of the a priori codes. Words that described the highlighted phrases were written in the margins of the transcripts. At this stage the researcher reviewed the coding from the scoping review which was used to develop

the a priori codes to ensure that the researcher had understood what was meant by each of the codes. On reviewing the initial codes it became clear that all the data “fitted” not only with the categories from the scoping review, but also with the sub-categories. A table was then developed (see Table 5.1. Comparison table of the data from Phase 1 and Phase 2) where the descriptive words from both the scoping review data and the interviews were categorised. It was therefore not necessary to create any new categories or sub-categories. The findings were written up according to the categories and subcategories which were substantiated using phrases and quotes from the original transcripts.

Brooks et al (2015) suggests that on a pragmatic basis, the researcher needs to decide when the coding template meets their needs for the project at hand. As there was no data that could not be fitted into the template, and due to the researcher believing that the data addressed the research question at this stage, no further analysis was done. What was still required, as suggested by Brooks et al (2015) was to refine the data in order to produce an analysis that informs an academic report. The discussion section of the report in chapter 5 of this dissertation provides such a refinement. This was done with reference to current literature.

2.7. Trustworthiness

Polit and Beck (2017) describe trustworthiness as “the degree of confidence qualitative researchers have in their data and analyses” (Polit and Beck, 2017:747).

Trustworthiness in this research study was established using the criteria described by Shenton (2004) which are; credibility, dependability, confirmability and transferability, described by Lincoln and Guba in Shenton (2004:64).

2.7.1 Credibility

Credibility of the study, according to Shenton (2004:64), is described as how the findings reflect the reality of the situation being explored. In this study, semi-structured interviews were used as a data collection method. The interviews were audio-recorded and transcribed verbatim. The researcher’s supervisor checked the transcriptions. A clear audit trail was maintained with clear accurate records of the research process.

2.7.2 Dependability

Shenton (2004:63) describes dependability of a study as if the specific study was to be repeated in a similar setting, the findings would be alike. This is in order to help another researcher to repeat the study. A detailed account of the methods used were recorded in this dissertation to this effect.

2.7.3 Confirmability

Confirmability, as stated in Shenton (2004:72), refers to the data being an accurate reflection on the information the participants supplied. No additional details were added by the researcher. The analysis of the data was conducted with as much objectivity as qualitative data permits. The interviews were recorded, and if necessary can be accessed to verify the content of the interviews. Prolonged engagement involved the primary reviewer immersing herself in extensively in the literature (in the case of the scoping reviews) and the data obtained from the participants which was done over an extended period. This deep engagement allowed for a comprehensive understanding of the literature, allowing the reviewer to identify patterns within the selected studies. Member checking was done during the interviews with the researcher repeating statements to the participants to check that she had understood their meaning.

2.7.4 Transferability

Transferability, as suggested in Shenton (2004:69), is described as the ability to utilise the findings in another setting. Whilst sufficient information was given in the study to replicate, the study remains limited as it only took place in one private clinic and only included nineteen (19) participants. Data saturation determined the sample size and was considered to have been reached when no new information was extracted during data collection, which was at fifteen (15) participants (Gray, Grove and Sutherland, 2017). Four (4) additional participants were purposefully selected to accurately display Mashishing population demographics as seen in Figure 2.1. Population distribution in Mashishing.

2.8. Ethical considerations

Approval for this study was obtained from the following entities prior to commencing data collection:

- Postgraduate Committee and Ethics Clearance was obtained from the Human Research Committee (Medical) of the University of Witwatersrand. (Annexure 5)
- Manager of the private clinic where the interviews took place.

The four ethical principles of autonomy, beneficence, non-maleficence and justice, suggested by Beauchamp and Childress (2009) were adhered to. The dignity and rights of the research participants were respected by maintaining all appropriate ethical standards.

2.8.1 Autonomy

With regard to autonomy, which relates to the right for an individual to make his or her own choice, participants were invited to participate. An invitation to participate explaining the research and the purpose of the interview (Annexure 2) were provided to them. The invitation to participate letter assured that confidentiality would be maintained, protecting participants' identities. It also clarified that there were no consequences to participating or declining to participate in the research study. Additionally, participants were informed of their right to voluntarily withdraw from the research at any stage. With this, informed consent was obtained from the participants.

2.8.2 Beneficence

Beneficence relates to acting with the best interest of the other person (Beauchamp and Childress, 2019). In this study, beneficence was upheld by ensuring the well-being of participants without inducing any harm or discomfort to participants. There was no direct benefit to the participants, however participants were informed that their contribution could aid in the availability of future maternity services. Confidentiality of information was maintained through participant codes known solely to the researcher, with no identifying information included in the dissertation.

Participants consented to the utilisation of anonymized quotes from their comments. Measures were taken to prevent tracing information back to participants. While no financial incentives were provided, participants will have access to the findings of the study. Consent was obtained to conduct the interviews (Annexure 3) and to audio-record them (Annexure 4). The data collected is securely stored and only accessible to the researcher. Consent forms are stored separately from the recording and transcripts. Audio-recordings and transcripts are kept on a password-protected computer. Only the researcher and the supervisors were able to listen to the recordings and read the transcriptions of the recorded interviews.

2.8.3 Non-maleficence

This principle refers to the researcher not acting in any way that would bring harm to the participant, either through commission or omission. In terms of this principle, researchers are obliged to carry out the study in a competent manner to ensure no harm occurs to participants. The same efforts to ensure beneficence applied to this principle.

2.8.4 Justice

The principle of justice refers to a concept that all participants were treated with fairness and equity. The researcher selected and treated all participants fairly and with respect. This involved asking each participant identical questions while ensuring their privacy by interviewing them in a private room, preventing any breach of confidentiality. All participants volunteered willingly, and their contributions were given equal weight when analysing and writing up the data.

2.9. Conclusion

This chapter outlined the research methods used in this study. The scoping review (phase one) provided a priori codes to assist with template analysis of the semi-structured interviews (phase two). Together this created a cohesive understanding of the criteria women use when choosing a maternity facility in both the public and private sector.

The next chapter explains the scoping review in detail.

Chapter 3: SCOPING REVIEW

3.1. Introduction

This chapter reports on the scoping literature review, which was done to meet the objective: to determine the criteria used to measure patient satisfaction in public maternity services in sub-Saharan Africa. The scoping review methodology outlined by the Joanna Briggs Institute (JBI) for scoping reviews was followed to capture a wide range of study designs. The stages in this scoping review consist of:

1. Defining and aligning the objectives and research question;
2. Developing and aligning the inclusion criteria with the objectives and research question;
3. Searching for the evidence;
4. Selecting the evidence;
5. Extracting the evidence;
6. Analysis of the evidence;
7. Summarising the evidence. (Pollock et al., 2021).

The previous chapter briefly discussed the methodology of the scoping review. In this chapter, further detail is given of the methods used in relation to data collection and analysis as well as the findings of the review.

3.2. Methods and findings

3.2.1. Stage 1: Defining and aligning the objectives and research question

The review aimed to address the following objective: to determine the criteria used to measure patient satisfaction in public maternity services in sub-Saharan Africa. By exploring the literature of studies conducted in developing countries, most of which are conducted in the public sector, it assisted with the establishment of the criteria patients use in the public sector to determine patient satisfaction. This was done in order to establish a priori codes for the analysis of the data to be collected in phase two of the study and then to compare the criteria used by patients in the public and private sectors to answer the research question of the study .“Do private sector health care user’s criteria for choosing a maternity service differ from those of public sector users? Table

3.1. Framework of review objective, shows the framework (population, concept and context (PCC) used to guide the review.

Table 3.1. Framework of review objective

Population	Women of child-bearing age between the ages of 18-35 years old.
Concept	Criteria used to measure patient satisfaction: Refers to any characteristic which allows users to classify themselves as being satisfied or dissatisfied with the utilisation of a maternity service.
Context	Sub-Saharan Africa

3.2.2. Stage 2: Developing and aligning the inclusion criteria with the objectives and research question

The eligibility criteria will determine which papers are included in the review. If these criteria are too broad, the number of included papers might become too overwhelming for a one review. Conversely, if the criteria are too narrow, there is a risk of not finding suitable papers. It is crucial that eligibility criteria is closely aligned with the research objectives and questions. Therefore, the PCC (Population, Concept, and Context) framework, as advocated by Peters, Godfrey, et al. (2020) and Peters, Marnie, et al. (2020), guides the development of research objectives and questions, which in turn informs inclusion and exclusion criteria, as well as the literature search strategy. A solid demonstration of this concept is depicted in Figure 2 of Feo et al.'s (2020) scoping review.

Furthermore, it's essential to provide a rationale for all exclusion criteria (Tricco, Lillie, et al., 2018; Tricco, Zarin, et al., 2018). For instance, if the review is restricted to a certain type of literature (such as peer-reviewed articles), a specific timeframe (e.g., within the last 10 years), geographical locations (e.g., rural and remote settings), or particular populations (e.g., individuals with Type 2 diabetes mellitus), justification must be provided for imposing these limitations.

For this scoping review, articles were evaluated on the following inclusion criteria:

1. Articles published between the years 2010-2021.
2. Articles published in English available in full text.
3. Primary study designs of all types (quantitative, qualitative and mixed methods study) and cross-sectional studies.
4. Research setting was in the public sector within Sub-Saharan Africa.

3.3.3. Stage 3: Searching for the evidence

The following electronic databases were searched to identify relevant studies: CINAHL, Proquest and Science Direct.

These databases were selected, as they were accessible through the Wits Library. CINAHL (Cumulative Index to Nursing and Allied Health Literature) indexes the top nursing and allied health literature. ProQuest Central is the largest multidisciplinary full-text database currently available. ScienceDirect is a premier database for advanced research and scholarship, providing access to peer-reviewed, full-text scientific, technical, and health literature. These three databases were deemed the most suitable electronic resources for comprehensive coverage of the subject matter.

Boolean operators and medical subject headings were applied in the search strategy when applicable. Boolean Operators are defined as simple words (AND, OR, NOT) used as conjunctions to combine or exclude keywords in a search, this allows the search to be more focused, by eliminating inappropriate articles. In this scoping review the Boolean Operator “OR” was used. This broadens the search by allowing either or both search terms to be included in the article. (Alliant International Universal Library. No date)

Search strings chosen in the search included:

Patient satisfaction OR Maternity care

Satisfaction OR Maternity care

Midwifery care OR Maternity care

Midwifery services OR Quality care

The search strategies were tailored for each database's thesaurus terms to ensure the inclusion criteria were respected.

3.2.4. Stage 4: Selecting the evidence

A total of 1057 articles were identified (CINAHL=61: Proquest=612: ScienceDirect =384). Eliminating all non-English articles and removing duplicates reduced the number to 104 articles based on a relevant title. From these, 49 articles deemed relevant after undergoing a closer review, A further 13 articles were removed at this point as they did not meet the inclusion criteria, leaving 36 articles to be included in the scoping review. The database search and the title screening were conducted by the primary reviewer (the student) with the assistance of a second person, who was, at that stage a co-supervisor. The eligibility criteria were adhered too. Duplicates were removed. Abstracts followed by full articles were independently screened by the primary reviewer. (Figure 3.1. PRISMA diagram of the literature search process)

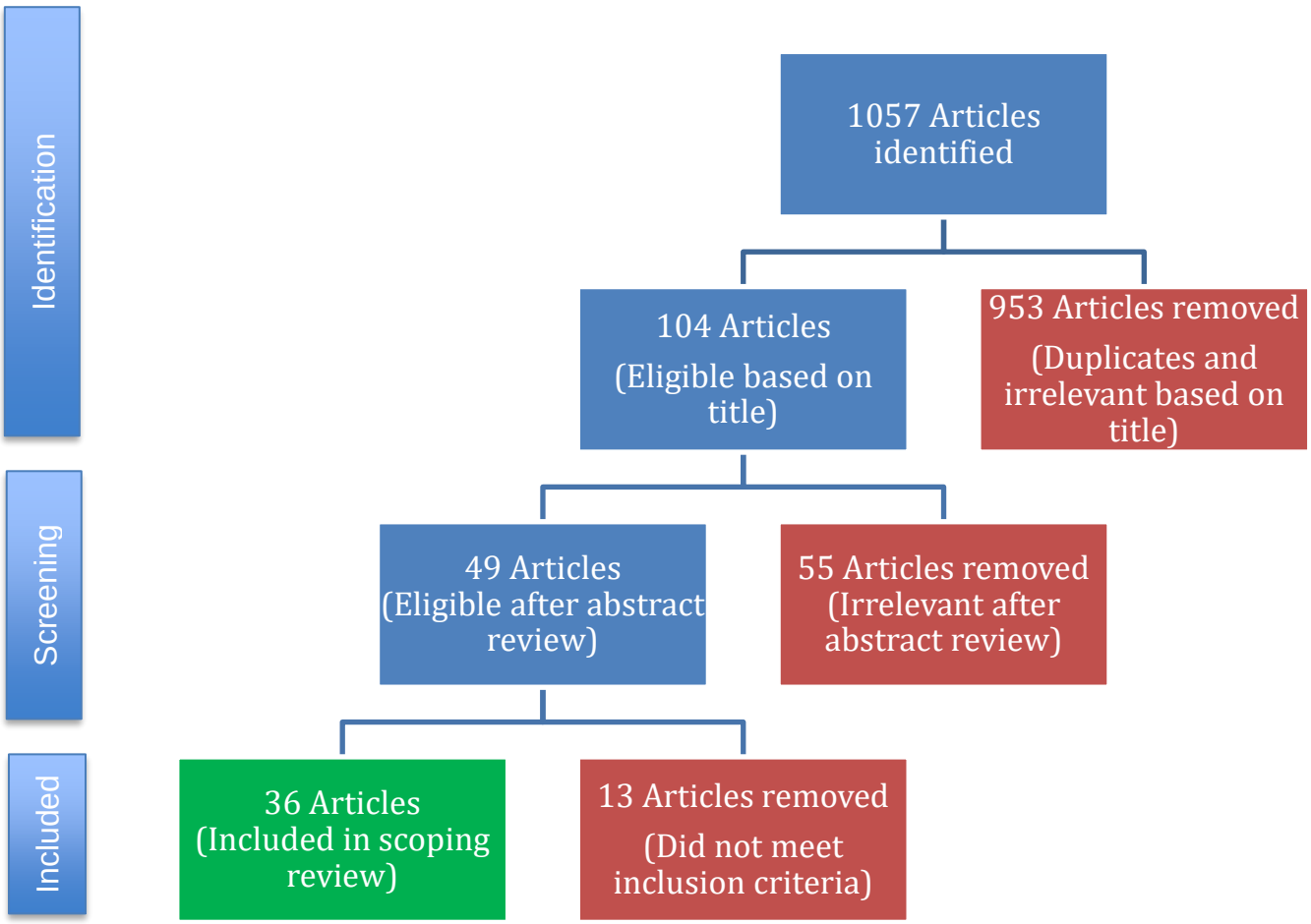


Figure 3.1. PRISMA diagram of the literature search process

3.2.5. Stage 5: Extracting the evidence

Data from the 36 articles were extracted to include key criteria such as author and publication year, study location, purpose/aim of the study, methodology, and factors associated with patient satisfaction/dissatisfaction (Table 3.2. Data Extraction tool). The reviewer presented the findings to two supervisors to oversee the extraction process. Consultation between the reviewer and supervisors ensued until all content was analysed and organised into key emergent categories. A colour coding system was implemented in the extraction tool to distinguish between the search strings used. This approach facilitated easy identification and differentiation of the various articles identified in the various search string among the chosen databases.

The colour coding for the following search string is as follows;
Patient satisfaction OR Maternity care = Blue
Satisfaction OR Maternity care = Red
Midwifery care OR Maternity care = Purple
Midwifery services OR Quality care = Green

Table 3.2. Data Extraction tool

Database	Article number	Search string	Article Title	Author, Date	Setting	Purpose of the study	Methodology
CINAHL	1	Patient satisfaction +maternity care	Women's satisfaction with maternity experience at a regional hospital in Swaziland: A cross sectional survey.	Zwakele Z Tfwala and Nai-Wen Kuo, (2021).	Swaziland	The aim of the study was to determined maternity experiences and women's demographic characteristics that affect perceived satisfaction with maternity care at a regional hospital in Swaziland	Cross sectional survey
	2		What are Pregnant Women in a Rural Niger Delta Community's Perceptions of Conventional Maternity Service Provision? An Exploratory Qualitative Study	George M Igboanugo and Caroline H Martin (2011)	Niger	Carried out to identify pregnant women in a rural Niger Delta community's perceptions of conventional maternity service provision.	Exploratory qualitative study
	3		.Factors influencing the utilisation of maternal and child care services in Balaka district of Malawi	C. M Makuta H.S. Du Toit (2016)	Malawi	Investigate the factors influencing the utilisation of MCH care services by mothers at 4 selected health facilities in the Balaka district in Malawi	Non-experimental, descriptive quantitative design
	4	satisfaction + Maternity care	Levels and dimensions of client satisfaction with the treatment of recent maternal, newborn and child health related illnesses by frontline health workers in rural Nigeria.	Godwin O. Unumeri, Ekechi Okereke and Babatunde A. Ahonsi (2020)	Nigeria	This study examined different aspects of client satisfaction at primary healthcare level in Nigeria	Quantitative study

Database	Article number	Search string	Article Title	Author, Date	Setting	Purpose of the study	Methodology
	5		Patients satisfaction with midwifery services at a regional hospital and its referring clinics in the Limpopo province of South Africa	T.G. Lumadi ,E. Buch (2011)	South Africa	Assess mothers' satisfaction with maternity services at a regional hospital in the Limpopo Province of South Africa, and its 11 referring clinics	A quantitative, descriptive, cross-sectional study
	6	Midwifery care + maternity	Women's views and experience of their maternity care at a referral hospital in Ghana	L. Floyd, N. Coulter, S. Asamoah, R. Agyare-Asante (2014)	Ghana	This article describes a qualitative study to explore the experiences of eleven newly delivered women at a large referral hospital in Accra, to identify which factors contributed to a positive or negative birth experience	Exploratory, qualitative approach
	7	midwifery + quality care	Mothers' expectations of midwives' care during labour in a public hospital in Gauteng	M. Sengane (2013)	South Africa	Purpose of the study on which this article is based was to determine mothers' expectations of midwives' care during labour	Qualitative, exploratory, descriptive and contextual study design
	8		Exploration of mothers expectations of care during childbirth in public health centres in Kumasi, Ghana	V.M. Dzomeku, B.E. van Wyk, L. Knight, J. R. Lori (2018)	South Africa	Explore and provide insight into mothers' expectations of childbirth care in public health centres in Kumasi, Ghana	Exploratory qualitative research design
	9		Phase 3 delay' threats to labouring women.	R. Laisser, S. Manangwa, E. Libaba, M. Kimweri and C. Bedwell (2015)	Tanzania	Determine factors associated with delay in accessing maternity care by labouring women in three districts of Tanzania	Descriptive cross-sectional survey

Database	Article number	Search string	Article Title	Author, Date	Setting	Purpose of the study	Methodology
Proquest (Page 1, 1-50)	10	Patient satisfaction +Maternity care + Sub-Saharan African	Health system responsiveness in maternity care at Hadiya zone public hospitals in Southern Ethiopia: Users' perspectives	R. A. Abdo, H. M. Halil, B. A. Kebede, A. A. Anshebo, M. D. Ayalew, S. A. Nedamo, S. E. Helill (2021)	Ethiopia	Assess the responsiveness in maternity care, domain performance and factors associated with responsiveness in maternity care in the Hadiya Zone public Hospitals in Southern Ethiopia	Cross-sectional study
	11		We just look at the well-being of the baby and not the money required': a qualitative study exploring experiences of quality of maternity care among women in Nairobi's informal settlements in Kenya	J. Oluoch-Aridi, F. Wafula, G. Kokwaro, M. B. Adam (2020)	Kenya	To examine how women living in an informal settlement in Nairobi perceive the quality of maternity care and how it influences their choice of a delivery health facility.	Descriptive Qualitative study
	12		Mother's satisfaction with the existing labor and delivery care services at public health facilities in West Shewa zone, Oromia region, Ethiopia	G.A. Bulto, D. B. Demissie, T. L. Tasu and G. A. Demisse (2020)	Ethiopia	Aims to assess the mother's satisfaction with existing Labour and delivery services and associated factors at all levels of health care in the West Shewa zone	Cross-sectional study
	13		Client satisfaction with existing labor and delivery care and associated factors among mothers who gave birth in university of Gondar teaching	K. T. Gashaye, A. T. Tsegaye, G. Shiferaw, A. G. Orku, S. M. Abebe (2019)	Ethiopia	Aim of this study was to better understand client satisfaction on existing labor and delivery care service and associated factors among mothers who gave birth in the University of Gondar Teaching Hospital, Ethiopia.	Cross-sectional study

Database	Article number	Search string	Article Title	Author, Date	Setting	Purpose of the study	Methodology
			hospital; Northwest Ethiopia: Institution based cross-sectional study				
	14		Satisfaction with Delivery Services Offered under the Free Maternal Healthcare Policy in Kenyan Public Health Facilities	C. M. Gitobu , P.B.Gichangi, and W.O.Mwanda (2018)	Kenya	To determine satisfaction level of mothers with the free maternal services in selected Kenyan public health facilities after the implementation of the free maternal healthcare policy	Cross-sectional analytical approach
	15		Qualitative assessment of women's satisfaction with maternal health care in referral hospitals in Nigeria	F. Okonofua, R. Ogu, K. Agholor, O. Okike, R. Abdus-salam, M. Gana, A. Randawa, E. Abe, A. Durodola, H. Galadanci (2017)	Nigeria	Aim of this study was to investigate women's level of satisfaction with the quality of care in the three dimensions of structure, process and outcomes in the continuum of maternity care - antenatal, intrapartum, and postnatal services.	Focus group discussions
ProQuest (page 2, 51-100)	16	Patient satisfaction +Maternity care + Sub-Saharan African	Health workers' disrespectful and abusive behaviour towards women during labour and delivery: A qualitative study in Durban, South Africa	S. Mapumulo, L. Haskins, S. Luthuli, C. Horwood (2021)	South Africa	This paper reports experiences of disrespectful care among informal working women in three public health facilities in Durban, South Africa.	Qualitative longitudinal study
	17		Exploring women's childbirth experiences and perceptions of delivery care in peri-urban settings in Nairobi, Kenya	J. Oluoch-Aridi, Patience. A. Afulani, D. B. Guzman, C, Makanga and L. Miller-Graff 2021)	Kenya	To describe women's childbirth experiences to assess their perceptions of PCMC and what contributed to positive and negative experiences, to provide a more holistic understanding of PCMC within	Descriptive, qualitative study

