WOMEN’S PERCEPTIONS AND EXPERIENCES OF ANTENATAL CARE RENDERED BY MIDWIVES

By

Winnifred Nonkonzo Mxoli

Submitted in partial fulfillment of the requirements for the degree of

Magister Curationis
(Advanced Midwifery and Neonatal Nursing Science)

in the

Faculty of Health Sciences

at the

Nelson Mandela Metropolitan University

JANUARY 2007

Study leader: Mrs L Jantjes
Co study leader: Professor J Strumpher
ABSTRACT

The general health status of pregnant women depends largely on the quality of the antenatal services available to them. The provision of good antenatal services ensures early detection and prompt management of any complication or disease that may adversely affect pregnancy outcome. In order to ensure high quality care, antenatal services need to be evaluated at regular intervals, both from provider and client perspective, to ensure their effectiveness in improving the health status of pregnant women.

The midwife, as the first contact person for most pregnant women attending antenatal clinics in South Africa, has the potential to play a major role in improving the health status of these women. However, for the midwife to be effective in achieving this, antenatal services need to be effectively utilized by women. One of the factors that affect utilization of any service is client satisfaction with the service being rendered. This study, therefore, explores the perceptions that pregnant women have of the care that they receive from midwives at the selected antenatal clinics.

The objectives of the study are to:

- Explore and describe the perceptions and experiences of pregnant women attending antenatal clinic regarding the care they receive from midwives.
- Make recommendations to assist registered midwives in optimizing the accompaniment of women during the antenatal period.

A qualitative, descriptive, exploratory and contextual design was used for the study. The sample was chosen from the target population by means of purposive sampling and data was collected through unstructured interviews with the participants. Before data collection, permission was obtained from the Eastern Cape Department of Health and the Nursing Service Manager of the Gateway clinic, in the district hospital where the research was conducted. The Nursing Service Manager was acting as a Medical Superintendent at the time of the study. Written, informed consent was obtained from all participants before conducting interviews. Trustworthiness was ensured by means of Guba's model throughout the study, and the aspects of truth value, applicability, consistency and neutrality were considered.
Tesch’s eight steps of data analysis were used to analyze the data collected, and four main themes were identified namely:

- Women perceive midwives as considerate and knowledgeable
- Women perceive midwives as lazy and rude
- Women experience mixed emotions about the care they receive from midwives
- Though their experiences, women identified certain needs in the services and care they received at the clinic.

Conclusions were drawn and recommendations for midwifery practice made based on the results of the study, with the aim of improving antenatal services rendered to pregnant women.

**Key words**

<table>
<thead>
<tr>
<th>Perception</th>
<th>Midwife</th>
<th>Antenatal care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience</td>
<td>Antenatal clinic</td>
<td></td>
</tr>
</tbody>
</table>
I would like to give thanks to the following people who highly contributed to the completion of this study:

- My God Almighty who always strengthens me to do all things.
- A special word of gratitude to the women who agreed to participate in the study.
- My supervisor, Mrs Louisa Jantjes and my co-supervisor, Professor Juanita Strumpher, who made this effort possible through persistent support and encouragement.
- Mrs Jafta, the Nursing Service Manager of St Lucy’s Hospital, for granting me the study leave.
- Mrs Chetty, the Port Elizabeth Campus Head - Lilitha College, for providing me with the opportunity to study.
- Barbara Pitt for her patience during editing.
- My loving husband, Lungelo, and our children for the support they gave me in spite of all odds.
- My colleagues at work, for their encouragement and support.
# TABLE OF CONTENTS