Database	Article number	Search string	Article Title	Author, Date	Setting	Purpose of the study	Methodology
						the informal settlement context.	
	18		Women's experiences of mistreatment during childbirth and their satisfaction with care: findings from a multicountry community-based study in four countries	T Maung et al. (2021)	Ghana, Guinea, Myanmar, Nigeria	Women's experiences of mistreatment and satisfaction with care during childbirth was explored	Secondary analysis of a cross-sectional survey
	19		Maternal perceptions of the quality of Care in the Free Maternal Care Policy in subSahara Africa: a systematic scoping review	M. Ansu-Mensah, F. I. Danquah, V. Bawontuo, P. Ansu-Mensah and D. Kuupiel (2020)	Sub-Saharan Africa	To explore evidence on the implementation of free maternal healthcare financing policies and pregnant women's perception of the quality of care.	Scoping review
	20		"I am alive; my baby is alive": Understanding reasons for satisfaction and dissatisfaction with maternal health care services in the context of user fee removal policy in Nigeria	A. Ajayi (2019)	Nigeria	To understand reasons of satisfaction and dissatisfaction with maternal health care services in the context of user fee removal policy in Nigeria	Mixed study design
	21		A Qualitative Study on Women's Experiences of Intrapartum	A. Afaya, V. N. Yakong, R. A. Afaya, S. M. Salia, P.	Ghana	The aim of this study was to explore mother's experiences regarding quality of	Focused ethnographic study (Qualitative)

Database	Article number	Search string	Article Title	Author, Date	Setting	Purpose of the study	Methodology
			Nursing Care at Tamale Teaching Hospital (TTH), Ghana	Adatara, A. K. Kuug, F. K. Nyande (2017)		intrapartum nursing/midwifery care.	
	22		Maternal Satisfaction on Delivery Service and Its Associated Factors among Mothers Who Gave Birth in Public Health Facilities of Debre Markos Town, Northwest Ethiopia	K. Bitew, M. Ayichiluhm, and K. Yimam (2015)	Ethiopia	This study aimed at assessing maternal satisfaction on delivery service and factors associated with it.	Community based cross-sectional study design
	23		A qualitative study of health system barriers to accessibility and utilization of maternal and newborn health care services in Ghana after user-fee abolition	J. K. Ganle, M. Parker, R. Fitzpatrick and E. Otupiri (2014)	Ghana	To explore health system factors that inhibit women's access to and use of skilled maternal and newborn healthcare services in Ghana despite these services being provided free.	Qualitative data
Proquest (page 3) 101-150	24	Patient satisfaction +Maternity care + Sub-Saharan African	Is quality maternal healthcare all about successful childbirth? Views of mothers in the Wa Municipality, Ghana	L. Baatiema, A.Tanle, E. K. M. Darteh, E. K. Ameyaw (2021)	Ghana	Explored women's perception of the quality of maternal health care they receive in the Wa Municipality of the Upper West Region of Ghana.	Qualitative cross-sectional study
	25		Understanding what women want: eliciting preference for delivery health facility in a rural	J. Oluoch-Aridi, M. B Adam, F. Wafula, G. Kokwaro (2020)	Kenya	To identify what women want in a delivery health facility and how they rank the attributes that influence the choice of a place of delivery.	A discrete choice experiment. (Quantitative)

Database	Article number	Search string	Article Title	Author, Date	Setting	Purpose of the study	Methodology
			sub county in Kenya, a discrete choice experiment				
	26		Why some women fail to give birth at health facilities: a qualitative study of women's perceptions of perinatal care from rural Southern Malawi	L. Kumbani, G. Bjune, E. Chirwa, A. Malata and J. Ø. Odland (2013)	Malawi	Explores the reasons why women delivered at home without skilled attendance despite receiving antenatal care at a health centre and their perceptions of perinatal care.	Descriptive qualitative study
Proquest (page 4) 151-200	27	Patient satisfaction +Maternity care + Sub-Saharan African	A mixed reception: perceptions of pregnant adolescents' experiences with health care workers in Cape Town, South Africa	R. Sewpaul, R. Crutzen, N. Dukhi , D. Sekgala and P. Reddy (2021)	South Africa	To report on the experiences of pregnant adolescents with health care workers when accessing antenatal care.	Qualitative phenomenological approach
	28		Factors influencing mothers' decisions regarding obstetrical care in Western Kenya: a mixed-methods study	G. Umutes, M. D. McEvoy, K. Bonnet, S. Druffner, D. G. Schlundt, H. E. Atieli, J. N. China, K. Onyango and M. W. Newton. (2021)	Kenya	To elucidate factors that influence mothers' decisions regarding where to seek obstetrical care.	Mixed-method study
	29		Women's perspectives on quality of maternal health care services in Malawi	K. Machira, M. Palamuleni (2018)	Malawi	To explore women's perspectives on the quality of health care service delivery in Malawi	Qualitative approach
	30		A facility-based study of women' satisfaction and perceived quality of	B. Oyugi, U. Kioko, S. M. Kaboro, C. Okumu, S. Ogola-Munene, S. Kalsi, S.	Kenya	To assess perceived quality of care and satisfaction of reproductive health services under the output-based	Cross-sectional study

Database	Article number	Search string	Article Title	Author, Date	Setting	Purpose of the study	Methodology
			reproductive and maternal health services in the Kenya output-based approach voucher program	Thiani, S. Gikonyo, J. Korir, B. Baltazar and M. Ranji (2018)		approach (OBA) services in Kenya from clients' perspective.	
Proquest page 5 (201-250)	31	Patient satisfaction +Maternity care + Sub-Saharan African	Prevalence of Antenatal Care Services Satisfaction among Mothers Attending Antenatal Care in Goba Hospital, Bale Zone, Oromia Region, Southeast Ethiopia	A. Yasin Mohammed, T. E. Wanamo and A. L. Wodera (2021)	Ethiopia	To assess ante-natal care service satisfaction and associated factors among mothers attending ante-natal care in Goba hospital, Bale zone, Oromia region, Southeast Ethiopia	Cross-sectional survey
	32		Childbirth experiences and their derived meaning: a qualitative study among postnatal mothers in Mbale regional referral hospital, Uganda	J. Namujju, R. Muhindo, L. T. Mselle, P. Waiswa, J. Nankumbi and P. Muwanguzi (2018)	Uganda	The purpose of this study was to explore childbirth experiences and their meaning among postnatal mothers	Qualitative study
Proquest page 8 (351-400)	33	Patient satisfaction +Maternity care + Sub-Saharan African	How do Malawian women rate the quality of maternal and newborn care? Experiences and perceptions of women in the central and southern regions	C. Kambala, J. Lohmann, J. Mazalale, S. Brenner, M. De Allegri, A. S. Muula and M. Sarker (2015)	Malawi	To measure women's perceived quality of maternal and newborn care.	Cross-sectional survey
Science direct	34	Patient satisfaction	Does institutional maternity services	D. Onchonga, M. t Keraka , V.	Kenya	Aimed at understanding perceptions and experiences	Qualitative descriptive study

Database	Article number	Search string	Article Title	Author, Date	Setting	Purpose of the study	Methodology
		+Maternity care + Sub-saharan African	contribute to the fear of childbirth? A focus group interview study	Moghaddam, H. ´Akos V´arnagy (2021)		of new mothers diagnosed with the fear of childbirth in Kenya; regarding the institutional maternity services offered and if they contribute to the fear of childbirth (FOC)	
Science Direct	35		Narratives of distress about birth in South African public maternity settings: A qualitative study	R. J. Chadwick, D. Cooper, J. Harries (2014)	South Africa	To explore the factors associated with negative birth experiences in South African public maternity settings from the perspective of women's birth narratives	Explorative, qualitative research study
Science Direct	36		Women's experiences of disrespectful and abusive maternal health care in a low resource rural setting in eastern Zimbabwe	B. Kanengoni , S. Andajani-Sutjahjo , E. Holroyd (2019)	Zimbabwe	To explore women's experiences and perceptions of disrespect and abuse from their maternity care providers in a low resource rural setting in Zimbabwe.	Qualitative research methodology

3.2.6. Stage 6: Analysis of the evidence

Among the 36 included articles that qualified for this study, the highest 19% (7) reported from Kenya, followed by 17% (6) from South Africa and 14% (5) from Ethiopia. While 8% (3) reported from Nigeria whereas 5% (2) of the included articles reported from multiple settings within Sub-Saharan Africa. Ghana and Malawi each contributed 11% (4) of the articles included. The remainder (15%) of the 36 articles were conducted in Swaziland, Niger, Zimbabwe, Tanzania and Uganda with 3% (1) each.

The prevalence of articles from Kenya and South Africa may be influenced by various factors such as, research infrastructure, funding availability, and academic networks. The Heshima project in Kenya is known for investigating the causes of disrespectful and abusive care during childbirth in Kenyan health facilities (Population Council, No date). This has led to several studies regarding respectful communication in Kenya. South Africa is known for their active research communities and well-established academic institutions. Support for funding has also contributed to the higher number of publications.

Of the 36 included articles, 18 (50%) articles were qualitative research, 15 (41%) were quantitative research of which 12 (80%) articles were cross-sectional designs. While, 2 (6%) were from mixed method research and the remaining 1 (3%) was from a scoping review. See Figure 3.2. Distribution of Study designs.

Qualitative research is a flexible and unstructured approach, allowing the exploration of diversity. Qualitative research places emphasis on description and narration of feelings, perceptions and experiences rather than their measurement (Hammarberg, Kirkman and de Lacey, 2016). The main focus of qualitative research is to understand, explain, explore, discover and clarify situations, feelings, perceptions, attitudes, values, beliefs and experiences of a particular population (Kumar, 2019). It is therefore understandable why the majority of the research articles were of a qualitative design.

As the researcher meticulously reviewed the selected articles and identified potential a priori codes, it was anticipated that breastfeeding would emerge as a notable topic, particularly due to Africa's widespread poverty and limited access to alternative feeding options. To the researchers' surprise, breastfeeding was only minimally mentioned in the research findings.

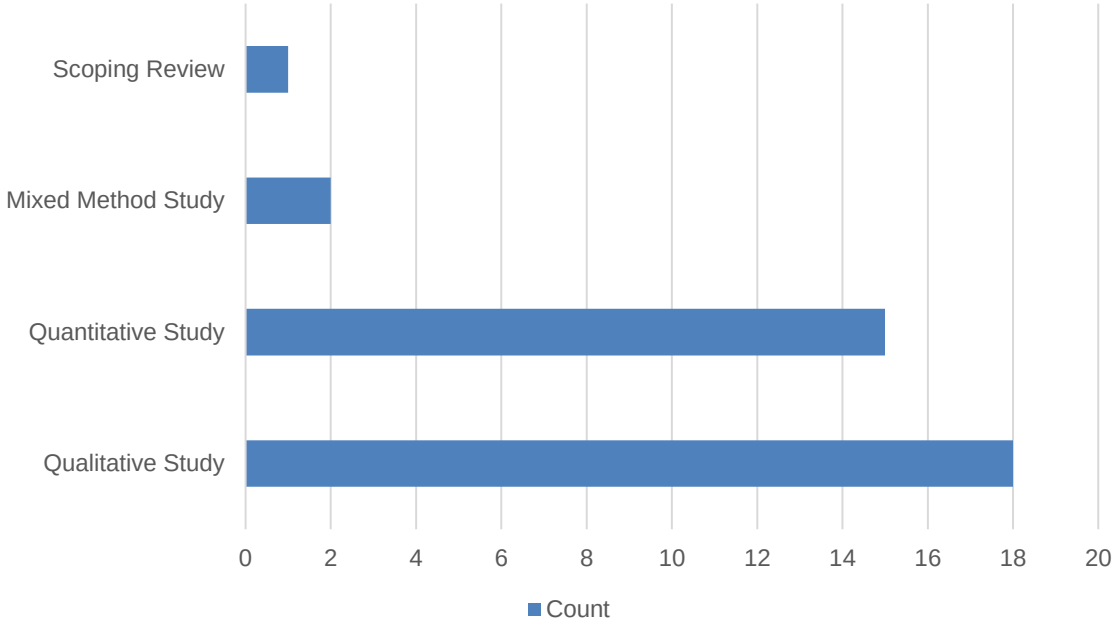


Figure 3.2. Distribution of Study designs

3.2.7. Stage 7: Summarising the evidence

This review has identified a wide range of factors that influence patient satisfaction, which are organised into categories outlined in Table 3.3. Categories associated with patient satisfaction. The primary categories include relationships, support, and service provision. Majority of the selected articles fell under the category, relationship and support with 59 references each. Following close behind is the category of service provision with 54 references.

The identified categories were subdivided into subcategories to offer deeper insights to the objective of the scoping review, which is; To determine the criteria used to measure patient satisfaction in the public maternity services in Sub-Saharan Africa. Each subcategory is thoroughly examined in reference to the selected articles, providing a comprehensive understanding of the topic under investigation. With the

completion of the scoping review's objective, the identified sub-categories within it served as predetermined codes that shaped the template utilised in phase 2.

The numbers listed in the column entitled, "supporting studies" refer to the article numbers from Table 3.2. Data Extraction tool.

Table 3.3. Categories associated with patient satisfaction

Categories	Sub-Categories	Supporting Studies
Relationships	Respectful communication	1, 4, 6, 7, 8, 11, 12, 13, 15, 16, 17, 18, 19, 20, 21, 23, 25, 26, 27, 32, 36
	Provision of information	2, 4, 5, 6, 8, 9, 12, 14, 15, 17, 21, 22, 26, 27, 31, 33, 35, 36
	Respect for Human Rights	1, 4, 5, 8, 10, 12, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 30, 32, 33, 34,
Support	Staff Presence	4, 6, 7, 8, 11, 12, 13, 15, 16, 17,21, 32, 35
	Birth companion	1, 12, 13, 16, 17, 32, 33, 34, 35
	Timely treatment	2, 4, 12, 14, 15, 17, 18, 20, 22, 23, 26, 27, 29, 31, 34, 36,
	Provision for basic needs	1, 5, 6, 8, 11, 12, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 28, 29, 30, 34, 36
Service provision	Provisions for Human Resources (Quantity and quality of staff)	2, 3, 4, 5, 6, 8, 9, 11, 15, 16, 17, 20, 21, 22, 23, 24, 25, 26, 29, 30, 32, 34
	Provision for other resources (Supplies, equipment and physical space)	1, 3, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 24, 25, 28, 29, 34,
	Access to facility	2, 3, 4, 9, 13, 14, 20, 23, 24, 25, 26, 28, 29, 33, 36

3.3. Discussion

3.3.1. Relationships

The category "relationships" identifies the importance of healthcare providers and health care users having a positive regard for one another which is demonstrated by the way both parties behave towards one another. Professionalism, respect, dignity and benevolence as well as respect for one another's human rights are characteristics of a positive relationship. Part of a quality healthcare provider-healthcare user relationship is to always ensure the healthcare user feels safe and comfortable throughout procedures; educating, advising and informing them on procedures

required to ensure they are well informed to feel empowered, safe, and in control of their care.

Three sub-categories were included under this category namely respectful communications, provision of information and respect for human rights.

3.3.1.1. Respectful communication

Throughout Sub-Saharan Africa, friendly, respectful and polite communication is a major determinant of patient satisfaction, as evidenced in studies in Swaziland, Nigeria, Ghana, Ethiopia, Kenya and Uganda (1, 4, 6, 8, 12, 13, 17, 18, 32). Patient satisfaction is increased by kind, respectful and polite communication (1). According to two Ethiopian studies, women are more satisfied when treated with respect, compassion and with a caring manner (12, 13). Women prefer to be spoken to in a polite and calm manner (6) and are satisfied with the care received by doctors and nurses with good attitudes (20). From a Kenyan study, women identified a positive birth experience when the care received was person-centred, responsive, dignified, supportive and communication was in a respectful manner (17). Kindness was the most positive quality, with participants describing healthcare providers who went out of their way to treat them with kindness (17). Women appreciate good interpersonal skills and being listened to (32). In another study conducted in Ghana, it was concluded that most mothers accepted disrespect and poor attitudes of midwives in order to obtain the care required, therefore avoiding conflict and expressing their feelings (21). The most highly valued attribute for women when making a choice regarding a birth facility was the attitudes of healthcare providers (25). The quality-of-care standards require women to be treated in a respectful manner and in a way that upholds their dignity. This Kenyan study demonstrated how women's experiences of care during birth and attributes such as the attitudes of healthcare providers affect the utilisation of a health facility (25).

Just as respectful communication was considered important, by contrast the articles showed that a lack of respectful communication resulted in poor patient satisfaction and a negative birth experience. Participants specifically referred to being treated with

unfriendly attitudes, rudeness, verbal abuse, impoliteness and being made to feel uncomfortable (6, 15, 17, 23, 26, 27, 35, 36). Several women recounted their experiences of how they were chided and scolded at (23), combined with humiliations during labour, such as being told by health care providers that they smelled (35). Unnecessary humiliations enhanced feelings of shame and were not conducive to the formation of a trusting relationship (35). Ghanaian studies (6, 23) verbalised that women were dissatisfied with the care received when being ignored, spoken to rudely or harshly and being shouted at by healthcare providers (6). From a secondary analysis of a cross-sectional survey done in Ghana, Guinea, Myanmar and Nigeria, the study indicated that women who were not physically or verbally abused, or discriminated against were more likely to be satisfied with care and would recommend the facility to others compared to women who were verbally abused and stigmatised (18). However, in the same context, more than 85% of the women were overall satisfied with the care provided, while 35% of the women reported experiencing physical or verbal abuse, stigmatism or discrimination, which suggests mistreatment has been normalised (18). Many participants perceived healthcare providers as rude, judgemental, neglectful and discriminatory (27) and that these unfriendly and inappropriate behaviours displayed were threatening and made women feel uncomfortable (36). With healthcare providers' lack of support, help and facilitation of the labouring process, health care providers were depicted as obstacles, making the birth process more difficult (35).

Women verbalised that healthcare workers should improve their communication skills, using polite language, and showing empathy towards women during labour as concluded in a Kenyan study (11). Mothers expect midwives to treat them with respect during childbirth and should call them by their names as a sign of respect; similarly, healthcare providers should introduce themselves to reciprocate respectful communication (8, 16). As concluded in a 2020 scoping review, the expectations of pregnant women include friendly attitudes of healthcare providers and the non-existence of verbal abuse still remain an impediment towards achieving quality maternal healthcare (19).

3.3.1.2. Provision of information

Provision of information is defined as the education, explanation and the informing of healthcare users on aspects of their health. It is providing medical knowledge to healthcare users to allow them to be informed on procedures and processes, which lie ahead. Provision for information from antenatal services right through to labour were identified as a determinant for patient satisfaction.

In studies conducted in Nigeria, Ghana, Ethiopia, Kenya, and Malawi, pregnant women were satisfied with the information they received while hospitalised (4, 6, 12, 14, 17, 21, 22, 26, 31). Women were satisfied when advised on medication prescribed and administered by their health care provider (4, 14, 22). The provision of adequate information regarding individuals' health conditions/illness was noted as an important feature of good quality care, which is associated with patient satisfaction in a study conducted in Nigeria (4). The majority of participants in a study conducted in Kenya (14) verbalised that the explanations of procedures received contributed to their overall satisfaction. Women are satisfied when they are informed throughout childbirth and as to why a procedure is being done (8, 17). Women particularly want to be informed as to how many centimetres of dilation has been reached, so that they can have an idea of how they are progressing through labour (35). Two studies from Malawi (26, 33), perceived the care received during antenatal services as good, as advice was provided on what to take with them when in labour (26), and explanations of procedures, medication and the purpose of blood specimens were explained (33). Studies from Ethiopia (12, 31) noted the antenatal factors, which affect patient satisfaction, were the provision of advice on HIV/AIDS, STDS (sexually transmitted diseases), family planning, vaccinations, nutrition and place of birth being discussed. As a study from Kenya (14) noted, explanations of procedures and medication are predictors associated with patient satisfaction. As concluded in a study from Ghana (6), women are also satisfied when counselled and reassured regarding procedures, such as a caesarean section.

Patient dissatisfaction was largely attributed to staff's negative attitude towards information (3). Two studies from South Africa (27, 35) reported that staff withheld information regarding the mothers and unborn child's health (27). Narratives of distress

were further characterised by a lack of information regarding the labour and birth process (35). Participants verbalised that their requests for information were met with hostility and threats of violence by the healthcare providers, deeming to be unhelpful. Participants feared asking pregnancy related and general health questions (27). Being denied access to medical information about labour/birth and receiving negative responses resulted in women being humiliated and disempowered, reducing them to a state of passivity in which they were unable to be active participants in their own birth experience (35). From a study conducted in South Africa (5), mothers were dissatisfied with inadequate explanations of procedures. Mothers were also asked to consume medication without any explanation according to a study from Zimbabwe (36). Due to the lack of information provided by healthcare professionals, many women do not realise and value the importance of attending a health facility (2, 9). Women seek to receive appropriate education regarding nutrition, dietary requirements, recognising complications and good foetal development (2). Mothers would like to be provided with information on how to look after themselves and their babies at home, including breastfeeding as stipulated in a study from South Africa (5). As per a study from Nigeria (15), women recommended that feedback, counselling and education of women should be provided to improve patient satisfaction.

3.3.1.3. Respect for Human Rights

According to the United Nations Children's Fund (UNICEF), Human rights are standards that recognize and protect the dignity of all human beings. These rights govern how individuals live and interact in society. (What are human rights?, 2022) The Human Rights Charter has been established by the Department of Health and is committed to upholding, promoting and protecting the human right to healthcare services. Access to healthcare and a safe environment, participation in decision-making, informed consent, privacy and confidentiality and the right to complain about healthcare services all form part of the Human rights Charter (Guidelines for a good practice in the Healthcare Professions, 2008).

The expectations of pregnant women were privacy, confidentiality, and informed choice to reach patient satisfaction (19, 23).