**ABSTRACT**

**CHAPTER 1: OVERVIEW OF THE STUDY**

1.1 INTRODUCTION

1.2 BACKGROUND AND SIGNIFICANCE OF STUDY

1.2.1 Effective Antenatal Care

1.2.2 Adequate Antenatal Attendance

1.3 PROBLEM STATEMENT

1.4 RESEARCH QUESTION

1.5 OBJECTIVES OF THE STUDY

1.6 CONCEPT CLARIFICATION

1.7 PARADIMATIC PERSPECTIVE

1.7.1 Man/human beings/person

1.7.2 World

1.7.3 Health

1.7.4 Nursing

1.7.5 Accompaniment

1.8 RESEARCH DESIGN AND METHODOLOGY

1.8.1 RESEARCH DESIGN

1.8.2 RESEARCH POPULATION AND SAMPLING

1.8.3 DATA COLLECTION

1.8.4 DATA ANALYSIS

1.8.5 Literature Control

1.8.6 Pilot Study

1.9 TRUSTWORTHINESS

1.10 ETHICAL CONSIDERATIONS

1.11 CHAPTER DIVISION

1.12 CONCLUSION

**CHAPTER 2: RESEARCH DESIGN AND METHOD**

2.1 INTRODUCTION
CHAPTER 3: PHASE 1 - DATA COLLECTION, ANALYSIS AND INTERPRETATION
3.1 INTRODUCTION................................................................. 39
3.2 PRESENTATION OF RESULTS........................................... 39
  3.2.1 Target population and sample........................................ 39
  3.2.2 Characteristics of the participants................................. 40
  3.2.3 Data collection.......................................................... 41
3.3...DISCUSSION OF RESULTS............................................ 44
  3.3.1 Theme 1: Women perceive midwives as considerate and knowledgeable................................................................. 44
3.3.1.1 Sub-theme 1.1: Women perceive midwives as considerate when they give priority to those staying far from the clinic................................. 44
3.3.1.2 Sub-theme 1.2: Women perceive midwives as knowledgeable when they execute their duties......................................................... 46
3.3.2 Theme 2: Women perceive midwives as lazy and rude...................... 47
3.3.2.1 Sub-theme 2.1: Women perceive midwives as lazy when they see them sitting having tea or lunch while women are waiting............... 47
3.3.2.2 Sub-theme 2.2: Women perceive midwives as rude when they shout at women.............................................................................. 49
3.3.2.3 Sub-theme 2.3: Women felt that their needs were ignored at times by midwives.............................................................................. 51
3.3.3 Theme 3: Women experience mixed emotions about the care they receive from midwives........................................................................ 54
3.3.3.1 Sub-theme 3.1: Women felt content about the care they received from the midwives................................................................. 54
3.3.3.2 Sub-theme 3.2: Women felt frustrated and angry when turned back home for being late............................................................... 56
3.3.3.3 Sub-theme 3.3: Women felt embarrassed when palpated by a male midwife.............................................................................. 57
3.3.4 Theme 4: Through their experiences, women identified certain needs in the services and care they received at the clinic......................... 58
3.3.4.1 Sub-theme 4.1: Women expressed a need for adequate information about pregnancy................................................................. 58
3.3.4.2 Sub-theme 4.2: Women wanted midwives to give reasons and explanations about procedures performed on them by midwives........... 62
3.3.4.3 Sub-theme 4.3: Women expressed the need for a doctor at the clinic for deliveries................................................................. 63
3.3.4.4 Sub-theme 4.4: Women expressed the need for pregnant women to be dealt with separately from other clients.................................. 64
3.3.4.5 Sub-theme 4.5: Women expressed a need for a clinic closer to their homes.............................................................................. 66
3.4 CONCLUSION............................................................................... 68
CHAPTER 4: PHASE 2 - CONCLUSIONS, GUIDELINES AND RECOMMENDATIONS