Privacy is a key element for women utilising maternity facilities, for physical examinations as well as for the birth process itself (4, 5, 13, 14, 17, 20, 21, 22, 30). Privacy is an essential component of a good healthcare facility (30). According to a study from South Africa (16), the lack of privacy within the healthcare facility was a recurring theme among participants. Healthcare providers often breached the patient's right to privacy during care, with some women reporting that they could see and hear other women giving birth (16). A woman narrated how her privacy was compromised as she was left exposed and naked, while waiting for theatre (32). Due to the availability of screens providing privacy during examination or when undergoing a procedure was a determinant of patient satisfaction in Ghana (21).

Patient dissatisfaction is also due to the lack of confidentiality (16, 21, 33). Healthcare providers tend to speak loudly when discussing women's health status, which was done in front of other patients without respect for confidentiality. Hearing news about a stillbirth or the death of a baby contributed to the stress and anxiety of women during labour (16). According to a study from Ghana (21), participants appreciated healthcare providers speaking quietly to maintain confidentiality. Women who are assured of their confidentiality rated the quality of interpersonal relationships higher than women who had not experienced confidentiality (33).

Higher satisfaction scores were given from women when involved in decision-making (18). Mothers were dissatisfied with when they had no choice of birth position and when they were not asked to consent before a procedure (12). Mothers were prone to score care poorly due to having no choice in a healthcare provider regarding gender or the credentials of the healthcare provider (Dr, Midwife, or Student Midwife) (1, 10). Women seek to be included in decision making regarding their care (5, 16, 34). The non-involvement of a mother in decision-making regarding her care resulted in a number of unanswered questions according to a qualitative study from Uganda (32). A South African study concluded that mothers expect healthcare providers to recognise their own opinions; mothers do not want to be controlled but rather be an active participant in their own care (8).

Factors associated with quality of care are, consent seeking, assurance of confidentiality by healthcare providers, and free movement during labour (13, 33). Women reported different experiences regarding their cultural and religious needs being respected (18). Cultural practices such as being assisted by a female healthcare provider were not adhered to in Kenya (34). Facilities which were respectful towards culture were more likely to be utilised according to a study from Ghana (12).

3.3.2. Support

The category “support” is defined as providing assistance, safety and comfort to a healthcare user during their hospitalisation. This allows the healthcare users to be aware of all support systems around, ensuring they feel loved, and cared for. Supportive care manifests itself in several ways. These include the presence of a healthcare provider when needed, a birth companion throughout labour and birth and basic necessities such as clean water and food.

Three sub-categories were included under this category namely staff presence, birth companionship, provision for basic needs and timely treatment.

3.3.2.1. Staff presence

In studies conducted in Ghana, Kenya, Nigeria and South Africa, pregnant women were left dissatisfied with healthcare providers as they felt neglected, abandoned and unsupported during labour (6, 11, 15, 16, 17, 35). In two South African studies (16, 35), women described being left unattended for several hours without attention or monitoring while in labour. Women were informed by the healthcare providers to call when birth was imminent, with one woman narrating how she witnessed a birth without professional assistance (16). Neglect and abandonment were indications of unsupportive care (17). Healthcare providers failed to assist women and abandoned them in critical moments such as during the actual birth, this left them feeling helpless in the most needed time of assistance (17, 35). Patient dissatisfaction was characterised by lack of connection between labouring women and their healthcare providers. Women described narratives of distress where they cried out for help with nobody responding to their calls for support, attention or assistance (15, 35). Healthcare providers were described as being busy or socialising among themselves

(35), leaving women feeling alone, with a sense of being forgotten and invisible (6, 16, 35). Feelings of neglect, abandonment and lack of support from healthcare providers heightened feelings of anxiety and fear (35).

Pregnant women desired midwives to be present and available (7, 8, 13), this is deemed as an important aspect of quality of midwifery care according to a South African study (7). Women expect midwives to show an interest in them and their welfare (8). Adequate attention from healthcare providers include attention without time constraint and hasty advice (4). Women desire to be guided, encouraged and reassured throughout labour (7). Women appreciate the support of a healthcare provider as it alleviated their fear and anxiety (6, 21), and according to a study from Ethiopia, women who were provided with continuous support were more satisfied with the care provided (12).

Besides the fact that women seek the presence and availability of healthcare providers, emotional support is an important factor to women according to a Ghanaian study (6). A study from Kenya (17) stated that pregnant women find comfort when healthcare providers inquire about their emotional state. A positive experience is associated with healthcare users being provided with physical and psychological support through counselling (32). The support and presence of a healthcare provider combined with the support of a birth companion (as discussed below), all contribute to the emotional support of a pregnant woman.

3.3.2.2. Birth companions

Throughout this scoping review, narratives of distress are verbalised due to the lack of a companion (1, 12, 16, 17, 34, 35). A study from South Africa (16), reported that women wished to have a birth companion during labour and birth, however despite being informed by notice boards in the ward that birth companions were allowed, healthcare providers refused access to birth companions. In a similar study from Kenya (17), healthcare providers refused to allow birth companions, citing health policy that disallowed birth companions due to the lack of sufficient space in the wards and privacy constraints at the facility. The lack of support by the healthcare providers combined with the lack of a companionship throughout the labouring journey, left the women

feeling stressed and unsupported (16). The denial of a birth companion was particularly distressing for primigravida (first time mothers) (35). In the context of a foreign and emotionally hostile environment, several primigravidas narrated that the absence of a familiar support system was anxiety-provoking (35). The lack of a companion has been identified as a form of suffering that heightened stress and fear during labour, making labour and birth more difficult and emotionally taxing for women (35). According to an Ethiopian cross-sectional study (12), evidence suggests that a companionship of choice during labour and childbirth may increase spontaneous vaginal birth, reducing the caesarean section rate and instrumental vaginal birth. When healthcare providers encouraged the presence of a companion, mothers were twice more likely to be satisfied with the care received than those who were not (12).

The presence of a chosen companion during labour and delivery significantly enhances a woman's satisfaction with her overall birth experience, as evidenced by studies conducted in Ethiopia, Uganda, and Malawi (13, 32, 33). The Ugandan study (32), highlighted mothers' appreciation for the emotional and physical assistance demonstrated by their chosen birth companions (mothers, sisters, mothers-in-law, aunties and husbands). Women appreciated being supported physically, by being provided with food and drinks, they were supported to walk around and having their backs rubbed to provide relief during contractions by their birth companion.

Physical support, such as providing food and drinks, encouraging movement, and offering back rubs for pain relief during contractions, was particularly appreciated by women. Another Ethiopian study (13) echoed these findings, emphasising that the labour process can be emotionally taxing, and having a familiar companion to share concerns and provide encouragement significantly contributes to a successful outcome (13). Mothers expressed that gaps in healthcare services could be filled by their companions, and the absence of such support may lead to decreased maternal satisfaction and even unassisted home births unless addressed.

Women prefer to have a birth companion present rather than being left alone (1). The denial of a birth companion is associated with a negative birth experience (17), which contributes to fear and anxiety (34).

3.3.2.3. Timely treatment

The promptness of treatment plays a crucial role in determining patient satisfaction, as evidenced by several studies (4, 12, 14, 17, 22). A study conducted in Kenya identified that patient satisfaction is closely linked to the timeliness of care, as well as the availability and preparedness of healthcare providers to deliver services when needed by women (17). Women verbalised their satisfaction and appreciation when healthcare providers came immediately and were ready to provide assistance when called (17). According to two cross-sectional studies conducted in Ethiopian studies reporting on timely treatment (12, 22), one concluded that healthcare users were 2,5 times more satisfied when attended to within 15 minutes compared to women who waited for a longer period of time to be seen (12). The other noted that women were more satisfied with less extensive waiting times, however was not specific about the length of an acceptable waiting time (22). Timely treatment appears to be a key determinant of patient satisfaction with maternity services (14).

However, prolonged waiting time for assistance is also an important determinant of patient dissatisfaction with services rendered by the maternity staff (14, 15, 17, 18, 20, 26, 27, 29, 34, 36, 31). Patient dissatisfaction manifested itself in various ways including poor reception at the facility, long waiting times before being attended to and non-responsiveness of the healthcare providers (17). From a study conducted in Kenya, women reported being denied entry at the hospital while being forced to return home without assistance. Women continued to describe waiting for hours to be attended to without explanation. Regardless of the unresponsiveness and lack of prompt treatment from the healthcare provider, women were explicitly told to not call for the nurses for help and were scolded when they called for assistance (17). Delayed onset of treatment combined with poor, insufficient quality contact time with a healthcare provider is to be attributed to the shortage of staff according to three Kenyan studies (14, 17, 34). Similarly, in two Nigerian studies, participants verbalised the poor time consciousness of the maternity staff, describing that their (the patients') early arrival at the hospital does not guarantee assistance (15, 20). One narrative in the study continued to describe her experience of women shouting and crying, without healthcare providers making any indication to attend to them (15). Dissatisfaction with prolonged waiting times was not only due to insufficient staff but was said to be due to

the provision of a free maternal healthcare system (20). Besides the prolonged waiting time due to insufficient staff (2), one participant verbalised that if one did not know someone at the hospital, one would not receive care leading to favouritism as a reason for patient dissatisfaction (20). From two qualitative studies conducted in Malawi, the concern among the delay in provision of care was striking (26, 29). Participants were dissatisfied when kept waiting at the antenatal clinic when it was opened late or were unattended when visiting the health facility (26, 29). It was concluded that the quality of care received from the healthcare providers during childbirth was much lower compared to the care received during the prenatal period as women complained more about delayed assistance while in labour (29). The delayed response of healthcare providers made pregnant women feel neglected and abandoned as they waited for hours before being attended to, which made them feel unimportant (27).

Prolonged waiting times are strongly associated with lower overall satisfaction scores (18, 31) as well as an important factor determining access and utilisation of the healthcare facility (23).

3.3.2.4. Provision for basic needs

The lack of appropriate pain management while in labour is an important determinant of patient dissatisfaction, as reported in a number of studies (1, 5, 12, 16, 20). From a study done in South Africa, no participants received any pain medication (16) and participants in a Nigerian study felt that healthcare workers did not care about their pain complaints (20). One study conducted in Kenya (14) noted the absence of pain medication administration; however patient satisfaction was still achieved. In another Kenyan study (17), patient satisfaction was obtained due to the effectiveness of pain remedies, such as movement and massage, and ‘health workers going out of their way’ to advise patients on pain management during childbirth. One study conducted in Ghana (21) acquired patient satisfaction due to mothers being encouraged and reassured by health care workers during labour. Mothers verbalised that the provision for comfort and pain relief is a necessity to patient satisfaction (12, 15, 22).

Inadequate and poor quality of meals emerged as a factor associated with patient dissatisfaction (6, 17, 28, 29, 34). An Ethiopian study concluded that mothers who

received coffee and porridge were two and half times more satisfied compared to mothers who did not receive coffee and porridge (12). A Malawian study noted that the overall quality of care is negatively rated when mothers are inadequately fed (29). This contributed to the findings of two Kenyan studies which found that clean drinking water is seen as an essential component of a good healthcare facility (30) and that the quality of meals are predictors associated with patient satisfaction (14). The denial of essential birthing items, such as sanitary towels, buckets and warm water for bathing left women feeling unsupported (17). Provision of warm water for bathing, clean sanitation facilities, stable electricity, quality food and availability of feminine hygiene products were essential components of a good quality facility as evidenced by studies conducted in Kenya (14, 17, 28, 30).

Several studies from the scoping review indicated that a clean environment affects the utilisation of a healthcare facility (5, 11, 12, 14, 15, 18, 20, 22, 34). According to a South African study, mothers are more satisfied when assisted in a clean environment (5). According to three Kenyan studies (11, 14, 34), women were dissatisfied with the cleanliness of the maternity ward, and found the environment unhygienic (14, 34). Women asked to be attended in a clean healthcare facility upholding basic standards (11). Reasons for satisfaction included a clean environment, especially the toilets (18, 20, 22) and appropriate infrastructure with adequate electricity and water (18).

Women expressed that they desired to feel safe with fear and uncertainties eliminated (8, 17). A Kenyan study noted how women were concerned about the security of their new-borns after being informed by other women's experiences of new-borns being stolen or exchanged (11). The aspect of safety revolves around the provision of ambulances (12, 24, 25, 34, 36). Women seek to be reassured that working ambulances are available with a good referral process set in place (17). A study from Ghana (24), found the referral process problematic due to poor transportation arrangements leading to patient dissatisfaction.

3.3.3. Service Provision

The category "service provision" refers to the presence and accessibility of trained and experienced healthcare professionals along with the necessary resources like equipment and supplies crucial for labour and childbirth. Adequate service provision is

evident in various forms, such as compassionate care from proficient healthcare providers, a comforting atmosphere with sufficient beds and linens, and available and safe transportation for easy access to healthcare facilities. Within this category, three sub-categories were identified: Human resources (Quality and quantity of staff), other resources (Supplies, equipment, and physical space), and Access to a facility.

3.3.3.1. Provision for human resources (Quantity and quality of staff)

Throughout Sub-Saharan Africa, concerns relating to understaffing, inexperienced healthcare professionals and lack of kindness among healthcare professionals were noted to have an influence on patient satisfaction.

In a Ghanaian study, participants highly appreciated and valued knowledgeable and skilful midwives (21). Trained professional staff were highlighted as a positive aspect of a healthcare system, with participants expressing satisfaction in the competence of healthcare professionals handling complications effectively (29, 30). A Ugandan study specifically emphasised the participants' positive perception of how labour complications were managed within the healthcare facilities, which increased patient satisfaction (32).

Good quality nurses also influenced patient satisfaction (4, 5, 21, 22). The quality of healthcare professionals were acknowledged through the thoroughness of examinations conducted by both doctors and midwives (5), highlighting frequent examinations, the availability and willingness of nurses to assist and the collaboration of care among midwives and doctors (21). Patient satisfaction was expressed due to the competency and helpfulness displayed by healthcare providers (5, 21, 22).

According to a Malawian study, patient satisfaction was related to the midwives friendly demeanour, which included the absence of harsh language, respectful treatment and a good temperament (21). Components of staff conduct and practice were judged relatively high which were honesty, compassion, respect, openness, and dedication; these provided a significant influence on the perceived quality of reproductive health services (30).

Just as qualified, experienced nurses were considered important, by contrast the articles showed that a lack of experience and qualified nurses resulted in poor patient satisfaction (11, 23, 24). Two Malawian studies (23, 24) concluded that women sought knowledgeable and motivated healthcare providers, who they could trust, indicating that young midwives possess book knowledge, but lack empathy and the ability to relate to their experience (23). Some participants were of the opinion that more experienced healthcare providers offered higher quality services resulting in a better birthing experience (24). According to a Kenyan study, women feared being attended to by unsupervised trainee doctors as they were inadequately prepared to attend to them and prone to making errors (9).

Dissatisfaction was also noted due to inhospitable midwives (2, 29, 32, 34), this influenced women's intrapartum attendance (2). Based on a Malawian study (29), women reported instances of unfriendliness and vulgar language from healthcare providers. Similarly, in Ugandan (32) and Kenyan studies (34), women described poor birthing experiences due to the non-caring attitudes and lack of kindness, honesty and understanding among healthcare providers (34). According to a South African study (16), the lack of respect and empathy in how healthcare professionals spoke to women during labour decreased patient satisfaction. Nurses did not acknowledge the women's distress but rather treated them with contempt (16). Neglectful care included examples of behaviour where nurses refused to help or support women during labour (16, 17), leaving women feeling abandoned during labour and birth (17). Findings from a study conducted in Kenya (25) concluded that women highly value their childbirth experiences and the factors such as healthcare providers' attitudes affect the utilisation of the healthcare facility. Women would like to be supported, treated with respect and politeness by hospital staff and be provided with better care (6).

Additionally, several studies indicated dissatisfaction due to insufficient staff (2, 3, 8, 9, 11, 15, 20, 24, 25, 34). Due to poor staff/patient ratios, healthcare professionals did not perform thorough check-ups due to time constraints according to a Nigerian study (20). This also resulted in long delays in treatment (2). In a South African study, women stated that they (patients) outnumbered the midwives in the facility (8). Based on a Tanzanian study (9), dissatisfaction resulted from acute shortages of midwives leading to inadequate care and mismanagement of women with obstetric complications and

unqualified staff conducting births. Similarly in a Kenyan study, women perceived poor quality of care when there were insufficient nurses to accompany them during labour and birth, this led to many feeling abandoned and forced to birth their babies on their own (11). Due to staff shortage, women identify poor clinical care such as unnecessary caesarean sections (11). Participants were unhappy when postnatal assessments were not done on them or their babies (26). According to a Ghanaian study (24), besides feeling abandoned, women were unhappy as they felt that the quality of care they received was compromised due to the limited staff.

3.3.3.2. Provision of other resources (supplies, equipment, physical space)

According to several studies, women expressed a preference for a welcoming environment and comfortable lodgings (1, 7, 13). According to an Ethiopian study (13), women were more likely to be satisfied by a welcoming environment. Just as in a South African study (7), women indicated that they desired comfort and a pleasant environment. Dissatisfaction was associated with substandard facilities, including dirty environments, lack of sanitation, and unclear signage (15, 28, 34). This directly influenced women's decisions on where to give birth. According to one Ethiopian study (12), the main source of patient dissatisfaction is the hospital's environment. Reasons for dissatisfaction included poor infrastructure, which contributed to the lack of privacy (16), poor sanitation (19), a dirty environment and substandard facilities (15). A poor healthcare facility contributed to a negative birthing experience (17).

Regarding comfortable lodgings, mothers outnumbered the available beds and chairs, according to a South African study (8). Mothers wished for larger facilities to accommodate them safely and comfortably (8). In both a Kenyan (14) and a Malawian study (3), women reported that they were required to share beds during their hospital stay. It was also noted that their babies were also required to share incubators (14). The inadequacies of the physical infrastructure, such as the dilapidated state of the maternity wards and the poor quality of the maternity beds and bedding resulted in patient dissatisfaction (24, 34).

Besides the concern of inadequate beds, another factor was raised with regards to the lack of drugs, equipment and supplies (3, 9, 15, 24, 25, 28, 29, 34). The inadequacies

of drugs included blood for transfusion according to a Malawian study (3). In a Tanzanian study, midwives reported a daily shortage of essential drugs and supplies (9). The majority of participants in a Ghanaian study considered the equipment in hospitals as insufficient and inadequate (24). A Kenyan study concluded that women's experience of care during birth and the availability of equipment and supplies may affect the utilisation of a healthcare facility (25). In a Malawian study (29), it was noted that facilities without medical equipment such as a scanning device affected quality of care among women during antenatal utilisation. Due to inadequate equipment, supplies and treatment, participants were dissatisfied (3). The most highly valued attribute for women when making a choice of a birthing facility was the attitude of healthcare workers; this was followed by the availability of medical equipment (25).

Satisfied participants gave reasons that revolved around structure and process, such as availability of routine drugs (15) and the availability of delivery kits (20). Mothers were satisfied when essential supplies were also available for their babies, such as baby clothes, soap and Dettol (20). In a Kenyan study, the availability of medicines is described as a positive element of a healthcare system (28).

3.3.3.3 Access to a facility

The findings of this scoping review indicate that accessibility to a healthcare facility prevents many women from utilising a healthcare facility. According to a Malawian study, women viewed the distance to the healthcare facility, availability and the affordability of public transport to the facility as major factors negatively impacting a women’s utilisation of prenatal services (29). Due to the unavailability of transport, Zimbabwean women were often left having to walk for three hours on a dirt road to seek medical attention at the nearest rural health clinic (36). Distance to a healthcare facility has been found to be one of the factors that impede accessibility of a healthcare facility (33).

Participants of another Malawian study revealed that because the exact timing of labour was uncertain many delivered at home or alongside the road due to the lack of transportation and no male escorts to accompany them to hospital during the night (26). In a Kenyan study, poor road conditions, which slowed travel time often, resulted

in a mother delivering on the side of the road (28). The fear of being harassed or becoming a victim of crime while walking to a healthcare facility influenced women's decision to stay at home which ultimately resulted in a home birth (28). The lack of public transportation money was also identified as an important deterrent of healthcare utilisation (3, 9, 24, 28, 29). Women who had access to motorised transportation were more likely to rate the maternity services highly compared to those who walked (33). According to an Ethiopian cross-sectional study, travel time to a healthcare facility had a positive influence on satisfaction, with women living in an urban environment demonstrating a 2.9% increase in satisfaction compared to women living in a rural area (13). These findings are similar to both a Kenyan and a Malawian cross-sectional study, which concluded that the time taken to access a healthcare facility due to distance is a predictor of patient satisfaction (14, 33).

Additionally, the affordability of healthcare services significantly influenced the utilisation of healthcare services (2, 3, 4, 20, 23, 24, 25). According to a qualitative study conducted in Niger (2), women cited cost of healthcare services as a major barrier, leading to their failure to attend clinics and potentially impacting patient outcomes with missed diagnoses and treatments, thereby reducing the efficiency of the healthcare system. Based on a quantitative study in Malawi (3), participants in this study indicated that services were not affordable or barely affordable with the majority of participants at 87.5% and 47.6%, respectively, responding that they did not use healthcare services regularly. According to two Nigerian studies (4, 20) and one Niger study (2), women believed that providing free healthcare services would increase clinic attendance. Women expressed satisfaction when healthcare services were freely available, eliminating stress and worries regarding the cost of childbirth (20). However, despite the high level of satisfaction reported, a few women blamed the removal of user fees as the reason for poor quality treatment (2).

A quantitative study from Kenya (25), displayed that one of the lowly valued attributes was the cost of childbirth services. However, an unexpected finding in this study was the disutility of lower costs. This finding suggested that the women found value in paying more money for better quality care (25).

3.4 Conclusion

This chapter outlined phase one of this study, which consisted of a scoping review. The scoping review identified the criteria used to measure patient satisfaction in the public maternity services in Sub-Saharan Africa, forming a prior code. A priori codes was used to assist with the template analysis of the semi-structured interviews for phase two of the study.

The next chapter explains the findings of semi-structured interviews.

Chapter 4: FINDINGS OF THE SEMI-STRUCTURED INTERVIEWS

4.1. Introduction

The results of the scoping review (phase 1) were discussed in Chapter 3. This chapter will describe the findings of phase 2 of the study which involved participant interviews. The objective of this phase of the study was to determine the criteria that private sector users use when choosing a maternity service to meet their needs and aspirations. The data was analysed by means of a template analysis using the a priori codes generated in phase 1 of the study to analyse the data.