4.1 INTRODUCTION

4.2 OBJECTIVES OF THE STUDY

DISCUSSION OF FINDINGS

4.4 RECOMMENDATIONS FOR CLINICAL PRACTICE

4.4.1 Empowering midwives with health education skills

4.4.1.1 Principles of adult learning

4.4.1.2 Appropriate teaching principles

4.4.1.3 Methods of presenting the subject matter

4.4.1.4 Evaluation of learning

4.4.1.5. The health education content that should be given to pregnant women

4.4.1.5.1 Interventions to reduce mother-to-child transmission of HIV

4.4.1.5.2 Information on pregnancy, labour and newborn care

4.4.1.5.3 Danger signs of pregnancy

4.4.1.5.4 Indications of medications and vaccines given during pregnancy and childbirth

4.4.1.5.5 Significance of essential screening investigations

4.4.2 Improving the midwife-client relationship

4.4.3 Recommendations for improving accessibility of antenatal services

4.5. Recommendations for nursing education

4.6. Recommendations for further research

4.7 LIMITATIONS OF THE STUDY

4.8 CONCLUSION

BIBLIOGRAPHY

FIGURES

Figure 1: Percent Clinics Providing EPI, FP, ANC and Child Curative Services

Figure 2: Percent Clinics Providing Antenatal Care

Figure 3: Antenatal Care Continuity
TABLES
Table 1.1: Schedule for Return Antenatal Visits in Low Risk Women.................. 5
Table 1.2: Time of visits according to WHO Antenatal care Model....................... 6
Table 3.1: Identified Themes Related To Women’s Perceptions and Experiences of Antenatal Care.................................................................................. 43

ANNEXURES
ANNEXURE A: Participant consent form.............................................................. 93
ANNEXURE B: Example of field notes................................................................. 94
ANNEXURE C: Example of a transcribed interview that was translated into English.................................................................................................................. 95
ANNEXURE D: Guidelines given to independent coder...................................... 96
ANNEXURE E: Letters of application to do research to Health Services............. 97
ANNEXURE F: Permission letters from University structures............................ 98
ANNEXURE G: Certificate of editing................................................................. 99
CHAPTER 1

OVERVIEW OF THE STUDY

1.1. INTRODUCTION

The general health status of pregnant women depends largely on the quality of the antenatal services available to them, as pregnancy tends to aggravate most potential diseases that can occur in women. The provision of good antenatal services ensures early detection and prompt management of such diseases. This statement is supported by the high death rate among women who never received antenatal care during pregnancy. A provincial overview of maternal deaths in the Eastern Cape (Department of Health, 2001: 4) revealed that 41% of maternal deaths in the year 2000 were among women who never received antenatal care during pregnancy. In order to ensure high quality care, the effectiveness of antenatal services needs to be evaluated at regular intervals, both from provider and client perspectives, and improved as required.

The World Health Organization (1998:2) maintains that good quality antenatal services should involve the clients in decision-making and see them as active participants in improving their own health. Women need to be encouraged to participate in planning services to improve and optimize service delivery for their benefit. Bluff and Holloway (1994:158) highlight that the provision of a client-centred service, where women are able to express their opinions, is ideal in improving utilization of services. However, apparently health care workers do not take the views and opinions of pregnant women regarding what constitutes effective antenatal care into consideration. In a study by Sikorski, Clement, Wilson, Das and Smeeton (1995:61), only the inputs of midwives and obstetricians were sought on possible changes in the provision of antenatal care. Little interest was shown in the views of pregnant women.
The researcher assumes that poor antenatal attendance may be the result of the midwives failing to meet the expectations of pregnant women.

The World Health Organization (1998: 6) views the role of positive interactions between women and health care providers as critical in improving client compliance. Providers and clients may perceive quality of care differently. Providers may be anxious to ensure technical correctness, whereas clients may be more concerned with issues like moral support and cultural beliefs. Adequate attention, thus, needs to be paid to their concerns. The midwife, as the first contact person for most pregnant women attending antenatal clinics in South Africa, has the potential to play a major role in improving women’s health status. However, for the midwife to be effective in improving women’s health status, antenatal services need to be effectively utilized by women. One of the factors affecting the utilization of any service is client satisfaction with the service that they receive (Enkin, Keirse, Renfrew and Neilson, 1995: 2). This study will, therefore, explore the perceptions and experiences pregnant women have of the care they receive from midwives at the antenatal clinics.