4.2. Demographic characteristics of the participants

The demographic characteristics, which included the age distribution, the racial distribution, and the parity of participants are described and displayed in Figure 4.1, Figure 4.2. and Figure 4.3 respectively.

4.2.1. Age distribution

A total of nineteen (19) women participated in this phase of the study. Six women (6 or 31.6%) were within the 18-26 years age group, ten women (10 or 52.6%) were within the 27-38 years age group, two women (2 or 10.5%) were between 39-49 years old, and one woman (1 or 5.3%) was older than 49 years old. The majority of the participants therefore fell into the 27-to-38-year category.

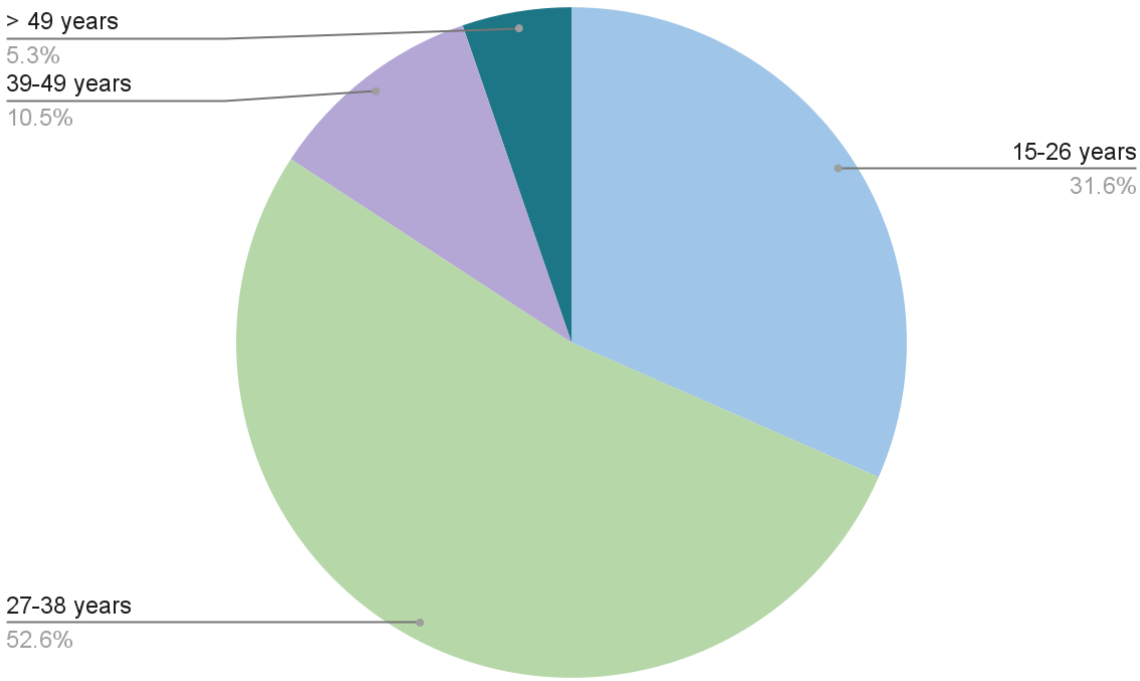


Figure 4.1. Age distribution of participants in phase 2

4.2.2. Racial Distribution

With respect to the racial distribution, fourteen participants were black women (14 or 73.7%), and five were white women (5 or 26.3%). No Indian or coloured women (0%) volunteered to participate in this research study. The observed distribution is likely influenced by socio-economic variations within the community who utilise the private facility where the study was conducted.

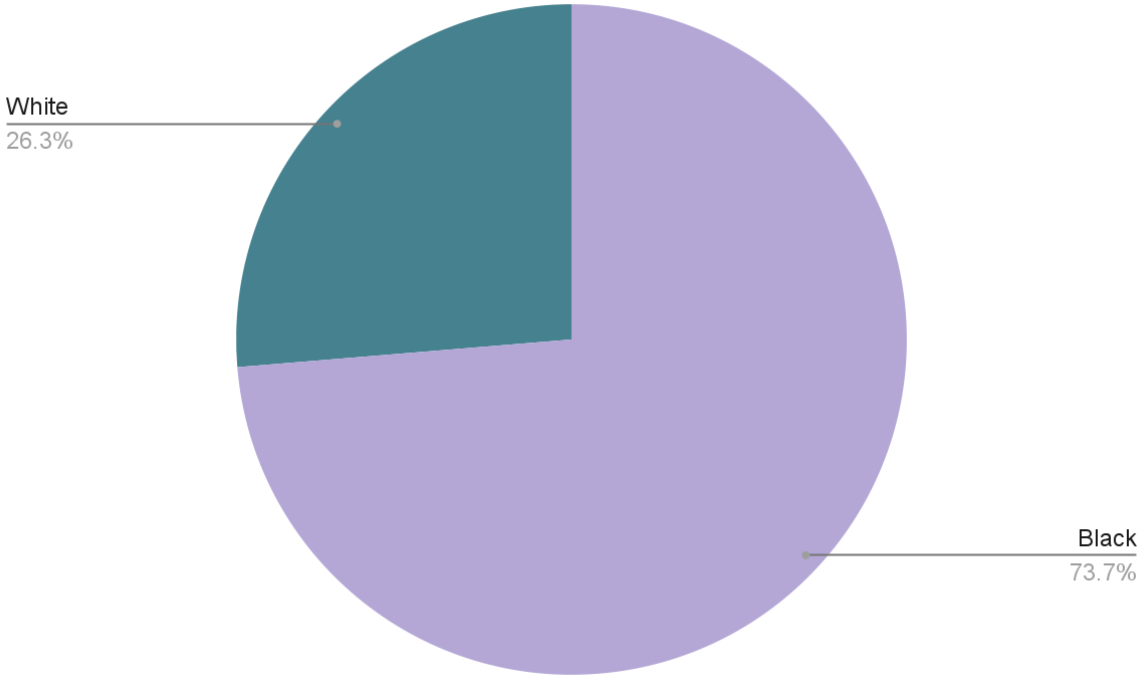


Figure 4.2. Racial distribution of participants in phase 2

4.2.3. Parity of participants

Parity is defined as the number of times a woman has given birth at 24 weeks or more gestation regardless of viability. Of the nineteen (19) participants, five participants (5 or 52%) had either no children or only one (1) child. Two participants (2 or 11%) had two (2) children, four participants (4 or 21%) had three (3) children, and three participants (3 or 16 %) had four (4) children. Figure 4.3 below shows the parity of the participants.

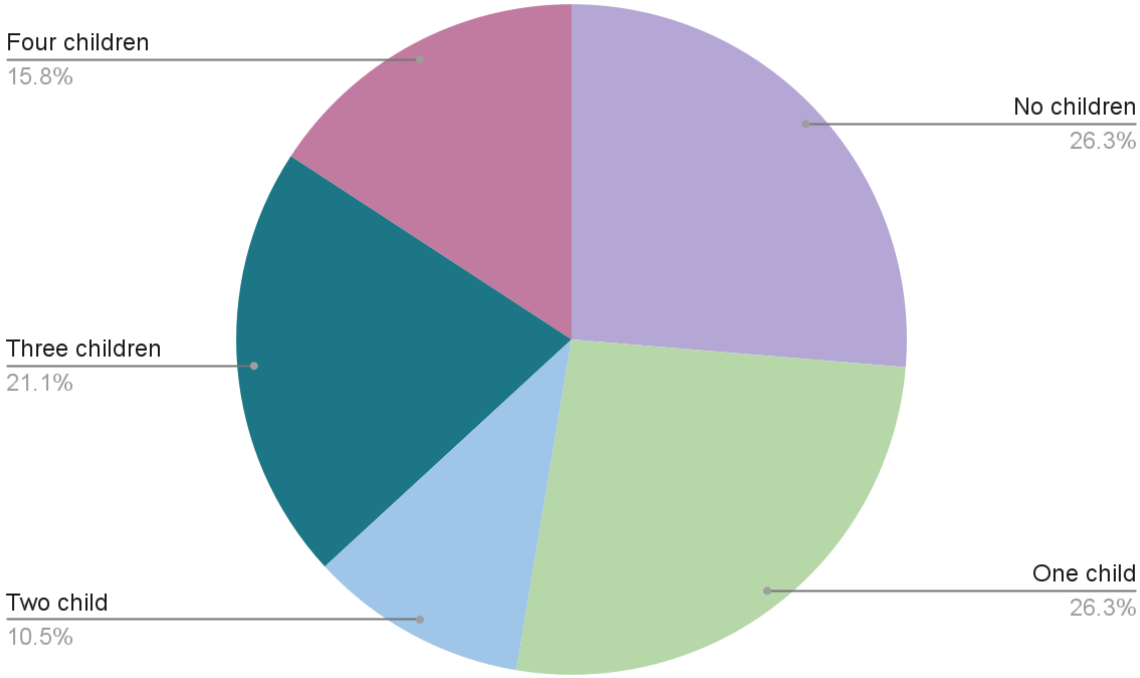


Figure 4.3. Parity of participants in phase 2 of the study

4.3. Location of previous birth experience

Participants who had previously given birth were asked whether they had delivered in a private or a public facility. This information was important to understand the context of their answers to the questions in the interview.

Fourteen (14) of the nineteen (19) participants had experience of childbirth. Of the fourteen (14), four participants (4 or 21.1%) birthed at a private hospital, eight participants (8 or 36.8%) birthed at a government hospital, two participants (2 or 10.5%) had had experience of birthing at both a private and government hospital, and one participant (1 or 5.3%) did not respond to this question.

Figure 4.4 displays the percentage of participants who have birthed at a government hospital and/or a private hospital.

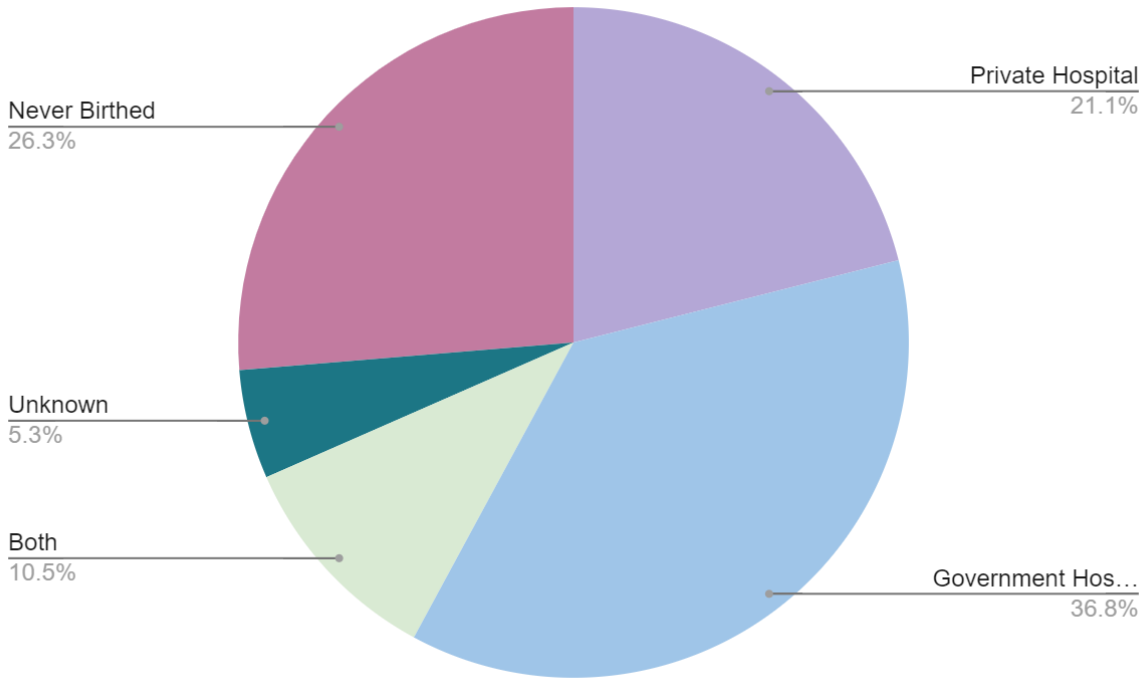


Figure 4.4. Location of previous birth experience

4.4. Findings of the participant interviews and discussion

As explained in Chapter 2 (the methodology chapter), patients were asked several questions regarding criteria or factors that would influence their choice of facility. Many participants had difficulty in answering these questions. Participants answered questions by providing examples from their previous birthing experiences rather than projecting what would influence future choices regarding the facility they wished to birth at. As a result, in order to apply the a priori codes that were used in the template analysis, the researcher had to "reverse" findings. For example, if a participant stated that "the nurses shouted at her" respectful communication would be the opposite i.e. the nurses did not shout. However, to preserve research integrity the verbatim quotes are included in the write up of the findings.

The priori codes which were derived during phase one of the study, and which guided the analysis of this phase of the study, are shown in Table 4.1 below:

Table 4.1. Table of priori codes derived during phase 1

Category	Sub-category
Relationships	● Respectful communication (Respect) ● Provision of information (Information) ● Respect for human rights (Human Rights)
Support	● Staff presence ● Birth companion ● Timely treatment ● Provision of basic needs
Service Provision	● Provision for Human Resources (Quantity and quality of staff) ● Provision for other resources (Supplies, equipment and physical space) ● Access to facility

In this section the findings are reported together with discussion of the findings of the interviews. In the following chapter the discussion will combine the findings of the two phases of the study in an attempt to answer the research question which was: Do private sector health care user's criteria for choosing a maternity service differ from those of public sector users?

4.4.1. Relationships

In the scoping review that formed the basis for developing the a priori codes for phase 2 of this study, positive relationships between healthcare providers and health care users were necessary to ensure that patients felt safe and comfortable, that they were well informed and treated with dignity and respect. They were also important in assisting patients to feel empowered and in control of their care.

It became clear in analysing the data from the interviews that the private health care users interviewed had similar thoughts and those who gave positive examples of care they had received emphasised the importance of the relationship between health care provider and health care user. Many spoke of negative past experiences and poor relationships with their health care providers, which inevitably had an impact on their birth experience and also future expectations and concerns of how they would be treated when having another baby.

The data for this category fitted the a priori codes indicating similarities between the data from phase 1 and 2 but the intensity of many of the participants' responses in phase 2 showed just how important positive relationships are in midwifery.

4.4.1.1. Respectful communication

Respectful maternity care has developed into an all-embracing concept or approach that focuses on respecting the rights of mother and baby and providing personalised care (Moridi et al, 2020). All the literature on the subject, however, refers to communication as an essential component of providing respectful maternity care. Moridi et al (2020) refer to "establishing friendly relationships" and Collins (2022) found that communication was the most important aspect in providing respectful maternity care, which assisted in patients feeling heard, being able to make decisions and having their dignity preserved. Hughes et al, (2022) reported that communication, while being essential in supporting respectful maternity care, was the most neglected aspect. Without communication, most other elements of respectful care will not be possible.

Finding peer reviewed articles on respectful communication as such is challenging, as searches result in articles of respectful maternity care as explained above. An un-authored Linked in communication (Linked in, undated) explains that respectful communication involves being clear, honest, and polite as well as non-judgmental and appreciating the diversity and uniqueness of each person (including) their cultural and personal background. Respectful communication constitutes a framework for interpersonal interaction, which involves the cultivation of an environment where participants are treated in a pleasant manner, which includes kindness, politeness, and patience (Beydoun, Beydoun, 2013). A culture of respectful communication should be evident right from the moment women enter a facility until discharged. Respectful communication can be seen as warmth, gentleness and a tenderness to one's language, providing a welcoming and safe approach to the healthcare services being provided (Shakibazadeh, Namadian, Bohren, et al, 2018).

In this study, participants perceived respectful communication as verbal expressions including greeting and using appropriate language. The participants also spoke in broader terms of the need for the midwife to be present or attentive and their attitudes

of kindness, patience and gentleness that were not specifically communication but were part of providing respectful communication.

Participant 19 appreciated a welcoming atmosphere, whereby they are greeted by a friendly smile. She said, *“I would be greeted by some friendly face”* (P19). Smiles were also important to P12 who said*, “I want them to communicate with me very nicely and smile and be happy”* (P12). Participant 14 used the words *“They should be kind, respectful”* (P14), and participant 13 said, *“...must be polite and friendly*” (P13). Participant 3 verbalised, *“I think the service must be gentle. Yeah, kind, yeah, have patience”* (P3). The words health professionals use are also important in terms of respectful communication as illustrated by participant 12 who said, “*I want them to speak a nice language”* (P12), and added *“they should be friendly and, like. I don't know, just decent – nice’’* (P12).

Participants continued to express a strong preference for respectful interaction, which is characterised by kindness, friendliness and politeness. Participants 14 emphasised the importance of a considerate approach, stating, *“She (nurses) should be nice. Attentive, there should be respect between the two of you”*. The sentiment against harsh behaviour was echoed by the same participant, *"She (nurses) shouldn't shout at people."* Several participants stressed the need for kindness and respect, with participant 14 noting*, "They should be kind, respectful,"* and participant 13 emphasising the desire for healthcare professionals to be *"...polite and friendly…"* while exhibiting patience. *“They must be polite and kind. Be patient.”* (P9). Others, such as Participant 12, emphasised the significance of a pleasant and friendly communication style*: “I want them to speak a nice language”. “They should be friendly and like I don't know, just decent. Nice. Don't yell at me."*

Three participants continued to emphasise that they should be treated with the same level of respect that the healthcare professionals afford to themselves *“They must respect me, like how they respect themselves. I’m also human.”* (P3), she continues, *“So you must respect me the way you respect yourself”* (P3). Participant 19 expressed that pregnant women wish to be acknowledged and treated beyond the context of illness. The participant wants healthcare providers to understand and recognize the human aspect of pregnancy, highlighting that being pregnant does not solely define

them as patients but as individuals undergoing a unique life experience. *“Just understanding that you're a human and not just a patient, like you're not there because you're sick”* (P19). *“Be straight with me. So tell me as it is, But with compassion, and gentleness, and with care to show that I'm not just another woman giving birth, but I'm human, I'm an individual”* (P16). The statement of being human highlights the expectation that women, regardless of their role or condition deserve to be treated with dignity and consideration. Healthcare professionals should resonate respectful communication that is compassionate and understanding that acknowledges the broader aspects of their identity beyond their medical condition.

While the above quotations provided information about respectful communication, the many negative comments indicated what troubles the participants and reinforces what is wanted, although not received, in terms of respectful communication.

Women were treated with disrespect; being shouted at, ignored, and left unheard. *“...they were aggressive…”* (P2), *“...they were shouting at me.”* (P2), *“...they just not patient”* (P5), *“...feel like they are rude…*” (P6*), “They shouted at us, not treating us well”* (P5)*. “... some are rude and they don't want to listen to you”* (P11). This implies that dissatisfaction with previous care stemmed from healthcare professionals' failure to provide respectful treatment. Establishing respectful communication is essential for a positive relationship and nurturing a healthy, supportive dynamic between patients and healthcare professionals, ultimately leading to increased patient satisfaction.

The absence of responsive care among the health professionals emerged as a significant concern, several participants recounted experiences where healthcare professionals failed to assist them despite seeking help: *“They don't want to attend to you”* (P5). Participant 1 explains her experience where she was told to sit and wait for assistance, *“she was being rude to us. It was not because of being tired ", "you cannot be rude to people just because of being tired”* (P1), *“Most of the nurses there are rude, they don't care. So sometimes you feel like you made a mistake by going there.”* (P9), *“they are not nice, it is like they don't even care”* (P14).

Furthermore, numerous participants perceived a sense of discontent and job dissatisfaction among healthcare professionals. Consequently, eliciting a sense of

animosity towards them. Additionally, the impolite and impatient demeanour displayed by healthcare professionals contributed to women feeling intimidated and reluctant to ask questions. Participant 1 verbalises; *"don't make them feel like, when they come to the hospital, you're just tired of them, don't even want to be there, like you hate your job, they displayed hate to us. They don't like their jobs"*, she continues; *"It made me feel like I'm making them suffer by coming there, like I'm not supposed to be here"*. (P1) "...it is like they are forced to do their job" (P14). *"I was scared because it's my first child"* (P2), *"they are rude, like even when you want to ask something, like you would like feel scared, like to ask them"* (P6).

Respectful communication is essential in building positive relationships, creating a healthy and supportive patient-healthcare professional relationship, which ultimately results in patient's satisfaction.

4.4.1.2 Provision for information

Provision for information is known to be a prerequisite for patient satisfaction and requires sufficient time to be put aside to talk to and listen to patients (Karaca & Durna, 2019). Communication between the health provider and the patient helps build trust and can affect patient outcomes and behaviour (Lotfi et al, 2019). While written information may be helpful to patients, patient centred communication and provision of information is an essential component in delivering quality patient care and is valued by patients (Alshammari & Guilhermino, 2019).

Participants in the study gave several examples of information they had received indicating that they valued this information and that it was an important component in choosing a healthcare facility. Participant 1 gave one example, saying, *"the midwife even showed me how to hold my baby, how to put the breast in the mouth".* Participant 5 related how the doctor *"explained to me that the baby was not sitting in the right position".*

Participants also highlighted the importance of having their questions answered. Participant 6 said, *"when I did not understand something I was asking them (nurses) then they answered me."* This same participant commented on the initiative taken by

healthcare professionals to enhance her learning opportunities, *"...they also gave me the parenting app, where you will learn more about pregnant women"* (P6). Highlighting the participant's eagerness to enhance her understanding through accessible and informative resources, ultimately contributing to a more positive and informed childbirth experience.

Some participants spoke of the manner in which information is conveyed. Participant 3 stated*: "I would like them to give me more information because it's my first time."* (P3). Participant 14, said that information should also be provided in a way that is understood and complete: *"...explain things thoroughly."* (P14). Participant 11 believed that education regarding breastfeeding is essential to a positive birthing outcome: *"... it is important because breast milk is healthier than the bottle, so I would like the nurses in that place to influence the mothers to give at least maybe 6 months…"* (P11).

Participant 17 agreed that information was important whether it related to good or bad news. She said *"They should put her at ease, telling her exactly what is happening to her and reassure her that she is going to be okay."* (P17), *"They must tell me what is happening, whether it is good or bad. If there are problems, what is the way forward…"* (P17).

Participant 16 expresses her thoughts on education: *"Well, birth is unpredictable, and never the same for any one woman. I feel educating the mother to be and her partner, if he's involved, prepares the family for any potential outcome. Therefore, (education) could lead to a smoother, more happy birth. And therefore, good bonding with the child and good postpartum experience."* (P16). Participant 19 believed that education prepares individuals, adding a sense of relief to an unknown situation and allowing for informed decision-making. She said, *".. they must be giving you the information and allowing you to make the decision"* (P19).