1.2. THE BACKGROUND AND SIGNIFICANCE OF THE STUDY

Antenatal care is the health care that a pregnant woman and her fetus receive from conception to the onset of labour (Fraser and Cooper, 2003: 251). According to De Kock and Van der Walt (2004: 9-2), the comprehensive aim of antenatal care is to prepare the pregnant woman and her family for pregnancy, labour and puerperium, including lactation and subsequent care of the newborn baby. The major components of antenatal care are:

- Complete assessment of the pregnant woman through history taking, physical examination and blood tests.
- Institution of a plan of action for problems identified.
• Health education on health promoting activities, like exercises, diet and anticipated pregnancy related problems.
• Close monitoring of both fetal and maternal condition throughout pregnancy (De Kock and Van der Walt, 2004: 9-2).

Hence, good antenatal care greatly improves women’s health status as the reproductive years between 15 and 49 years (Department of Health, 2001: 3) cover almost half of their lifetime. Any health risk for women is likely to be identified during this period.

The impact of good antenatal care in improving the health status of the population is acknowledged by the World Health Organization (Ross, 1998: 21), whereby the maternal mortality rate is regarded as one of the factors that reflect the health status of the population. The Department of Health (2000:18) maintains that good antenatal care should ensure the best possible pregnancy outcome for women and their babies. This implies that good antenatal care will be evidenced by a drop in both maternal and perinatal mortality rates.

In a Perinatal Care Survey of South Africa, the Department of Health (2000b: 41) identified two factors that form the cornerstone in ensuring the best possible pregnancy outcome; these are:
• Effective antenatal care.
• Adequate antenatal attendance.

These factors will now be discussed in more detail.

1.2.1 Effective Antenatal Care

Enkin et al (1995: 12) define effective antenatal care in terms of its accessibility to the women who need it. Accessibility involves both bringing services closer to women, and bringing women closer to the services. Ross (1998: 87) emphasizes the need to balance upgrading services with mobilizing women to utilize them. Accessibility of antenatal services can be improved by:
• Improving transport and communication facilities between health centres for easy referral from one centre to another.
• Building clinics within walking distance of all women.
• Making antenatal services affordable in terms of cost. Ross (1998: 14) maintains that maternal health programmes are unlikely to succeed if women cannot afford to pay for the services rendered by that programme. The South African Government has acknowledged this and has approved the provision of free antenatal services in the public sector (African National Congress, 1994a:45).

1.2.2 Adequate Antenatal Attendance
Adequate antenatal attendance is determined by three factors:

• Number of antenatal visits before the expected date of delivery.
• Time at which the initial antenatal visit, commonly known as ‘the booking visit’, was done.
• Frequency of antenatal visits.

Each of these factors will now be clarified.

Number of antenatal visits
A pregnant woman’s antenatal care is accepted as adequate in a low risk woman if she has had a minimum of three antenatal visits before the expected date of delivery (Westaway, Viljoen, Wessie, McIntyre and Cooper, 1998: 57). This is also supported by the Department of Health in the Guidelines for Maternity Care (Department of Health, 2000a: 3) where it postulates that the three antenatal visits are necessary to monitor the progress and take action on the results of rhesus status, haemoglobin level and serological tests for syphilis. The new WHO antenatal care model (Ntombela, 2005: 3) recommends four antenatal visits for low risk women who are eligible to receive routine antenatal care.

Time of booking visit
The initial visit to the antenatal clinic is expected to be as soon as the woman realizes that she is pregnant, which is usually at four to five weeks of
pregnancy (Department of Health, 2000a: 19), or within 16 weeks of pregnancy (Ntombela, 2005: 4). The first visit is critical in that it provides a baseline against which the progress of pregnancy is assessed. The rate of fetal growth, for instance, is evaluated by comparing the current findings on abdominal examination with those of the booking visit.

**Frequency of visits**
The South African Nursing Council regulation R2488 (South Africa [Republic], 1990: 2) regarding the conditions under which the Registered Midwife may carry on her profession, states that a low risk pregnant woman is expected to attend an antenatal clinic once a month until she is 28 weeks pregnant, twice a month from 28 to 36 weeks and then weekly until delivery. The Department of Health (2000a: 26), in the Guidelines for Maternity Care, adopted a schedule for return visits from Zimbabwe (see table 1) that the health care providers can modify to suit their communities. However, more frequent antenatal visits are expected in high risk pregnancies.