As with the previous category, many participants gave examples of poor or lacking information provision. Participant 1 expressed a desire for clarity with regard to information, stating, *"You (should) just explain to me what you think might happen, and (not) have me just sit there not knowing what's going on."* (P1) Similarly, Participant 3 lamented, *"They do not tell you anything. You'll just see by yourself,"* (P3) emphasising

the prevailing sense of abandonment and the absence of proactive communication and education. Participant 15 conveyed a sense of neglect when seeking guidance, stating, *"They show no interest in helping you."*

Participant 17 recounted her induction experience, highlighting the deficiency in information provision: *"They informed me on my dilation, but they did not tell me why I got an induction and what happens when being induced."* (P17). She emphasised the need for anticipatory knowledge, expressing, *"I would have felt better beforehand if I knew what induction means, and the process and that it could lead to an emergency caesarean. In hindsight, I probably would not have agreed to an induction if I knew."* (P17).

The need for information was evenly more strongly felt when participants experienced difficulties. Participant 1 disclosed, *"I didn't know how to actually hold her and how to actually breastfeed,"* (P1) while Participant 15 also revealed the challenges with breastfeeding and the absence of guidance: *“They say that motherly instinct kicks in, but it doesn’t kick in immediately. I struggled a lot with breastfeeding, the child didn’t want to drink, I didn't know how to get her to feed. If someone could have just shown me what to do...”* (P15). Participant 2 echoed this sentiment, recounting a distressing lack of information during a critical situation involving her baby's health: *"...they didn't explain anything, they just told me that the heartbeat… your child could have been dead…I didn't know what was the cause."* (P2).

The need for personal guidance was further emphasised by Participant 2's experience in the neonatal ICU, where she struggled with tube feeding*: "They tell you, but they don't show you how to do it."* (P2). This sentiment was reinforced with a call for more practical education: *"They need to show you how to do it and how to pour inside the pipe."* (P2). Additionally, Participant 8, reflecting on her accidental home birth, highlighted a lack of awareness, stating, *"It was my first pregnancy, so I wasn't aware if I got pains, I'm going to have a baby. I just kept quiet and said maybe it will be better."* (P8).

Participant 15's concerns extended to the medication given to her new-born, expressing distress over the lack of information*: "They did not inform us on the medication they gave us, my child was just sleeping."* (P15). She continues to

verbalise: *“They don't tell the parents what they are giving your child; no one tells you what is going on.”* (P15).

This lack of transparency led to heightened anxiety, with the participant fearing the worst: *"They should inform us as parents a lot more because they leave your child, and I was very worried thinking my child is busy dying."* (P15).

The participants' narratives regarding the provision of information collectively underscore the critical need for improved communication, education, and hands-on support during childbirth experiences to empower individuals with the knowledge and confidence needed for informed decision-making and care.

4.4.1.3 Respect for human rights

According to Hausen and Launiala (2015), writing for the United Nations Children's Fund (UNICEF), human rights are standards that recognize and protect the dignity of all human beings. These rights govern how individuals live and interact in society. The Human Rights Charter was established by the Department of Health and is committed to upholding, promoting and protecting the human right to healthcare services. Access to healthcare and a safe environment, participation in decision-making, informed consent, privacy and confidentiality and the right to complain about healthcare services all form part of the Human Rights Charter. (Guidelines for a good practice in the Healthcare Professions, 2008).

Knowing what human rights are and respecting them are not the same thing. Nampewo, Mike and Wolf (2022) point out that while health workers are assigned duties to care, respect and protect human rights, it is not possible to legally enforce such respect and protection leaving health care users open to disrespect. Gutterman (2023) echoes this opinion but refers to the need to “embed” human rights into policy documents and that the task of ensuring implementation should be assigned to a level of management. All the participants who raised issues related to the respect for human rights assumed it was the obligation of the health professionals to be respectful. The participants were specific about the types of human rights they wished to be respected rather than any system to protect them that did, or did not, exist.

Amongst the responses from participants explaining what they require to satisfy them, they referred to the importance of informed choice. Participant 19 said, *"I think informed consent, not imposing their ways without consulting me."* (P19), She continued, *"I don't like being told I have to do something. I like to make that informed decision."* (P19). Participant 16 explained how she would like to be in control in a difficult situation, "*So I would expect the care providers to explain fully why they think there is something wrong, that increases the risk and give me options. Don't tell me exactly what I have to do now. Give me a choice. Even if it's a hard and fast one and a hard one to make, give me the choice to be in charge of my pregnancy."* (P16) Participants want to be respected and heard by healthcare professionals, *"What you are choosing is valued."* (P19).

Privacy is one of the human rights. Of those who spoke about privacy both participant 6 and participant 10, spoke positively of their experiences and the importance of having their own room. *"I had my own room, I was not sharing"* (P6), *"The privacy, get all the privacy that you want because you have your own room"* (P10). The benefit of having your own room is highlighted by participant 19, where healthcare professionals respected her privacy by knocking before entering, *"...I think that's part of like having your own room where I mentioned hospital experience, like it is nice to be able to not just be barged in on…they will at least knock."* (P19).

Another human rights issue raised by participants was that of safety. Participant 6 spoke about how safe she felt, *"... it's safe and there are security guards all over and even the doors were locked and when you want to go out you have to wait for the security guard to give you the password to open the door…".* (P6), *"I was not even scared, like being scared when after giving birth or maybe someone will steal my baby or go out you see, it was safe, there were cameras all over. "* (P6).

The right to information was also raised. Participant 6 explained how she appreciated the information and reasoning provided before procedures were commenced, *"... they give you all the information you need, before they touch your body, they will tell you, "okay we are going to do this and that."* (P6) indicating that informed consent was

obtained. Participant 16 describes informed consent as, *“Vital. From start to finish.”* (P16).

As with the other categories, several participants spoke about negative issues including where their human rights had not been respected. With regard to privacy, participant 1 articulated this concern, stating*, "there was no privacy"* and continued to lament, *"I could see what's happening to the other person. The other person could see what's happening to me… I could see everything, I could hear everything”* (P1). Participant 4 also spoke of a need for improvement in respect of privacy, *“There is no privacy there, it is just open, maybe they must also improve there"* (P4). Participant 11 said, *“privacy is needed, especially in hospitals. You find that you are in a whole hospital where there's not even a division for your privacy. It is really not nice”*. (P11) Participant 11 verbalised how witnessing a negative birth induced fear for her own imminent birth and advocated for a re-evaluation of the facility's layout (P11).

The lack of privacy has had profound and lasting effects on several participants. Participant 1 described the experience as *“traumatising”* and participant 15 expressed horror while witnessing a birth, *“No curtains, I saw everything. The baby came out, placed that baby just like that, it was a horrible thing to see.”* (P15).

The provision for human rights not only included privacy but also extended to patient confidentiality. Participants did not want to be privy to healthcare professionals' conversations with other patients. Participant 11 explained, *“I wouldn't like that, hearing what they say about another person. That's bad.”* (P11) she continued, *“They shouldn't be talking about someone else. And I'm hearing that. No, it's not right”* (P11). Privacy and confidentiality is a human right and everyone deserves it as stated by participant 9, who said, *“Everyone deserves their own privacy”* (P9).

Participant 16 explained how confidentiality should not be breached among healthcare professionals by having a surplus of unnecessary healthcare professionals, *“... in whatever room I'm in whoever needs to be there whatever professional needs to be they must come in if they need to. Along with the partner but beyond that, if it's not necessary for five doctors to be present, two or one will do, then that must be the case.”* (P16).

4.4.2. Support

In the scoping review that formed the basis for developing the a priori codes for phase 2 of this study, the category “support” was defined as “providing assistance, safety and comfort to a health care user during hospitalisation”. It was acknowledged that support manifests itself in several ways including staff presence not only to provide psychological support but also to provide for basic needs during labour when the woman would otherwise not be able to care for herself.

Elke et al (2018) point out that the quality and level of support during childbirth is the most important predictor of patient satisfaction. Nash (2020) states that supportive care enables a woman to maintain a sense of control during labour, improves her sense of security and has improved outcomes including fewer caesarean sections, less need for analgesia and a reduced incidence of postpartum depression. There are many elements of support, which include advocacy, monitoring, physical support such as massage and assistance with breathing techniques (Elke et al., 2018). An important aspect is the continuity of the support given (Collins et al., 2022). Support can be provided by midwives, trained birth attendants and birthing companions such as husbands and mothers – all of whom can provide valuable support and are appreciated by the women in labour (Chen and Lee, 2020; Bostanoglu and Bal, 2021; Heelan-Fancher and Edmonds, 2021).

The participants in the study referred to the need for support from both midwives and birth companions – an aspect that was usually lacking in the past experiences of the participants.

4.4.2.1. Staff presence

Staff presence is a fundamental aspect of healthcare delivery and yet literature on the topic is hard to come by. Mcharo et al. (2022) completed a scoping review on nursing presence in paediatric oncology units and state that nursing presence can take the form of physical presence where nursing tasks are performed but also a metaphysical presence and to “spend herself on the patient’s behalf”. Atashzadeh et al. (2022) developed a nursing presence scale. They refer to nursing presence as “the most basic

component of humanistic care" and state that nursing presence literally means "being with someone in need". They also provide evidence that nursing presence and patient satisfaction are positively linked. Staff presence ensures that patients receive the attention, care and support they require to obtain a satisfactory birthing experience.

In this study, several participants referred to aspects of staff presence, but all described incidents of either where they did not have a staff presence or when they would have liked to have staff presence. Most spoke about the physical presence (or lack of) staff members and it was often linked to other needs such as communication which cannot occur without staff presence.

Participant 1 expressed a desire for more personalised care, stating, *"I think it would have been a different experience, if the midwife was there for me as a pregnant lady"* (P1). Participant 8 emphasised the need for midwives to be accessible in the ward rather than at the nurses station, *"they must not go to the nurses station, they must (be) all around on the people's place where they are lying there."* (P8). She described a sense of isolation, noting that although the midwife was present, she was not readily available, *"Present, but not around, maybe in the nurse's room… especially during the night."* (P8).

Participant 15 shared her negative experience where she felt neglected and abandoned, *"no one showed interest in me, they left me for hours lying there, you have no one that talks you through it especially with my first child, I did not know what to do."* (P15). Additionally, participant 15 describes a distressing situation where she had no assistance, leaving her baby unattended on a hospital bed. *"I was bleeding and there was no one to help me, I walked to the shower, I had to leave my baby alone on the bed, I didn't even have the baby crib, I had to leave her on the hospital bed alone while showering, I almost died, I had no one to assist me."* (P15). This highlights the critical need for attentive and supportive care among healthcare professionals.

Participant 2 conveyed the importance of staff presence by guiding and supporting women during childbirth, particularly first-time mothers making the experience less frightening, *"I would be less scared…. So it would be easier if ever like they were someone to tell me that. 'No, relax. You need to breathe in and breathe out. Then if*

you feel the pain you must push. If you don't feel the pain, you hold on then until you feel the pain then you push'" (P2).

4.4.2.2. Birth Companion

The relationship between having a birth companion present and patient satisfaction is well documented (Gasaye et al, 2019; Chaote et al, 2021; Sena et al, 2023). Birth companions are usually lay people with no training who the pregnant woman chooses to have with her during labour to provide support.

Several participants shared reflections on their past birthing experiences, expressing satisfaction when having their partner or family member present. Participant 6, for instance, emphasised the significance of her mother's presence, stating, *"Because I was not feeling alone"* (P6). Participant 10 highlighted the enduring importance of such moments, *"...those are memories that need to last forever."* (P10), suggesting that childbirth is a special experience, which is meant to be shared with a birthing companion. Participant 10 expressed such satisfaction with the presence of her birthing companion saying that, *"The policies were fair enough, because even the husband can go to the theatre with you."* (P10), indicated agreement that the hospital policy should encourage the presence of a birth companion. *"...your husband must be with you, that is what I was allowed"* (P17).

Unfortunately, a notable portion of participants were not given the opportunity to have a birth companion present but would have liked to. Participant 1 said, *"...not by choice. would have liked him to be present"* (P1). She further expressed disappointment, revealing, *"He wanted to be part of everything, he wanted to be there for me. He wasn't allowed to be anywhere near me"* (P1). She believed that the presence of her birth companion could have provided crucial support, lamenting, *"I think I would have had support"* (P1). Similarly, Participant 15 conveyed the sense of loneliness resulting from the absence of her partner during childbirth*, "I was alone, my partner was not allowed in the hospital"* (P15), emphasising the emotional toll of the experience*, "I wanted to have him there. I was alone, my child was being born, it's painful and there is no one".* (P15).

Participant 8 reflected back on her birth, *"You give birth alone"* (P8) and continued to reason that a birth companion provides emotional support and advice, *"if maybe they allow your partner to go with you, can support you and giving you some advice or maybe to look after you then you'll be better…".* Further stating, *"All the pains would be gone"* (P8), suggesting that support from a birth companion could alleviate the pains associated with childbirth.

Participant 16 offered a thoughtful perspective on the role of a birth companion, emphasising their understanding of the birth process and their ability to assist in decision-making, *"He or she would be able to understand the process and therefore help me to make decisions if it comes to it that I have to change my idea or plan, they could then support me according to what I've expressed I want, and they know the history of the appointments and of the facility itself, then he or she could, could help me in that decision. And then it also helps the professionals. If there is a history of a supporting partner, and there's a relationship there, and I'm unable to answer a question or, or respond, then they know he or she could."* (P16). She recommends that healthcare professionals should encourage the presence of birth companions*, "...they are encouraging family members to give support to the woman…"* (P16) asserting that it not only benefits the woman but also aids the healthcare professionals in providing better care.

Additionally, participant 11 expressed the importance of a birth companion in relation to safety, *"I wouldn't feel alone…So when I'm having someone around who is close to me and feel much safer"* (P11). Participant 14 indicated that a birth companion is important for *"Moral support"* (P14). Both participant 16 and participant 19 verbalised that the presence of a birth companion is a deciding factor for them as to where they would choose to deliver, *"if I was not allowed my partner present with me, I wouldn't go there. That would be a deciding factor."* (P16) and *"If I was told I couldn't have my partner there, I wouldn't birth there."* (P19).

In summary, participants' experiences varied regarding the presence of birth companions, with some finding immense value and support in their presence while others lamented the absence of such companions and the impact it had on their birthing experiences.

4.4.2.3. Timely treatment

The literature sourced to explain the concept of timely treatment is commonly used in relation to timely diagnosis and treatment to optimise patient survival both in general medicine (Chen et al., 2023; Jain et al., 2022) and in obstetrics (Vuncannon et al., 2023; Ford et al, 2022). Literature related to waiting times in obstetric units was abundant but all referred to patient dissatisfaction or inequalities in waiting times between groupings of patients, and access to services rather than to patient satisfaction as such (Ngene et al., 2023). A source of dissatisfaction with healthcare, often noted by patients, was the amount of time they had to wait during an office or clinic visit. Studies have documented the relationship between waiting for service and overall satisfaction, with longer waiting times being associated with decreased patient satisfaction (Camacho et al., 2006).

A few participants shared reflections on their past antenatal experiences, expressing satisfaction regarding timely treatment. Participants 10 and 3 stated how they were quickly attended to by healthcare professionals, stating, *"I have never queued, when I get there. I've got myself a bed in time."* (P10). Due to the quick service, participant 3 claimed, *"We were very important at the clinic"* (P3).

However, the majority of participants experienced a delay in treatment, which required them to wait for assistance for an extended period of time. Participant 1 said, *"I was at the benches for so many hours without being checked first."* (P1). She continued to suggest, *"I think when I got to the hospital they were supposed to check me before they said sit there. But they did not check me"* (P1).

Participant 2 explained her antenatal experience*, "I was going to the (name redacted) clinic, there I stay and stay. When I'm going to the clinic I would even go with a lunch box because there you would stay and stay and stay."* (P2) She expressed how*, "...if it's lunch time, all of the nurses go to lunch, and they can't go all of them, some of them must wait and when they come back the other ones must go. So it was long for you to get checked"* (P2). Due to a prolonged wait before being assisted, participant 2 explained how her unborn child was compromised*, "... it is not okay. I was scared because I was also bleeding, so I was like is my baby going to survive, and when they*

checked me they said that the heart beat is beating low and stuff." (P2). She continued to express how healthcare professionals would take their time, when immediate assistance was required*, "they would but on their time, but maybe you need help now, I need help they wont come now"* (P2).

Several participants stated that, in order to prevent long waiting times, they needed to get to the clinic for their antenatal check-up early in the day. Participant 4 said, *"That was bad. You know when you go there you must wake up very early in the morning so that you can be treated first and go back home"* (P4). Similarly, participant 6 explained her early start to beat the queue, *"When I get to the government clinic, I woke up at around 5 in the morning…and I have to go wait there until 7 o'clock before we can see the nurses for the line…Because they open at 7, so since from around 5, I think 1 hour 30 minutes I'll be waiting"* (P6).

Participants had opinions on the amount of time that is reasonable to wait. Participants 2, 9, 13, 15 and 16 were all of the opinion that a waiting time of thirty (30) minutes is an acceptable time to wait to maintain patient satisfaction. Participant 9 said, *"30 minutes is enough"* (P9). One participant, participant 11 was willing to wait longer than 30 minutes*, "And I'd like to wait for not more than 2 hours."* (P11), depending on the situation as stated by participant 14, *"If it is an emergency then definitely not long."* (P14). Participant 16, expressed how the length of a satisfactory waiting time depended on the healthcare professional, *"That's funny, because maybe midwife, 30 minutes because yeah that's actually looking drawing on previous experience of knowing they stick to time better. Whereas with a doctor, they always seem to run behind schedule. So, I would be willing to do 45 minutes for a doctor until I started, like really showing, or asking and complaining."* (P16).

Participants also spoke of the hardships caused by long waiting times. Participant 8 spoke of *a "long day, ... maybe after 5 you go home."* (P8) Participant 10 said, *"other facilities you'll sit on the benches, and they will tell you that you have to wait for a bed"*. This was linked in participant 10's mind to rights issues, *"According to me, actually, each and every person has a right to get a bed. The minute he is admitted, but in government facilities, there is no such thing."* (P10).

P19, who had experience of a private health care establishment, said, *"The longest I've waited to see (name given) was – I don't know – 15 minutes. Probably half an hour would be like (OK) – I would not really want to wait longer that half an hour. I'm wasting my time especially with the second child in tow"*.

4.4.2.4. Provision of Basic needs

While Maslow's hierarchy of needs is commonly used in nursing and midwifery when explaining patient needs, the literature related to basic needs and patient satisfaction spoke of psychological satisfaction. The participants in this study however confined their responses to the lower levels of Maslow's hierarchy of needs i.e. physiological needs and safety needs.

The cleanliness and hygiene of a healthcare facility was considered a critical factor by participants. Participants 2, 4, 9, 11, 12, 13, 15, 16, 17, 18, and 19 all emphasised the importance of cleanliness and hygiene when choosing a birthing facility. Their preferences included a clean and safe environment, with a focus on various aspects such as the overall cleanliness of the hospital, including the floors, beds, and bathrooms. Participant 2 said, *"I prefer a clean hospital whereby I will be safe of the hygiene and the environment."* (P2). Participant 11 said*, "The bed must be looking clean. The linen must be clean and the floor."* (P11). Participant 11 continued to stress the need for essential items such as toilet paper to be readily available and expressed a desire for a hygienic atmosphere that does not emit unpleasant odours. *"They should be clean, and the toilet paper should be there. I shouldn't be looking for toilet paper while I have to go to the toilet and Yeah. Everything should be clean."* (P11) Participant 16 expressed how messes should be cleaned up quickly, *"So the floor mustn't have dirt on it or spells are obviously inevitable but they must be cleaned up quickly. And the bathroom must be hygienic and when you go in, you don't smell something funny."* (P16).

Participant 17 stated that a history of safe deliveries was important. She stated, *"I think I would choose a hospital with a good delivery rate, if there is a complication then they will look after you and the baby. Your health, I don't want to get infections, I don't want my baby to get sick, so hygiene must be good. The entire hospital should have a good*

rating whether it is for births or emergencies, it must just in general be a good hospital." (P17). Participant 17 referred not only to cleanliness but the need for a pleasant environment. *"It is nice if it is beautiful, if the decor is nice but cleanliness is more important and the comfort."* (P17).

As with the other categories, many of the participants cited negative experiences regarding basic needs and what results in dissatisfaction rather than satisfaction. The participants highlighted significant concerns about the cleanliness and hygiene standards of healthcare facilities. The first individual described a disturbingly dirty environment stating, *"The environment was so dirty. Even when we go to the labour ward, there were blood towels everywhere"* (P1). Participant 2 said, *"... in the maternity ward, where we were sleeping was clean, but the bathrooms it wasn't clean. Also the taps where we wash ourselves, also the shower, like it wasn't, it wasn't fixed, it was like broken, with the shower thing it wasn't coming water out nicely, also the bathtub it was dirty, they don't even wash."* (P2).

Concerns were raised about the potential for contracting infections and becoming sick due to the overall dirtiness witnessed by participant 4*, "For, you know, you can go there like not having some other, what can I say, bacteria or infections or what, but you can be infected there and get some sickness there because of the dirtiness of the place"* (P4). Another participant (P7) specifically mentioned, *"Sewage is out there"* (P7) continuing to state, *"It's too dirty"* (P7) indicating a serious sanitation problem.
The lack of cleanliness was emphasised as a barrier to comfort and basic needs, such as having a clean place to sit, as explained by participant 1*, " the hospital was so dirty…you get there, you must be comfortable, not even knowing where to sit because its blood, it's a mess"* (P1). Participant 1 continued to explain how the cleanliness of the facility influenced her appetite*, "in the morning they gave us soft porridge. I was just unable to eat because of the environment, the dirtiness of the place"* (P1). Participant 15 expressed concern regarding contaminated medical consumables lying around, *"It must be clean, that is a big factor. Today's hospitals are not clean, you will see needles just lying around."* (P15). The presence of blood-stained sheets is highlighted as a specific concern, posing potential health risks by participant 14, *"The sheets should be clean because they normally have blood stains."* (P14).