<table>
<thead>
<tr>
<th>Gestation age at current visit (weeks)</th>
<th>Schedule return visit (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-19 weeks</td>
<td>24 weeks</td>
</tr>
<tr>
<td>20-23 weeks</td>
<td>28 weeks</td>
</tr>
<tr>
<td>24-28 weeks</td>
<td>32 weeks</td>
</tr>
<tr>
<td>29-36 weeks</td>
<td>After 4 weeks</td>
</tr>
<tr>
<td>37-38 weeks</td>
<td>After 2 weeks</td>
</tr>
<tr>
<td>39-40 weeks</td>
<td>41 weeks</td>
</tr>
<tr>
<td>41 weeks</td>
<td>42 weeks</td>
</tr>
</tbody>
</table>

Adapted from Guidelines of the Department of Health (2000: 26).

The schedule of four visits for low risk women, as recommended by WHO is shown in table 2 below. The antenatal activities are distributed over the four visits, so that each visit has a purpose. A checklist is used for activities
performed at each visit to ensure that all essential antenatal activities have been performed for every client (Ntombela, 2005: 4).

**Table 2: Time of visits according to WHO antenatal care model**

<table>
<thead>
<tr>
<th>Visit</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st visit</td>
<td>Within first 16 weeks of pregnancy</td>
</tr>
<tr>
<td>2nd visit</td>
<td>Between 24 to 28 weeks of pregnancy</td>
</tr>
<tr>
<td>3rd visit</td>
<td>At 32 weeks</td>
</tr>
<tr>
<td>4th visit</td>
<td>At 36 weeks</td>
</tr>
</tbody>
</table>

Adapted from AED/LINKAGES, Ntombela 2005: Antenatal package.

The South African government’s commitment to ensuring the best possible pregnancy outcome is reflected in its constitution, relevant legislation and policies. The following are just a few examples of the government policies and acts aimed at improving women’s health status:

- The Constitution of the Republic of South Africa 1996 (Act 108 of 1996), which states that everybody has a right to make their own decisions concerning reproduction (South Africa [Republic], 1996: 18). This resulted in legalizing abortion through the Choice on Termination of Pregnancy Act, 1996 (Act 92 of 1996) (South Africa [Republic], 1996: 2). The government assumed that women would welcome this attempt at reducing unwanted pregnancies.

- The Patients’ Rights Charter (Department of Health, 1999: 4), which includes the right to choose health services one prefers and a particular health care provider as an attempt to improve utilization of health services.

The descriptions of effective and adequate antenatal care are based on what the government, obstetricians and midwives perceive as important for the pregnant mother. In a study by Sikorski et al (1995: 61) on the views of midwives, obstetricians and general practitioners regarding antenatal care, inputs were sought on possible changes in the provision of antenatal care.
Modifications were implemented based on these inputs and little interest has been shown in the views and opinions of pregnant women regarding what constitutes effective antenatal care. The South African government, in its National Health Plan, has specifically approved the provision of free antenatal care in the public sector (African National Congress, 1994a: 45). The provision of free antenatal services is aimed at ensuring that all pregnant women have access to adequate and effective antenatal care. Free antenatal care does not guarantee utilization of services. A study by Westaway et al (1998: 57) on the effectiveness of free antenatal care in a Gauteng settlement concluded that the provision of free antenatal care did not automatically increase utilization of services. Among other things, client satisfaction with the service they receive was cited as one of the factors that affected utilization of services.

Schott and Henley (1996: 19) maintain that midwives tend to regard the way they organize maternity care as the best and the only way, ignoring the interests of the very women for whom the services are planned. Bennett and Brown (1999: 119) confirm that consumer satisfaction increases if the service is acceptable and meets the expectations of women for whom it is provided. A client-centred service should be provided through identifying what women want and need. The best care will not be effective until women themselves realize they need the service and accept it (Enkin et al, 1995: 13). Consequently, it is becoming more important to listen to the women who use the maternity service and ascertain how they perceive the antenatal services they receive from midwives.