The unappealing conditions also extend to the provision of food, affecting the well-being of postpartum individuals who require nourishment for recovery and breastfeeding. Participant 1 said, *"it is very important. Because after giving birth. I was very hungry. I was very exhausted, even my mental health after giving birth, I didn't know I was all over the place. so I think food is important and when you want to breastfeed, you cannot breastfeed without eating without having warm food, a warm drink or something"* (P1). Participant 15 vocalised a similar statement, *"Because after birth you are so tired and hungry. You used all your energy, and after birth when your baby is born you need that energy to continue to assist your baby."* (P15). Participants 16 and 17 expressed how food at a facility was not a deciding factor, however a healthy meal would be appreciated, *"It wouldn't be a deciding factor… But it is important that a patient is fed on time. I mean, it doesn't have to be five star, but a healthy meal with starch, protein and vegetables."* (P16) and *"...it must be nice"* (P17).

Additionally, participants highlighted the significance of pain relief during childbirth. Participants expressed dissatisfaction with the attention given to them, citing a lack of provision of pain relief medication as a contributing factor. Participant 2 expressed, *"There was no pain relief at all"* (P2), she *"... bought painkillers when I got home"* (P2). Participants 2 and 3 expressed their reasoning for not requesting pain medication*, "I didn't even ask.... thought maybe if they were supposed to give me they would give me, but I did tell them that I was in pain"* (P2), *"I was quiet. I thought it was normal for me to be like that."* (P3). This indicates that patients are un-informed regarding pain relief options and are also unable to approach healthcare professionals with questions and inquiries. When choosing a healthcare facility, participant 16 stated, *"I think it's necessary for the facility to have it (pain medication) available."* (P16), similarly participant 19 said*, "...if I was choosing a facility, because I'm at a facility, I would like pain relief to be available."* (P19)

Overall, the accounts of the participants underscore a pressing need for improved hygiene and cleanliness standards in healthcare facilities, with specific attention to sanitation issues, broken facilities, and inadequate attention to patients' well-being.

4.4.3. Service provision

In the scoping review that formed the basis for developing the a priori codes for phase 2 of this study, the category “service provision” was defined according to the United Nations Population Fund (2014) which is “the capacity of health facilities to provide …services for key MCH (and includes) …the availability of services, existence of critical equipment, supplies and procedures (including management), provider capacity, performance and perceptions, and the client’s perspectives on the services she received.”

In the scoping review service provision included access to facilities as well as the provision of human and other resources. The participants in this phase of the study spoke of all three aspects identified in the scoping review. Many of the issues raised were closely related to those in the previous category i.e. support and there was an overlap in this regard.

4.4.3.1. Provision of human resources (quantity and quality)

Negero et al (2021) confirm that well-trained, competent and motivated human resources are essential for ensuring the delivery of quality maternity services and also indicate that this is required as part of meeting the Sustainable Development Goals.

In describing the factors they would take into consideration when choosing a birthing facility, participants agreed that the provision for quality healthcare professionals should include, not just the provision of numbers of health professionals, but more important, or certainly more often cited, the need for professional, caring and competent health professionals. The need for them to be qualified and trained was raised by participant 10: *“when I see well trained people, they know what to do. Why I came for. They actually know their jobs”* (P10). Participant 15 similarly emphasised, *“someone who is professional and knows exactly what they are doing and can guide you through each and every step”* (P15). Participant 16 emphasised her choice in choosing a birthing facility, *“Where the professionals are highly trained for what they're doing. They're experienced. And if there is an inexperienced person, it's because they're training and there's an experienced individual looking over their work”* (P16). In addition, participant 16 advocated for a more focused role of healthcare professionals

on pregnancy and birth, by stating *“I think their roles as doctor or midwife, ideally, would be very focused on pregnancy and birth… so their role is not split between pregnancy and birth and dealing with TB patients…”* (P16). She continued to justify her answer, *“Because birth, and pregnancy is not an illness, and I don't want to be treated like I have a medical problem. I would like those professionals to be passionate about pregnancy and about birth”* (P16).

The opinion that private healthcare professionals provide better quality service was expressed by participant 11, *“The private nurses, they are caring. They are dedicated to doing their work. Unlike the government workers, they are just there to get paid. They don't care about how their patients feel, they just don't want to hear our side of the story, they just conclude whatever they want and you find that at times, they just don't care about how a patient feels”* (P11). Participant 9 explained why she would choose a private facility, *“Because they make sure and they take good care of people and they treat them well. They make sure that they are happy”* (P9).

Participants indicated that they would choose a facility based on the quantity and availability of healthcare professionals, as indicated by participant 8 and 19, *“I see there are a lot of doctors there…the doctors must be around every now and again, to assist the nurses”* (P8) and stating “*Doctors will be important”* (P8) when choosing a healthcare facility. Participant 19 stressed the importance of having *“The option to have midwifery rather than just doctors”* (P19).

As with other categories, several participants expressed dissatisfaction with their previous birthing experiences when referring to the provision (or lack of) human resources. They highlighted issues such as unkind and neglectful behaviour from nurses, insufficient staff, and a lack of prompt and thorough care.

Participants stressed the significance of professional and compassionate care, with a desire for healthcare providers to actively check on patients, address patients' needs promptly, and prioritise the health and well-being of both the mother and the baby. Participant 1 said, *"when I got there, the nurses were not nice…They were just saying I must chill there and they will look at me later"* (P1), this made her feel like, *“I was in bad hands"* (P1). Participant 4 shared an instance where she felt ignored, *“I've been*

telling the sister that I want to pee. She was ignoring me until I screamed" (P4), she continued to explain *"...they will just ignore, ignore you and until whereby I couldn't even speak and then they came, and they realised that the baby is no more like kicking in the normal way"* (P4). Participant 8 said, *"We have to shout, you see, before we can give birth"* (P8). This emphasised the importance of being treated by quality healthcare professionals, with the immediate focus on the well-being of both the mother and the baby. Participant 9 emphasised, *"My baby should come first. Make sure that the baby is healthy, and I give birth very well and healthy"* (P9).

After a negative birthing experience, participant 4 *"...opted to be released and go home"* (P4). She continued to lament, *"They (healthcare professionals) must change the way that they treat the patients"* (P4). When asked what quality care looked like, her response was, *"I can tell that maybe that is a calling, she did not just choose the career because she wants to earn money. She chose the career because she has that care for women, especially women, she have that patient, she's maybe naturally have that thing, yeah. I can say in nature they have that thing…. also care naturally, have that care, have respect… that person is patient with her work"* (P4). Similarly, participant 4 said, *"They should be kind. They should be checking up on me to show that they care and maybe every hour or whatever interval and then, yeah. That would make me happy"* (P4).

Participant 1 puts the poor quality of nurses down to *"they might be tired because there is not enough staff"* (P1), verbalising that *"when I came, I could see there was one nurse, and a lot of pregnant women with no one to check them"* (P1) indicating a severe shortage of healthcare professionals. Participant 13 expressed how appropriate time management is a key to quality healthcare, *"they must be there for me because in the hospital you are not the only one, but they must manage to take care of their patients. Like in time and do their work very well"* (P13). She continued to explain how poor time management and neglect led to a preventable situation, *"Sometimes they take time to chat on their phones while the patient is busy, like with something serious. Maybe in the toilet. Some other patients give birth on the toilet while the nurse is busy chatting on her phone* (P13).

In another distressing incident, participant 15 indicated how healthcare professionals lacked professionalism and respect towards a participant in labour, *“when I was in hospital with my youngest child, they let me birth on my own, no one helped me, I pushed the child out, she fell on the bed and no one helped me. I eventually started screaming and the nurses just laughed at me and said that I wanted to do it alone so they did not want to help me any further”* (P15). Participant 15 continued to express*, “I want someone who understands what you are going through, who assists you when you need assistance”* (P15). Participant 17 emphasised how quality healthcare professionals should conduct themselves*, “I think it's for them to just be a fellow human, to know that this is a person who is scared, uncertain and is not in the medical profession. They should put her at ease, telling her exactly what is happening to her and reassure her that she is going to be okay”* (P17).

Overall, the participants expressed the need for improvements in the public healthcare system, with a call for increased staffing, better training, and a more compassionate approach to patient care. The contrast between private and public healthcare experiences highlighted the impact of these factors on the overall birthing experience and the perceived quality of care.

4.4.3.2. Provision of other resources (Supplies, equipment, physical space)

When searching for peer reviewed articles on the provision of resources (other than human resources) needed to provide quality services and therefore keep patients satisfied, all relate to resources as a constraint rather than saying what is required. Ismaila et al (2021) reviewed eleven (11) research papers that indicated a lack of equipment and a lack of space and infrastructure as barriers to quality midwifery care. The National Core Standards (OHSC, 2022) provide information about resources required in a maternity ward and include resources for infection control, patient safety and emergency situations. With respect to “general “equipment, no details are given but instead inspectors can choose which 20 items of equipment to check during a site visit. No requirement for space is set out in the standards and yet this is one of the aspects that the participants desire and use as a criterion for choosing which facility to use. Participants indicated that there was more space and more privacy in private facilities, and they valued this.

Several participants suggested that healthcare facilities should improve their maternity rooms to provide more space with fewer beds, minimising overcrowding and ensuring a comfortable environment for mothers. Participant 8 expressed, *"... if they can improve something like, maybe in the maternity rooms, maybe they must have few beds so that people can have enough space"* (P8). Participant 17 echoed a similar sentiment, *"There must be a bed, and space for when you are busy with the baby, getting out of bed when you need to bath the baby"* (P17). This highlighted the importance of sufficient space for attending to one's baby, emphasising the need for comfort during the postnatal period. Participant 8 raised concern for sufficient space for visitors in a crowded ward setup*, "You see, something if your visitors is coming they must not have a lot of people in the same one room, maybe we are 10 so our families come, then there are 10 families maybe they come in 2-2s, you see, big crowd but if maybe it's maybe 4 or 3 in the one room, at least it's better"* (P8). Participants 3 and 5 emphasised the importance of having their own space during birth with participant 3 declaring, *"I would like to give birth in a (Private Clinic named). In the (named clinic) I'll be in my room…I would like my own space"* (P3). Participant 5 expressed, *"It's private and is just enough space (referring to a private healthcare facility)"* (P5). Participant 19 expressed how having her own bathroom was a nice factor to consider*, " …what was also nice is to have a bathroom attached to a private room. Because you don't always get that in hospitals"* (P19). This indicates that private healthcare facilities offer enough space with privacy to obtain patient satisfaction.

From previous birthing experiences, participants addressed the provision of supplies and equipment in a healthcare facility. Participant 3 mentioned giving birth without any medical intervention and did not observe any availability of consumables should they have been required, she stated*, " I did not see any equipment, I gave birth normally, no stitches, no operation, no drips, nothing"* (P3). *"they don't even have enough blankets"* (P14) participant 14 expressed. A more alarming statement from participant 15 indicated an urgent need for intervention regarding the provision of supplies. She said, "*You will see six new-borns lying around without tags so you don't really know which one is yours, they just give you a child"* (P15).

Participant 4 acknowledged the visibility of clean equipment by saying, *"At least you'll see them unfolding them, you can see it was cleaned up"* (P4), this indicated a level of reassurance. Both participants 11 and 13s expectations for choosing a healthcare facility, included all necessary equipment to be readily available within the birthing environment to avoid distributions. Participant 11 expressed*, "Yeah, they should be having everything because I will be paying for the services they are giving me. So I expect them to have everything"* (P11). While participant 13 said*, "I don't know what you guys called it, but like every corner, like the things that they are using, the things you need to give birth, they mustn't go to another room to take some equipment while you are giving birth"* (P13). *"I would want everything required for the pregnancy to be at one place"* (P16) participant 16 said. When asked how she would feel about being informed that certain stock was unavailable during her birth, she said, *"Well, I would, I guess, depending on what wasn't available, I might become anxious, especially if it's something that could affect my health or the baby's health. And that anxiety could then affect the labour itself as well. In terms of what I would do, I don't know if I would leave and go somewhere else if I'm in the midst of labour"* (P16). Participant 18 similarly expressed, "*I think I definitely want a well-equipped hospital. Because if anything goes wrong, you need those things there. And then you can't have like, Oh, now we need to find these things or take you somewhere else while you're doing all this hectic stuff. You want to stay there, and if anything goes wrong, you know that they've got you"* (P18). This emphasised the expectation of comprehensive services by providing the reassurance and convenience of having all required birthing supplies and equipment within the same room. This was an important factor to participants when choosing a healthcare facility for childbirth.

Participant 19 indicated a preference for a homely atmosphere to compliment a comfortable environment. She expressed, *"That's very important. I like in terms of giving birth, I liked it not to look too much like a hospital. I like the rooms to have a feel of homeliness"* (P19). She continued to explain*, "you don't walk into a normal hospital room and you see wires everywhere and you see machines everywhere. Where at (name redacted) you walk in, and it's very pleasant. Like it's, you don't see wires everywhere. You don't feel like you're a patient"* (P19).

4.4.3.3. Access to facility

When discussing factors influencing access to obstetric facilities, Kubeka et al (2023) refer to three types of delay namely a delay in seeking care, a delay in reaching the facility and a delay in receiving care. Sacks et al (2022) refer to commonly cited barriers to obstetric care as being distance, cost, lack of transport, perceived poor quality of care and linguistic barriers.

None of the participants in this study spoke of a delay in seeking care, but they did speak of issues of distance and transport and the quality of care as well as the issue of cost. None spoke of linguistic barriers. The issue of distance and availability of transport to the facility was important to the participants and many spoke of these factors being influential in their choice of facility for childbirth.

Participants 5 and 7 stated that they would choose a healthcare *facility "because it was a place that I am near to"* (P5), and it *"Is not far. It's short"* (P7), indicating that proximity played a role in choosing a healthcare facility while pregnant. Participant 15 said*, "I would say that is very important, a hospital must always be closer rather than further, you don't want to drive to another town "*(P15).

The issue of distance was important because there was concern that when in labour, they may not reach the facility in time. Participant 3 expressed this concern: *"what if I give birth on the road"* (P3). She noted that she only had to travel 20 minutes to the hospital. The urgency of childbirth was also acknowledged by participants 14 and 8, who stated*, "If you are pregnant because what if you need to give birth soon"* (P14) and *"...some they can get delivered on the way going to the hospital"* (P8). One participant (P10) indicated that if one is booked for an elective caesarean section, distance is not an issue as there was no urgency in getting to the hospital. *"According to me, the distance was not a problem because I'm using a Caesar. With Caesar, you don't have to wait for the labour pains. You just take your things and go. So for me, the distance meant nothing".* On the other hand if one is in labour, distance is an issue and one has to balance the need for immediate care over one's choice of facility. She said, referring to the person she was transporting*, "Went to the closer hospital because she*

was already in pain, but would have preferred the further (private) hospital because it is better."

Not all participants were able to exercise their choice to go to a particular facility due to a lack of finance. Participant 17 said, *"If you have the money and you want to go to that specific hospital then yes, but if you do not have the money to travel, then you don't really have a choice"* (P17). Several participants had the impression that paying for a service resulted in better quality of care and would therefore travel further to a private healthcare facility rather than attend a nearer government healthcare facility.

Participant 11 explained, *"I mean, (I) will choose to go to the nearer, but I will go to the one that is further for the better (care)"* (P11). She continued explaining, *"Because if you're going to the government hospitals, the services are way different than going to a private hospital. So, for the better, it's best to be paid"* (P11). Participants 11 and 14 believed that travelling further to a private healthcare facility would provide better quality care as verbalised by participant 14*, "Because they will be treating me, they will make me feel at home and give the best treatment"* and P11*, "so, I'd rather go far than be treated like a nobody"* (P11). Similarly, participant 15 expressed*, "If I had the choice now, I would rather fork out the money than go to a government hospital. I learned the hard way…I would rather drive 2 hours before giving birth at a government clinic*" (P15). Participants 16 and 2 sang the same song respectfully, *"I would go slightly further, because I know that the professionals there are going to take care of me (P16) and " I will choose a further one because I think they would have care and they will be patient whenever I am in pain*" (P2).

Participant 19 reflected back to her previous birth*, "...we drove miles to get there. So I would say no"* (P19) when asked if distance was a deciding factor in choosing a healthcare facility. She continues to express*, "I would still drive to get to where I think I want to go. I'm not just going to choose the hospital around the corner"* (P19). Participant 6 stated*, "I'll go because I know private hospitals are different than the government ones"* (P6). Participant 14 expressed*, "Because in order to get good quality care you have to pay"* (P14).

The practicality and easy access to appointments were also considered by participant 18, *“Just practicality, getting to appointments, needs to be easy…”* (P18), however despite the fact that travelling further to a healthcare facility could be seen as an inconvenience, participant 18 expressed*, “... although, if a facility is further away than I would like, it has all of the other things I really want. I'm willing to travel"* (P18). Participant 16 expressed how distance was not a deciding factor, *“But I feel like the other factors are more important to be honest, like them being prepared, and then being friendly and stuff”* (P16).

The conclusions drawn from the participants' responses indicated that some participants considered the urgency of the situation and proximity, opting for the nearest hospital despite a preference for a better one further away. Others prioritised their life and well-being, expressing a willingness to pay for better quality services even if it involved travelling further.

4.5. Conclusion

In this chapter the findings of the interviews with private patients have been described. Many of their opinions were based on previous experiences of public hospitals due to the limited access to private facilities in the area. There was a clear preference for private facilities based on the experience or assumptions that all aspects of relationships, support and service provision were superior in the private sector.

In the next chapter, the findings of the scoping review (public sector users) and the findings of the interviews (private sector users) will be compared in order to answer the research question: “Do private sector health care user’s criteria for choosing a maternity service differ from those of public sector users?”

Chapter 5: DISCUSSION OF THE COMBINED FINDING OF PHASE 1 AND PHASE 2

5.1. Introduction

In the previous chapter, the findings of the semi-structured interviews were provided. In this chapter, the findings of both the results of the scoping review and the semi-structured interviews (phase 1 and 2 respectively) will be examined in an attempt to answer the research question, “Do private sector health care users’ criteria for choosing a maternity service differ from those of public sector users?

The purpose of the study was to understand whether the private patients’ needs and preferences are any different to those of the current public sector users of the maternity services. At the time of conducting this study, there was a great deal of literature available on public sector patients’ criteria for choosing a maternity service, but no attempt had been made to determine the criteria used by private sector patients in the study setting. This data is needed for forward planning of private / mixed services in the study setting in preparation for the implementation of equitable services according to the guidelines of the NHI.

While the results of the scoping review were used to develop a template for analysing the perceptions of the private sector users, which proved useful, it became clear during analysis that as the scoping review relied on researcher’s interpretations/ write up of the participant’s input and tended to be more explicit and better defined than the data collected during the semi structured interviews. The scoping review data came from a number of different sub-Saharan Africa countries so inevitably covered a wide range of cultural groupings, socio economic groupings and geographic areas with differing terrains, infrastructure and levels of education and expectations of “normally available” services in a country or area. The quality of the health services offered in the different sub-Saharan countries also varied which impacted on expectations of the participants. The researcher, on the other hand, was dealing with raw data from one geographically selected group so the responses were bound to be more limited than those from the scoping review. Nevertheless, there was a remarkable coherence in responses and

the differences resorted not at category or subcategory level but in the detail of what was said.

In order to write the discussion which emanated from a comparison of the data for the two phases, the researcher first compiled a summary of the data which can be seen in the table below (Table 5.1) Any negative comments made by the participants were changed to positive statements as the aim was to identify criteria that participants would use in choosing a birthing facility.

Table 5.1. Comparison table of the data from Phase 1 and Phase 2

Category	**Sub-category**	**PERCEPTIONS FROM SCOPING REVIEW (PUBLIC SECTOR PATIENTS**	**PERCEPTIONS OF PARTICIPANTS (PRIVATE PATIENTS)**
Relationships	Respectful communication (Respect)	● Friendliness ● Respect ● Politeness ● Caring ● Compassionate ● Calm manner ● Person-centred ● Responsive ● Kindness ● Supportive ● Being listened to ● Courtesy ● Made to feel comfortable ● Dignified ● Trusting relationship ● Non-discriminatory ● Non-judgmental ● Empathetic ● Attentiveness	● Greetings ● Smiling ● Attentive ● Gentleness and kindness ● Patience ● Friendliness ● Politeness ● Understanding ● Being there
	Provision of information (Information)	● Procedures & processes ● Prescribed medication ● On condition/illness ● On dilatation ● What to pack with to hospital ● Purpose of blood specimens	● On caring for baby ● On Breastfeeding ● On birthing ● Giving good and bad news ● Answering questions

Category	Sub-category	PERCEPTIONS FROM SCOPING REVIEW (PUBLIC SECTOR PATIENTS	PERCEPTIONS OF PARTICIPANTS (PRIVATE PATIENTS)
		● Advice on HIV/AIDS, STDS (sexually transmitted diseases) ● Family planning, ● Vaccinations, ● Nutrition ● Place of birth ● Labour process ● Signs of labour ● Foetal condition ● Reassurance on procedures (caesarean sections) ● Empowered ● On recognition of complications ● Access to medical information ● On breastfeeding	
	Respect for human rights (Human Rights)	● Privacy ● Confidentiality ● Informed consent ● Involvement in decision making ● Choice in birthing position ● Choice in healthcare professionals (gender) ● Respectful towards culture	● Privacy ● Confidentiality ● Right to information ● Safety ● Informed decision making / choice
Support	Staff presence	● Attentiveness ● Caring ● Caring during the labour process ● Monitoring during labour ● Professional assistance ● Supportive care: Attentiveness and presence ● Connection/Relatable	● Accessible midwife ● Shows personal interest ● Monitors to keep safe ● There to guide patient ● Attentiveness ● Caring ● Physical presence ● Personalised care ● Readily available ● Assistance ● Supportive care

Category	Sub-category	PERCEPTIONS FROM SCOPING REVIEW (PUBLIC SECTOR PATIENTS	PERCEPTIONS OF PARTICIPANTS (PRIVATE PATIENTS)
		● Understanding ● Midwives presence and availability ● Emotional support ● Guidance	
	Birth companion	● Partners presence ● Family presence of choice ● Being supported ● Reduces stress, anxiety, fear ● Companionship reduces C/S rate ● physical and psychological support ● Physical support-walking, given food, backs rubbed ● Mothers prefer to have someone they know to share their concerns and encourage them	● Need to share experience with another ● Provide policies to allow for birth companions ● Reduces loneliness ● Provide advice and help to make decisions ● Emotional support ● Moral support ● Feel safe ● Partners presence
	Timely treatment	● Availability ● Readiness to assist ● Immediate assistance ● Short waiting times ● Attended ANC ● Good reception ● Prompt attention when attending the clinic ● Delayed assistance led to feelings of neglect, abandonment and unimportant	● Wish for no long delays in receiving attention ● Nurses prioritise their lunch over patients ● Patients ignored although bleeding ● 30-minute wait reasonable ● Quick service ● Immediate assistance
	Provision of basic needs	● Pain relief ● Cleanliness ● Quality of food ● Clean drinking water ● Essential birthing items	● Cleanliness ● Infection prevention ● Comfort (including seating or a bed) ● Food ● Pain relief

Category	Sub-category	PERCEPTIONS FROM SCOPING REVIEW (PUBLIC SECTOR PATIENTS	PERCEPTIONS OF PARTICIPANTS (PRIVATE PATIENTS)
		● Warm water ● Sanitation ● Electricity ● Safety ● Provision of ambulances ● Referral process	
Service Provision	Provision for Human Resources (Quantity and quality of staff)	● Sufficient staff ● Qualifications and training ● Knowledgeable and skilful midwives ● Competent ● Thoroughness ● Responsive ● Helpfulness ● Good temperament ● Experienced or supervised trainee ● Relatable (older midwives) ● Empathetic ● Hospitable midwives ● Friendliness ● Helpfulness ● Supportive ● Competency with complications	● Qualifications and training ● Focused expertise in midwifery and obstetrics ● Caring ● Availability (sufficient) staff ● Actively involved ● Responsive ● Empathetic
	Provision for other resources (Supplies, equipment and physical space)	● Welcoming/pleasant environment ● Sufficient equipment ● Sufficient beds and incubators ● Well-maintained infrastructure ● Sufficient drugs/supplies ● Privacy ● Cleanliness ● Good sanitation ● Larger facilities to accommodate them comfortably	● Space / privacy ● Cleanliness ● Availability of equipment and stock ● Homely atmosphere

Category	Sub-category	PERCEPTIONS FROM SCOPING REVIEW (PUBLIC SECTOR PATIENTS	PERCEPTIONS OF PARTICIPANTS (PRIVATE PATIENTS)
	Access to facility	● Availability of transport ● Distance ● No men to escort at night, unsafe to walk ● Financial constraints ● poor road conditions slow travel ● Public transport costs ● Affordability ● Free services	● Distance – in urgent situations ● Distance related to normal situations ● Availability of transport ● Financial constraints

5.2. Discussion of the comparative findings

5.1.1. Relationships

The importance of the relationship between midwives and patients has long been recognised and literature shows that research into the topic continues. The White Ribbon Alliance, originally endorsed by the World Health Organisation (WHO, 2011), which advocates for respectful maternity care, includes the need for midwives to build positive relationships with women during their maternity care as they are essential for ensuring positive birth outcomes. Bradfield et al. (2019) conducted a study on relationships within private obstetric services and found that they are also most important in this context, and, to some extent, are more complex as there is usually a triad to consider in terms of relationships as, in the private sector, an obstetrician often provides part of the care making a triad of the patient, the midwife and the obstetrician. The relationships within this triad are key to providing “with women” practices often referred to as ‘being there” for the woman.

Mbekenga et al. (2018) established that connecting with women and establishing a relationship with them was necessary before information could be shared. Building such a relationship requires time and a sustained relationship. Abraham and Clow

(2023) refer to this process as “journeying together” but as Mbekenga (2018) points out this can be challenging when pregnant women do not see the same midwife for each antenatal visit and are commonly cared for by a different midwife during labour. Another factor that may influence relationships is the public sector's larger patient volume, and the fact that they may face greater resource constraints, leading to less time for individual patient interactions. Almorbaty et al. (2023) list amongst organisation factors that impact on relationships between midwives and patients as continuity of care; time and workload and physical environment. The birthing room design and the availability of resources influences relationships as born out by the “support” category in this study. In that section of the study patients referred to many physical factors that they needed such as cleanliness and privacy which are therefore inter-related with the relationship category.

Other factors impact on building relationships including language. Doering et al. (2022) refer to the patient’s need to “have a voice” and say that although having a voice should be a legitimate right in healthcare, some women’s voices are either unheard or “lost in the experience”. Having a voice impacts on the right to choose and on a woman’s sense of control and autonomy and it is vital for a positive birth experience. Bridle’s et al. (2021) study dealt with a specific reason for not having a voice – either having little or no English in an English speaking healthcare environment. Patients with little or no English not only had lower patient satisfaction scores than those who were able to communicate in English but also negatively affected birthing outcomes. Language is thus an important issue in establishing and maintaining relationships and in the research setting this is an important factor as the community is multi-cultural thus having patients with varying ability and choice of home languages.

De Kok et al. (2020) study carried out in Malawi emphasises the need to tailor care to local relationships. They point out that certain behaviours which may be seen as abusive (such as shouting at a patient to push), and others who consider it necessary to fulfil the patient’s right to a freedom from harm. They contend that it is necessary to examine what women and midwives in specific contexts and situations consider “good” and “bad” care. This advice is pertinent to this study where the intention was to compare criteria used by public and private sector users to choose a maternity service. Shan et al. (2023) raised a related issue when they studied the perception of women

who were middle class and those who were migrants from the same cultural group to determine if they had different perceptions of the quality of care they received. They established that socio economic status does seem to influence perceptions in that the middle-class women were quite vocal about their needs whereas the migrant women were ambivalent and, interestingly, lower level health care users had difficulty in interpreting the needs of the middle class women. These findings raise parallels with the researcher's study as patients in the public sector are commonly less privileged (in terms of income and medical aid cover) than those using the private sector. It is acknowledged however that, in the study setting, patients have, until recently not had the option to use private facilities as they have only recently been offered and a birthing facility is yet to open.

A concern of the researcher was that, in the semi-structured interviews, most of the participants who had birthed previously had done so in public sector facilities and their past experiences influenced their perceptions. The data was still useful in that these women were very certain of what was not acceptable, and the researcher turned this into information about what they would like. The concern was whether perceptions of a previous bad experience could be erased or changed in order to make subsequent birthing experiences more positive or whether those negative perceptions would continue to influence their perceptions. An article by Greenfield et al. (2022) which sought to answer the question of whether it was possible for a patient to rebuild trust with a midwife after a traumatic birth gave the researcher hope in this regard as the author detailed steps in a process that can be followed to rebuild trust.

Yet another article which reflected some of the findings of the researcher's study was one authored by Pařízková and Clausen (2019) that reported on a study of patients who had travelled away from their place of residence to seek and receive better services. Women in the study chose to travel long distances to find a midwife with whom they could have a trusting relationship and deliver in a friendly environment. The crux of the issue was they were seeking a midwife who shared their values. In some instances the patients found a "suitable" midwife who was willing to travel long distances to come to them rather than them having to go to the midwife. This latter aspect was not evident in the researcher's study.

With specific reference to respectful communication, which was one of the sub-categories in the researcher's findings, it was clear that this was important in both public and private maternity services. Both private and public healthcare users want to be treated with friendliness, politeness, kindness and attentiveness. Issues mentioned in the scoping review but not in the researcher's study were a trusting relationship, non-discrimination, being non-judgmental, empathetic, responsive and to be treated with dignity, and being listened to. As pointed out earlier, this does not mean that private sector patients do not value these aspects; it simply means that they did not mention them. On the other hand, Javed et al. (2019) state that patients who use public hospitals have different expectations from their service providers than their counterparts who visit private hospitals. These same authors also found that private sector users are more likely to be satisfied with the services they receive.

With specific reference to the provision of information which was another sub-category in the relationships category, the similarities between the scoping review and the research study includes the provision of information on caring for the baby, breastfeeding assistance and labouring/birthing procedures. The scoping review demonstrated more detail with a need for information on caring for the baby specifically including mentioned vaccinations; information on labouring and birthing procedures, including dilatation, conditions and illness and the recognition of complications during the process of labour. Once again this does not mean that the participants do not need this information but could be due to the fact that 26% (19) of the participants were nulliparous (never given birth), and therefore may not have known that such information would have been helpful. Another factor that may have influenced the differences in mentioning specific information needs is that the study participants, being users of the private sector, may have better access to media including the internet than many of the scoping reviews participants. Having such information, they may not have identified it as a criterion for choosing a birth facility. The participants in the semi-structured interview mentioned a need to answer questions, which may indicate that they wish to check the veracity of the knowledge they already have. This is however quite a complex debate as although patients with low literacy are known to use websites for gaining information, they are also less likely to trust information from health professionals and prefer using sources of lower quality information (Chen et al., 2018). Breastfeeding assistance and information on labour and labour procedures

were common to both. Reassurance was needed by both groups – the scoping review participants having referred specifically to caesarean sections and other complications and the interview participants mentioned information when conveying good and bad news. All seemed necessary in order for them to be empowered to make their own decisions although Werbrouck et al. (2018) warn that knowledge in itself is not enough to empower patients. Patients need to set goals and plan actions as part of the empowerment journey although it does begin with gaining the knowledge.

With specific reference to the last sub-category in the “respect“ category, the right to privacy, confidentiality and informed decision making was common to the findings for both phase 1 and 2. The scoping review included the right for women to be involved in decision making and also the right to have one's culture respected which were not issues raised in the researcher’s study.

The researcher made use of an interview schedule for phase 2 of the study, which included predetermined probing questions, but the questions and probing questions did not consider any cultural considerations. It is possible that this accounts for the lack of the participants in the semi structured interviews raising such issues. This highlights an opportunity for future research to delve deeper into cultural reasons of women's decision-making processes regarding the choice of a birthing facility.

Due to the existing disparities in health care provision in South Africa, public hospitals often serve a more diverse patient population, including individuals from various cultural backgrounds, ethnicities, and socioeconomic statuses. Recognizing and respecting cultural differences becomes essential for providing equitable and patient-centred care. The fact that the issue was not raised in the interviews does not mean it is not an important criterion for selecting a birthing facility. The consideration of socio-cultural background and beliefs is listed in the WHO recommendations for ensuring a positive childbirth experience (WHO, 2018).

5.1.2. Support

Evidence shows that an important predictor of patient satisfaction is the quality and level of support given to pregnant and labouring women (Elke et al., 2018). The question of who women wish to provide that support varies as supported by the scoping

review and the semi-structured interviews. Participants referred to a need for support from the midwives and the need for a birth attendant of their choice. In Elke et al. (2018) study, which was conducted in the Netherlands, the authors established that 100% of participants wanted support from a partner, 95% from a midwife, 29% from a midwifery care assistant and 15% from a nurse. Many aspects of support overlapped with the previous category “relationships”.

The choice of a care assistant was not specifically mentioned in this study but may not have been open to the participants in any of the studies included in the scoping review or the researcher’s study although, according to the WOMBS website (2024) there are “doulas” practising in eight of the nine provinces of South Africa including in Mpumalanga which was where the semi-structured interviews were conducted. The need for support from both midwives and birth companions was mentioned by many of the participants and it is a sad reflection on the quality of professional midwifery care that women are, according to Rigg et al. (2020) increasingly choosing to use “unregulated” birth attendants irrespective of the risk of doing so as they believe they provide better support, are more flexible in catering for the woman’s needs and because they had previous negative experience with being “cared for” by a midwife. Choosing to use an unregulated birth attendant inevitably led to needing to deliver at home, as the bureaucracy of the healthcare system did not allow their presence. Darling et al. (2022) are somewhat sceptical about the value of birth companions but do admit that their value lies in providing continuous support.

The issue of continuous support was not named in either of the phases of the study but was implied in both that participants referred to the importance of coming immediately, being accessible and readily available and being present. Many of the negative incidents referred to in the interviews spoke of being abandoned and left alone even when in difficulty and felt that the absence of support put them at risk. There is evidence that the absence of support increases risk. Wang et al. (2018) reported a significant difference in the rates of caesarean sections in women who had received continuous support during labour (3.3% of women) and 24% of women who did not receive continuous support during labour. Elke et al. (2018) however concluded that not all women want continuous support and that it is preferable that the midwives are

available on request rather than applying what in the study was standard practice of having a midwife present throughout labour.

The presence of a partner to provide support was mentioned in both the scoping review and the interviews. This may be taken to refer to the father of the baby, which raises another interesting aspect of the choice of a specific partner. While in developed countries, it is common practice for fathers to attend the birth, Roberts and Spiby (2020) reported that while fathers felt useful in the early stages of labour, they felt like "spare parts" in advanced labour despite having the knowledge gained from antenatal preparation of their roles.

It was of interest in comparing the elements identified in the subcategories of support of staff presence and support from a birthing partner that there were many similarities. This indicates that there are generic elements of support valued by women but that as long as there is someone to provide these elements of support they would be satisfied. Given Maputla's findings of shortages of staff in maternity units, and acknowledged by the South African Nursing Council (2023) it would seem wise for authorities to allow birthing partners in to support women on a routine basis.

Sosa et al. (2018) report that support is a combination of presence, midwife-woman relationships, coping strategy, labour progress, birthing partners and midwifery support. Their point is captured in the title of their article – "More than a Ratio" meaning that the quality of support is at least as important as the amount of support. The elements of presence raised in phases one and two of the study highlight the need for healthcare professionals who are attentive, and caring, and who actively monitor women throughout labour, are readily available, and offer guidance and their assistance. It was sad that in the interviews, participants had learned what was needed in terms of support from the absence of such aspects in previous labours. It would appear that having a birth companion complements support given by midwives or, in some of the cases cited by the participants in the interviews, would have replaced an absent midwife.

A study carried out in Limpopo (Maputle, 2018) specified what type of support is needed by patients which included, amongst others, communication of information,

interpretation of the experienced and perceived pain in labour, and supportive care activities which included the provision of physical care, attendance to elimination needs. The authors also indicated a lack of individualised care due to a shortage of staff where midwives were caring for more than one patient at a time. Only 25% of the midwives in Maputle's study provided physical care such as touching, and massaging. This may be a reason why touch and massage were not specifically referred to in the interviews as if patients who had not previously experienced such care may not even think it was possible let alone desirable. The private patients in the researcher's study referred more frequently to the need for greater emotional and moral support from their birth companions, whereas, in contrast, the scoping review recognized that women often seek more physical support in the form of assistance with tasks like walking, providing food, and receiving back rubs from their birth companion.

The fourth sub-category is related to the provision of basic needs. Here pain relief, cleanliness and food were mentioned in both phases of the study. However, even though the provision of food was noted as a similarity between both the private and public sectors (in phase 1 and phase 2 respectively), the public healthcare users provided more detailed responses on the quality of the food and the need for clean drinking water. Public healthcare facilities, and particularly those in the developing countries in the scoping review, often operate with limited resources compared to private healthcare facilities, and a stricter budget impacts the quality and variety of food options available to patients. Private sector patients may consider good food and clean water to be a given. This same reasoning could apply to why the public sector patients mentioned warm water, sanitation, electricity and safety.

Ambulances and referral processes were mentioned by the public sector patients but not by the private sector patients. As the provision of district health services (which include referral and the provision of ambulances) are integral components of the public healthcare system (Tshabalala & Rispel, 2023), where public healthcare facilities serve as primary points of entry for patients, public sector patients have an expectation that these will be provided. The referral process is essential for coordinating care between different levels of healthcare facilities, ensuring that patients receive appropriate treatment and follow-up care based on their medical needs. In contrast, private healthcare facilities may not have emphasised ambulances and referral processes

because they typically have their own transport and have contracted with a private medical provider during the antenatal period who is specialised to provide specialist care if needed at the health facility where he/she practises.

There is evidence in the literature that supports that the provision of basic needs is a factor in determining patient satisfaction. Kasim and Reishaan (2023), Ilyas et al. (2023) and Sands (2023) all refer to the need for a conducive physical environment for maternity patients. Sands et al. (2023) refers to the need for "supportive spaces" which include sufficient space for the patient and for the midwife to comfortably complete her tasks and allow for flexibility of birthing positions, storage space for equipment and the patient's belongings, thermal comfort and ambient or natural lighting, room layout and comfort. Sands et al. (2023) also refer to "design issues"- something that was raised by participants in the researcher's study but specifically related to privacy issues.

Infection prevention was raised by the private patients, but not the public sector patients although both referred to cleanliness. Oni et al. (2023) showed that patient's knowledge of infection control in Nigeria was fair in contrast with a study in Queensland, Australia (Smyth et al., 2015) where knowledge was better. This evidence is not sufficient to support the researcher's idea that the private patients in her study may be more aware of infections (and thus mentioned the issues) than those in the public sector but would be worthwhile investigating further.

5.1.3. Service Provision

The provision of services related to the provision firstly of human resources but also physical resources and lastly issues of access. Brundell et al. (2022) point out that trying to compare the provision of services of one maternity service to another is difficult as there are no consistencies in structure and even the language used when assessing services from one provision framework to another. Katinaitė-Vaitkevičienė, and Patapas (2023) support this view saying that the assessment of the provision of services is subjective.

With regard to the provision for human resources there were marked similarities between the participants of the two phases. Both said that availability of sufficient staff with qualifications and training was important in determining their satisfaction / criteria

for choosing a facility and they also wished for staff to be responsive and empathetic. This latter requirement overlapped with two of the other subcategories namely respect and staff presence. These aspects have been discussed earlier.

Having an adequate number of healthcare professionals with the necessary qualifications and training ensures that patients receive high-quality care, whether in a private or public healthcare setting. Competent and well-trained healthcare professionals are essential for accurate diagnoses, effective treatments, and positive patient outcomes. There is a great deal of evidence that the provision of staffing is important in maternity service provision but the work of Onchonga (2021) who completed a study in Kenya brought this into stark reality in showing that there is a link between patient's perceptions of staff shortages (and other services) and the fear of childbirth.

It is difficult to know when a shortage exists, as there are currently no international standards for clinical staffing of delivery care in maternity units (Stones, Visser & Theron, 2019). Patients in the interviews seemed to assume there was a shortage of staff if they did not receive the care they expected. In the absence of staffing norms, perceptions are all we can go on and health professionals' perceptions of being short of staffed is a key variable concerning motivation and attrition (Bradley et al., 2015) which could explain the apparent relationship seen in the study between shortage of staff and midwives negative "attitudes". There is no question however that staffing provision is a key factor in the quality of maternity care and is referred to as being "inexorably linked with avoidable perinatal and maternal mortality" (Cronje, Rosman & de Vries, 2022). Participants clearly understood this and rightfully identified it as an important criterion for choosing a birthing facility. Whether they would be able to determine ahead of time if the facility was adequately staffed or not may be a moot point.

With regard to the provision of supplies, equipment and physical space, there were again many similarities between the findings of the two phases of the study. Private and public healthcare users expressed a common desire for assistance within a welcoming and pleasant environment, reflecting a sense of homeliness. Having sufficient equipment and supplies readily available emerged as a crucial factor

influencing the choice of healthcare facility, irrespective of whether the user belonged to the private or public sector. Additionally, women expressed a preference for larger facilities that afford comfort and privacy during their healthcare visit.

Yucel et al. (2022) conducted a study in Turkey where she had determined the birth preferences of private hospital maternity patients and, in common with the researcher's study, found that the physical environment significantly influenced the patient's childbirth experiences. Cleanliness was a stated requirement as was the preference for a single delivery room so that they "could not hear anyone else". Onchonga et al. (2021) established that unclear signage, an "ambiguous" structure of the maternity unit, the dilapidated state of maternity wards and poor quality beds and bedding and a generally unhygienic environment were aspects that contributed to the fear of childbirth.

In the scoping review it was mentioned that women would like to be provided with sufficient beds and incubators for their infants during their hospital stay. This was not an aspect raised in the interviews, possibly because the private patients believe that the provision of sufficient beds and incubators for infants is standard practice. Masaba et al. (2022) found in a study carried out in Kenya that patients were concerned about the lack of blood and essential medicines but it is doubtful that the participants in this study would give these factors any thought unless they had previously encountered shortages of this nature.

The scoping review also noted that women desire a well-maintained infrastructure, which could stem from their encounters with substandard facilities. Due to the fact that the research sites where the studies included in the scoping review had taken place, this is a distinct possibility as the public sector in developing countries has a continuous battle with limited funding.

With regard to the third sub-category, access, both public and private healthcare sectors have legal and ethical obligations to provide care that meets established standards of practice and professional conduct. Access to health care is one of the aspects included in the Patient Rights Charter (NDOH, undated). This includes

ensuring that healthcare staff are appropriately qualified, trained, and equipped to meet the needs of patients in a responsive and empathetic manner.

Again, similarities arose in both the scoping review and the researchers' study'. Two of these were the availability of transport and financial constraints. The availability of transport in both the private and public sector are essential as it determines whether pregnant women can physically reach a healthcare facility in a timely manner. The scoping review mentioned more specific aspects regarding access to a healthcare facility. Women utilising the public healthcare facilities mentioned that due to the safety and the absence of men as escorts, birthing facilities were unreachable. They also specifically mentioned the poor road conditions, which led to slow travelling time.

Nabieva and Soures (2019) point out that there are intrinsic factors that influence a woman's decision whether or not to access maternity services including affordability, cultural beliefs and widely spread myths about health services. Financial constraint was an issue raised by participants in both phases of the study. This related not only to the cost of the actual service provided (which, in South African public facilities is free) but it related to the associated costs of access including transportation expenses and out-of-pocket payments for medical care.

Distance from facilities was another issue raised by both groups and this factor was even more important should there be an emergency. This is a problem not only in rural areas of sub-Saharan Africa but even in Australia (Bradow et al., 2021) and the United Kingdom (Heys et al., 2022) where services are being closed for various reasons including a falling birth rate in certain areas and the subsequent need for women to travel further to reach maternity services. The problem of distances, poor road conditions, a lack of private transport and a lack of ambulances has been tackled in Zimbabwe with the development of an app which connects maternity patients needing transport and drivers who charge for their services (Nyati-Jokomo et al., 2020).

The situation for the private patients in the study is somewhat different with most having access to private transport. Their potentially higher socio-economic status most probably results in them not encountering the same barriers related to safety concerns or transportation challenges. Generally, private healthcare facilities are in better

environments with better surrounding road infrastructure, making accessibility for patients easier.

Private healthcare users mostly have access to medical insurance which gives them greater flexibility in choosing a healthcare facility, including the choice of a private hospitals located further away should it meet their needs including being attended to by a preferred provider, even if it requires travelling longer distances due to the comfort of having a personal vehicle.