The focus on women’s opinions of effective antenatal care is intended to improve utilization of services, thus improving the health status of women, their families and the population as a whole.
1.3. PROBLEM STATEMENT

Adequate antenatal attendance is, mainly, the responsibility of the pregnant woman. Regardless of how effective antenatal services are, all efforts will be ineffective if women do not utilize them. Women need to be motivated and their commitment to, and acceptance of, the care provided enhanced.

However, in her role of mentor to student midwives in the maternity unit of one of the district hospitals in the Eastern Cape, the researcher has noted that a number of pregnant women either start attending antenatal clinic late (after 20 weeks of pregnancy), or have registered less than three attendances before the expected date of delivery. This makes early detection of any pregnancy and fetal complications difficult. The specific reason for late attendance at the antenatal clinics is not known. The National Committee for Confidential Enquiry into Maternal Deaths suggested that these reasons be established so that intervention can be introduced (Eastern Cape Department of Health, 1998: 5).

Enkin et al (1995: 15) suggested that giving women more control during pregnancy may enhance their commitment to the care provided for them. Accordingly, poor antenatal attendance could be indicative of women not being given a chance to express their views and expectations regarding antenatal care. Knowledge of women’s perceptions of antenatal care increases the midwives’ understanding of their expectations relating to the provision of antenatal care.

Poor antenatal attendance at St Lucy’s Hospital antenatal clinic has prompted the researcher to explore pregnant women’s experiences and how they perceive the antenatal care they receive there from midwives. St Lucy’s Hospital is situated in a predominantly rural area in the Qumbu Health District, in the Eastern sub-region of the Eastern Cape Province. The Eastern Cape Province is regarded as one of the most disadvantaged and underdeveloped provinces in South Africa, particularly with regard to the quality of health
services (Mahlalela, 1997: 5). The fact that the province inherited the previously neglected former Transkei and Ciskei homelands has aggravated the situation. In 1994 the Eastern Cape Province was divided into five health regions, of which Regions D and E incorporated the former Transkei. The Qumbu Health District is in Region D of the Eastern Cape Province.

From 1994, due to poor health services in the area, the National Government focused its development programmes mainly on the Eastern Cape province in an attempt to create a more effective, equitable and affordable health care delivery system (Mahlalela, 1997: 5). By 1997, three years after the implementation of the National Health Plan (Department of Health, 1998: 9), some improvements were noted, particularly in the accessibility of services in Region D. Five new community health centres were built and most clinics were upgraded. Emergency ambulance services were established in areas where previously they did not exist. Health care for pregnant mothers is provided free (Department of Health, 1998: 9). According to Equity’s preliminary survey of 1997 (Mahlalela, 1997: 41), integration of services is adequately implemented in Region D. Sixty nine percent of clinics provide at least four maternal and child health services five days per week, while all clinics provide antenatal services at least once a week. Figures 1 and 2 illustrate the percentage of clinics providing all four services namely the Extended Programme of Immunizations, Family Planning, Antenatal Care and Child Curative Services in the five regions of the Eastern Cape Province.
In spite of the above efforts to improve accessibility of antenatal services, utilization patterns are less favourable than anticipated. According to Mahlalela (1997: 48), only 61% of women in Region D had three or more recorded antenatal visits by their expected day of delivery (Figure 3).
The target of the National Department of Health is to provide antenatal services to 90% of all pregnant women (African National Congress, 1994b: 46). The 1998 Report of the National Committee on Confidential Enquiries into Maternal Deaths (Department of Health, 1998:5) reflects that the most common, patient related, avoidable causes of perinatal deaths can be linked directly to no antenatal care, late initiation of antenatal care or infrequent attendance at antenatal clinics.