5.3 Conclusion

In this chapter, the findings of both the results of the scoping review and the semi-structured interviews (phase 1 and 2 respectively) were examined in an attempt to answer the research question, “Do private sector health care users’ criteria for choosing a maternity service differ from those of public sector users? While there are a few differences, the similarities far outweigh the differences with both groups using similar criteria when able to exercise a choice of facility.

Chapter 6: MAIN FINDINGS, LIMITATIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter provides a summary of the research study, the main findings and limitations, and recommendations for further midwifery research, midwifery practice and for midwifery education.

6.2 Summary of research study

This was done by means of a multi-method qualitative study. Phase 1 included a scoping review, which determined the criteria used to measure patient satisfaction in the public maternity services in sub-Saharan Africa. Phase 2 of the study included semi-structured interviews of nineteen (19) women of childbearing age to determine the criteria that private sector user's use when choosing a maternity service to meet their needs and aspirations. The scoping review provided the a priori codes for phase 2 of the study. The data from the semi-structured interviews in phase two were analysed by means of a template analysis, using the a priori codes generated in phase 1. This facilitated a comparison between the two methods in order to answer the research question: Do private sector health care user's criteria for choosing a maternity service differ from those of public sector users?

6.3 Main findings

Ultimately, there were no major differences found in the criteria used for choosing a maternity facility among the private and public healthcare users. Differences arose in the specific detail. This is significant as although currently the quality of care is seen to be different for private (fee paying) facilities and free public health facilities this is ethically unacceptable and as the NHI approaches it is essential to create parity of quality of care.

Perceptions are always subjective but in this study the use of the scoping review, which generated a priori codes assisted the researcher to make a relatively objective

comparison of the findings. The researcher did not find any aspects in the interviews that did not fit in with the a priori codes, which is an indication that there is little difference in the substantive aspects of criteria used when choosing a maternity service.

6.3.1. Main findings related to the relationship category

Women accessing maternity facilities, whether from the private or public healthcare sectors, share common desires regarding respectful communication. Women value being treated with friendliness, patience, and politeness by healthcare professionals. They seek to establish a trusting, supportive, and understanding relationship with their providers, irrespective of the healthcare setting. This mutual desire reflects the importance of interpersonal and person-centred communication in healthcare encounters, where women prioritise feeling respected, heard, and cared for during their maternity care experiences.

While both public and private sector maternity care users express similar preferences for respectful communication, a distinction emerged between the private and the public sector women concerning the stated expectation for non-judgmental or non-discriminatory communication. This may have arisen due to the diverse and economically disadvantaged population utilising the public healthcare system. This population may have experienced discrimination or stigmatisation in other aspects of their lives. Additionally, public sector healthcare facilities face resource constraints, leading to overcrowding, which can exacerbate feelings of vulnerability and the need for sensitive and respectful communication. Furthermore, historical inequalities in healthcare access and treatment may make patients in the public sector more attuned to issues of discrimination and bias in their interactions with healthcare providers. While private healthcare users may not explicitly mention these factors, they remain important. In the private sector there is a heightened awareness of legal ramifications and high litigation rates so healthcare providers in the private sector may be more aware of the need to avoid any form of discriminatory or judgmental behaviours, ensuring equitable and respectful communication with all patients.

The main similarity observed among women in both private and public healthcare sectors concerning the provision of information is their desire to be informed, especially

during labour. Women across both sectors expressed the need for information during the labour process. Women utilising public healthcare were particularly specific in their information requirements, seeking updates on their progress, including details such as dilatation, procedures, and the recognition of potential complications. The shared emphasis on being informed during actual labour underscores the active involvement in decision-making for women during the childbirth experience, regardless of the healthcare setting.

Privacy, confidentiality, and informed consent emerged as shared priorities among women utilising both private and public healthcare facilities. Regardless of the healthcare setting, women expressed a common desire for their privacy to be respected, their personal information to be kept confidential, and for healthcare providers to obtain their informed consent before any procedures or treatments. This alignment underscores the universal importance of ethical principles in healthcare delivery.

One difference observed was that women utilising public healthcare expressed a desire to be culturally respected. This entails healthcare providers acknowledging and honouring their cultural backgrounds, beliefs, and practices throughout the care process. The emphasis on cultural respect may be more pronounced in the public sector compared to the private sector due to the heterogeneous demographic makeup of the patient population in the public setting. Public healthcare facilities often cater to a more diverse and economically disadvantaged population, including individuals from various cultural backgrounds and ethnicities. (The scoping review included articles from all over Sub-Saharan Africa). These patients may have unique cultural beliefs, practices, and preferences that shape their healthcare experiences and interactions with healthcare professionals. In contrast, private healthcare settings may serve a more homogenous or affluent population, where cultural considerations vary to a lesser extent.

6.3.2. Main findings related to the support category

Support from healthcare professionals is of paramount importance as noted by women from both the private and public sector. Regardless of whether the facility is in the private or public sector, women emphasised the necessity of healthcare professionals'

presence and readily availability throughout their pregnancy journey. Specifically, women highlighted the importance of consistent staff presence while monitoring their pregnancies, underscoring the need for consistent and attentive care. Another aspect women raised was the preference for a skilled health professional presence during the labour process. This preference underscores the critical role that healthcare providers play in ensuring a positive birthing experience for women, regardless of the facility type. The presence of a skilled professional not only instils confidence but also contributes to better outcomes and overall satisfaction during childbirth.

Beyond the presence of healthcare professionals, the inclusion of a chosen birth companion emerges as a crucial consideration for women, irrespective of the facility's private or public setting. The encouragement and presence of a chosen birth companion by the women influences their decision when selecting a birthing facility. Women emphasised the essential support birthing companions offer, extending beyond physical presence and including emotional encouragement and practical assistance. Women appreciated the presence of a birth companion to assist with pain management techniques, such as back rubs, as well as their input in decision-making processes during labour; this was an important factor raised in both the private and public setting, influencing a woman's choice of choosing a birthing facility. Thus, it is important that facilities have a policy that allows for the presence of a birth companion.

6.3.3. Main findings related to the service provision category

The research findings for this category displayed overlapping criteria for choosing a birthing facility similar to the relationship category. Women preferred to be assisted by responsive and empathetic healthcare professionals. They prioritise competency and person-centred care when deciding on a birthing facility, regardless of the setting. Women from both the private and public sector desire to be supported by qualified and trained healthcare professionals during their labour. This included the need for hospitable midwives who exhibit friendly and helpful behaviour, a criterion also raised in the relationship-focused category.

The research study also recognised cleanliness as an important factor in a woman's decision in choosing a birthing facility. Interestingly, women from the private sector expressed a desire for a clean and comfortable environment, mirroring the preferences

of women in the public sector. This finding suggests that women's priorities are centred around cleanliness and functionality rather than luxury or extravagance. What they seek is not opulence but rather a clean and adequately spacious room that can accommodate their needs during the birthing process.

The findings of the research study indicate that all women, whether utilising the private or public sector, require easy access to a healthcare facility, and travel time is dependent on the topographical setting.

6.4 Limitations of the study

Whereas data from thirty-six articles which represented the contributions of many participants from several sub-Saharan African countries, the semi-structured interviews were conducted on a total of nineteen participants from one geographic district in one province of South Africa. While saturation was reached amongst this group and an effort was made to recruit additional participants to represent the cultural groupings in the area, this sample is limited and only represents the opinions of that group of participants. Having said that, the purpose of the study was to use the findings for forward planning of a birthing facility in that geographic area so the findings were relevant. As there is no private birthing facility currently operating in the research setting a clinic providing primary health care including antenatal care had to be used as the research setting for this study.

The method of semi-structured interviews was fit for purpose but despite including only participants who indicated they were able to speak and understand English, several participants struggled to express themselves. This resulted in the researcher rephrasing and explaining the questions which may have impacted on their responses. The researcher herself lacked experience in interviewing and may have missed opportunities to probe more deeply to enhance the depth of the qualitative data.

The fact that some of the participants had previously given birth in a public sector facility coloured their sentiments about birthing facilities but nevertheless gave them some context to frame what they would like in a facility. Whereas the participants who had never previously given birth may have not considered some aspects, which would

influence future decisions regarding their choice of birthing facility. This is a common difficulty relating to self-reported data in qualitative studies.

No research study has previously been conducted in the research setting relating to preferences for birthing facilities making it impossible to compare the findings of this study with previous studies.

6.5 Recommendations

6.5.1. Recommendations For Midwifery Education

- In the public sector, where a multicultural environment prevails, midwifery education should place a strong emphasis on meeting the diverse cultural needs of patients. Training programs should prioritise multiculturalism and foster a respect for cultural diversity.

- With the anticipated implementation of the National Health Insurance (NHI) system, there should be increased emphasis on offering services related to patient rights and the "Batho Pele" principles (a set of principles focusing on responsiveness, respect, and professionalism in public services).

- The presence of a birth companion should be allowed and encouraged in both sectors. Midwives should receive in-service training that clarifies their role in this regard to promote acceptance of birth companions. Training to empower birth companions to take on more responsibilities should also be introduced to encourage their active involvement in the childbirth experience.

6.5.2. Recommendations for Midwifery Research

- Conduct a comprehensive study comparing the actual quality of care between private and public maternity services to quantify and address the perceived differences.

- Conduct a longitudinal study to assess long-term outcomes for mothers and infants of the care received in both public and private facilities.

- Examine how socioeconomic factors, cultural beliefs, educational levels, geographical location, previous childbirth experiences and social support networks influence the choice of maternity services and the perceived quality of care

- Explore the use of technological innovations and digital health solutions to enhance the quality of maternity care in public facilities.

- Conduct a comparative analysis to compare experiences and perceptions of pregnant women who choose private sector maternity services with those who opt for public sector services to identify key differences in decision-making criteria, satisfaction levels, and perceived barriers to accessing care.

- Investigate how private sector healthcare facilities, professional associations, and regulatory bodies should implement quality improvement initiatives that are aimed at improving quality of care and patient satisfaction.

6.5.3. Recommendations for Midwifery Practice

- Explore the possible use of a Zimbabwean app, which connects maternity services with drivers.

- An appointment system should be implemented to reduce waiting times.

- Patients should be attended to by the same midwife at each antenatal visit to establish a trusting relationship with continuity of care.

- Due to the limited availability of resources, human and financial resources for midwifery practice should be concentrated in labour wards, as this is where women feel the greatest need. It is however acknowledged that quality ante-natal care is essential to prevent problems and resource reallocation should not be to the deficit of ante-natal care.

- When planning facilities for the National Health Insurance (NHI) basic essentials such as cleanliness, trained midwives, access to food, and a safe, private space for delivery should be provided.

- More emphasis should be placed on antenatal classes, to enhance knowledge on the birthing process so that women arrive at birthing facilities educated and well informed. Birthing companions should also attend these classes so that they too are informed and educated on the birth process, and are able to assist the women throughout the birthing process.

6.6 Conclusion

The purpose of the study was to understand whether the private patients' needs and preferences are any different to those of the current public sector users of the maternity services. The rationale for this was that an understanding of private patient's needs and preferences would assist in forward planning for the time when both private and

public sector patients are to use the same services according to the NHI guidelines. This is important for equitable quality services as promised by the NHI bill are provided.

The findings of this study indicated that all women, irrespective of social class, culture or socio-economic status have similar needs and preferences and would use those similar criteria for choosing a birthing facility, should they be given that choice. The study emphasised that women need caring, responsive midwives to be present at their birth together with a birth companion of their choice in an accessible, clean and comfortable environment. This should not be much to ask and mirror the requirements contained in the human rights charter.

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Annexures

Annexure 1: Interview Guide

code:_____

How old are you?
How many children do you have and how old are they?
Where did you birth your children?
Are you currently pregnant or intending to have another baby in the future?
Do you have medical insurance? If so, does it cover your maternity costs?
1. If you had a choice of where to receive care when pregnant, and for your delivery, what criteria or factors would influence your choice? Probes: ● Why is that important to you? (for each criteria mentioned) ● Of all the criteria and factors you have mentioned, which would be the deciding factor? ● Can you tell me why that one is so important?
2. I want to explore some specific issues with you. If you had to choose the facility you give birth in, what is it about **the people**, such as the doctors and the midwives that would be important to you? Probes: ● Can you tell me why that is so important? ● How about communication and information? Do they matter? ● What about respectful care? Is this important? ● And the relationship with the carer? What would matter in relation to that?

3. If you had to choose the facility you give birth in, what is it about **the place, or the environment**, that would be important to you?
Probes:

- Can you tell me why that is so important?
- How about privacy, meals, cleanliness, equipment? Are any of those important? Why or why not?
- Is proximity of the facility important? For example, would you consider convenience an issue?

4. If you had to choose the facility you give birth in, what is it about the **policies, or rules and regulations,** that would be important to you?

Probes:

- Can you tell me why that is so important?
- Would you consider policies regarding breastfeeding important? Why, or why not?
- What about policies regarding pain relief? Are they important? Why or why not?
- And waiting times, policies regarding birth companions?
- Does it matter what the cost of care would be? Are you willing to pay for the service in the hope of getting better quality care?

Annexure 2: Invitation to participate in a study

INVITATION TO PARTICIPATE IN A STUDY

Study title: PRIVATE SECTOR HEALTH CARE USERS' CRITERIA FOR CHOOSING MATERNITY SERVICES IN A DISTRICT IN MPUMALANGA

Good day, my name is **Nadia Clay**. I am a Master's student at the University of Witwatersrand in the Department of Nursing Education. I will be conducting a research entitled: "Private Sector Health Care Users' Criteria For Choosing Maternity Services In A District In Mpumalanga"

The purpose of this study is to identify and compare the criteria used by both private and public health care users when choosing a maternity service. Once differences and/or similarities have been identified, it will be possible to start planning maternity services which meet both public and private health care users' needs to provide patient satisfaction.

I would like to invite you to take part in this study which will involve participating in a semi-structured interview where I will ask you some questions relating to the criteria you would use in choosing a maternity service. The interview will take between 30 and 45 minutes at a time convenient to yourself.

You will be asked to sign a consent form to show that you agree to take part as well as a consent for audio recording of the interview. There will be no direct benefits to you in participating nor will there be any risk, however the results collected from the study will be used to make recommendations relating to the implementation of the National Health Insurance policy.

Your participation is completely voluntary, and you are free to withdraw at any time without giving a reason**.** All information will be treated in the strictest confidence. Information received will not be publicly reported in a manner that identifies you.

All data collected in the course of the study will be securely retained for two (2) years, if a scientific publication arises from the study and six (6) years, if there is no publication. Thereafter it will be destroyed accordingly.

The study will be written up as a dissertation and will be available online through the university's library website. Should you wish to receive a summary of this report I will be happy to send one to you on request.

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Professor Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Alternatively you may contact my supervisors who are Dr Barbara Hanrahan at Barbara.hanrahan@wits.ac.za and Dr Sue Armstrong at sue.armstrong@wits.ac.za.

Annexure 3: Participant consent form

PARTICIPANT CONSENT FORM

Study title: PRIVATE SECTOR HEALTH CARE USERS' CRITERIA FOR CHOOSING MATERNITY SERVICES IN A DISTRICT IN MPUMALANGA

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

Researcher	Supervisor	Co-Supervisor
Nadia Clay	Barbara Hanrahan	Dr Sue Armstrong
0820530261	Barbara.hanrahan@wits.ac.za	sue.armstrong@wits.ac.za.

Informed consent

I……., hereby confirm that I have been informed by the researcher, Nadia Clay about the nature, conduct, benefits and risks of the study.
I have also received, read and understood the above written participant information sheet regarding the research.
I am aware that results of the study will be anonymously processed into a study report and may, at any stage without prejudice, withdraw my consent and participation in the study.
I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in study.

Date: _____ Witness:_____

Annexure 4: Consent form for audio recording interviews



CONSENT FORM FOR AUDIO RECORDING OF STUDY PARTICIPATION

Study title: PRIVATE SECTOR HEALTH CARE USERS' CRITERIA FOR CHOOSING MATERNITY SERVICES IN A DISTRICT IN MPUMALANGA

I hereby consent to audio recording of the interview.

I understand that:

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

Name of Participant: _____
Date : _____
Place : _____
Signature or mark : _____

Annexure 5: Ethics Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG	HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

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

TO:	Ms N Clay School of Therapeutic Sciences Department of Nursing Education Medical School University E-mail: nadia.kruger174@gmail.com
CC:	Supervisor: Drs S Armstrong and B Hanrahan <Sue.Armstrong@wits.ac.za> and <HREC-Medical Research Office@wits.ac.za>
FROM:	Mr Iain Burns Human Research Ethics Committee (Medical) Tel: 011 717 1252 E-mail: Iain.Burns@wits.ac.za
DATE:	2022/02/10
REF:	R14/49
PROTOCOL NO:	**M211147** (This is your ethics application reference number. Please quote it in all enquiries, oral or written, relating to this study.)
PROJECT TITLE:	*Criteria used by private health care users for choosing maternity services in a district in Mpumalanga*

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



MSWorks2000/Iain0007/Clearscan.wps

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R49 Ms N Clay

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M211147

NAME: (Principal Investigator)	Ms N Clay
DEPARTMENT:	School of Therapeutic Sciences Department of Nursing Education Medical School University
PROJECT TITLE:	*Criteria used by private health care users for choosing maternity services in a district in Mpumalanga*
DATE CONSIDERED:	2021/11/26
DECISION:	Approved unconditionally
CONDITIONS:	
NOTE:	If contact information regarding student study participants is required, please contact the Registrar's office - <Nicoleen.Potgieter@wits.ac.za>
SUPERVISOR:	Drs S Armstrong and B Hanrahan
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	2022/02/10

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

DECLARATION OF INVESTIGATORS

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

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

Clay

Signature of Principal Investigator

2022/02/11

Date

Annexure 6: Example of a section of a transcribed interview with analysis

Interview : 1

Interviewer	Okay, thank you so much for participating in my interview and as I explained, it is just for my master's degree, your name will not be mentioned, you can withdraw from the interview at any time. Okay, so how old are you?	
Participant 1	I'm 32.	Age
Interviewer	How many children do you have?	
Participant 1	I've got two children.	Two children
Interviewer	Two children. How old are they?	
Participant 1	The first born is 11.	
Interviewer	And the second one?	
Participant 1	Is four.	
Interviewer	Oh, gee big gap. And where did you give birth to your children?	
Participant 1	The first one I gave birth at (Name redacted) Hospital.	Government Hospital
Interviewer	Okay, that's in Hoedspruit?	
Participant 1	Yes, somewhere there on that side of Hoedspruit.	
Interviewer	And the second one?	
Participant 1	Here in Lydenburg but not in hospital.	
Interviewer	Where?	
Participant 1	In my house.	
Interviewer	Oh, house birth, interesting was it by choice or by accident?	Home birth
Participant 1	No by accident.	
Interviewer	Was the ambulance late?	
Participant 1	My friend drove me after birth, I was not alone.	
Interviewer	Okay, we'll come back to that. Are you currently pregnant? Or do you want a third baby?	
Participant 1	I'm not even planning on having a third one now.	
Interviewer	Okay, not anytime soon. And do you have medical aid?	
Participant 1	I don't have it.	No Medical aid

Interviewer	Okay, so the first question is, if you had a choice on where you could receive care for your pregnancy and for birth, you know, back then or for your future pregnancies. What criteria or factors would influence your choice? Like why would you choose a specific facility?	
Participant 1	I think I'll choose MediClinic or private hospital.	Choose PVT
Interviewer	And why?	
Participant 1	Because the service at the private hospitals, It's not good. Because I remember when,	
Interviewer	You mean the service at the government hospital is not good?	Service Provision
Participant 1	Yes, at the government hospitals is not good because when I when I got my first daughter, I was still at university and then I went home. To my home hospital, I am from Akwanone (Hoedspruit area). So even when I got there, I already had pain. It was my nine months I knew I was due. I was attending GP doctors.	Attending GP, informed
Interviewer	Yes, private doctors.	
Participant 1	But I knew I had no money to go to private hospitals. So even when I got there, the nurses, they were not nice. They were just saying I must chill there and they will look at me later as they are still busy and stuff. And then my water broke	Respect Staff Presence Timely treatment
Interviewer	In front of them while you were waiting?	
Participant 1	Not even in front of them, in front of people that were sitting on the benches, my water broke there and then they rushed when they saw the water broke and they will saying why didn't I tell them, but how was I supposed to know that my water would break. So, a few hours later, I got an older nurse, she was a little bit nicer because she was not at the scene when my water broke. So she was saying why did they let me sit there when they see that you are in a lot of pain. But she was nice. I gave birth around 4am. And then by seven-eight, I was discharged. They just checked me in the morning, checked the baby. And then I went home. So, it was not a good experience.	Privacy Pain Respectful Bad experience
Interviewer	Not a good experience just because of the nurses not attending to you quick enough.	
Participant 1	Even the environment was so dirty. Even when we went to the labour ward, there were blood towels everywhere. It was bad.	Cleanliness-Environment was dirty
Interviewer	And you said when your water broke the nurses asked you Why didn't you tell them? Did you do any antenatal classes?	Information-Attended ANC
Participant 1	Yes I did. I was told everything I knew, I knew even when I went to the hospital I knew already, I had a bag. I knew what I needed to bring to the hospital and when you give birth, I knew everything, I even knew the dates that I was going to give birth, the doctor told me maybe it will be from the 20th going through to month end of March. So I came back from	Informed on due dates, hospital bag Pain Timely treatment Privacy

	school, I think beginning of March because I was not sure because when they say you are due March, and then the doctor said maybe from the 20th. But I came back early and then I even went to the clinic I think on the 28th for my last checkup and they said you are due anytime. So on the 29th I went to the hospital I think it was 5pm, and then they said no I said I'm in a lot of pain and they just said sit there at the benches, we will attend to you. I was with a lot of women who were pregnant. Women were crying there, but they were busy doing the things that and then I was the first one- my water broke at the benches. And then someone called the nurses they came they rushed me to the bed, they checked me they say no, you are what what centimetres. You're going to give birth soon. But I was at the benches for so many hours without being checked first. I think when I got to the hospital they were supposed to check me before they said sit there. But they did not check me. They just said no you people come here, you don't even know your dates you just come here, and cry day and night, we are tired of such, just sit there at the bench we will check you later. And then a few hours later my water broke, I was not checked, so it was not a good experience.	Quality of staff Respect Communication