Mahlalela (1997: 49) suggests that women’s perceptions of the standard of care provided in antenatal clinics are among the possible reasons for inadequate attendance at antenatal clinics. Hence, the focus of this study is the exploration of women’s perceptions and experiences of the quality of antenatal care they receive from midwives.

1.4. **RESEARCH QUESTION**

The researcher would like the following question to be answered:
• How do pregnant women perceive and experience the quality of antenatal care they receive from midwives?
• What can the midwives do to assist in optimizing the accompaniment of women during their antenatal period?

1.5. OBJECTIVES OF THE STUDY

The primary objective of this study is to explore and describe the perceptions and experiences that pregnant women have of the antenatal care that they receive from midwives so that utilization of services can be improved.

The specific objectives of this study are to:
• Explore and describe the perceptions and experiences of pregnant women attending the antenatal clinic regarding the care they receive from midwives.
• Make recommendations to assist registered midwives in optimizing the accompaniment of women during their antenatal period.

1.6. CONCEPT CLARIFICATION

The following concepts are clarified for the purposes of this research study.

1.6.1 Perception
The Oxford Dictionary (Pearsall, 1995: 609) defines perception as an intuitive recognition of a truth. Perception in this study refers to how pregnant mothers see or regard antenatal care they receive from midwives.

1.6.2 Experience
Experience refers to either the skill or knowledge gained in actual observation of facts or events, or how the individual is affected by the event (Pearsall, 1995: 365). In this study, women’s experiences refer to how women are affected by the antenatal care they receive.
1.6.3 Midwife
A midwife is defined in the Oxford dictionary as a person trained to assist at childbirth (Pearsall, 1995: 525). The International definition of a midwife is quoted by Fraser and Cooper (2003: 5) as ‘a person who, having been regularly admitted to a midwifery educational programme duly recognized in the jurisdiction in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery’. Blackwell’s Nursing dictionary, however, defines a midwife as a specialist health professional who is qualified to give total care to a woman and her baby during pregnancy, labour and after birth (Freshwater and Moslin – Prothero, 2005: 362). For the purpose of this study, a midwife is a person trained for accompaniment of a woman’s pregnancy and who is registered with the South African Nursing Council as a midwife according to the Nursing Act, 1978 (Act 50 of 1978) (South Africa [Republic], 1978.)

1.6.4 Antenatal care
The word ‘antenatal’ relates to any event or condition that occurs or exists in the embryo or the mother during the period between conception and delivery of the infant (Freshwater and Moslin-Prothero, 2005: 39). Antenatal care, therefore, is the care of a pregnant woman and her fetus by health care staff, including midwives, from conception to the onset of labour (Fraser and Cooper, 2003: 251). Antenatal care in this study refers to the care provided to the pregnant woman by the midwife.

1.6.5 Antenatal clinic
An antenatal clinic refers to any department of the health service devoted to the care of a pregnant woman (Pearsall, 1995: 317). For the purpose of this study, an antenatal clinic refers to any department that provides care to the pregnant woman prior to delivery.
1.7 PARADIGMATIC PERSPECTIVE

The researcher will use the Nursing Accompaniment Theory of WJ Kotzè as a point of departure. The four components of the nursing metaparadigm, as described by Kotzè, are: Man/human being/person, world, health, nursing (Kotzè, 1998: 3).

1.7.1 Man/human being/person
Man is a unique, multidimensional, total being, consisting of body, psyche and spirit, continuously becoming within an inseparable and dynamic relationship with the world, time, fellow-beings and God. The body is experienced by the individual through interaction with the world and others, while the psyche is the centre of man’s perception, consciousness and emotions. In terms of human beings, the focus of this study is the pregnant woman who is accompanied by the midwife through the provision of antenatal care (Kotzè, 1998: 7).

1.7.2 World
The world in which man exists consists of the objective or external world and the subjective or life-world.

Objective world
This is the world outside the life-world of the individual of which he is vaguely or not at all aware. It includes the world of science and technology, nature, ecology and micro-organisms. Those parts of the objective world which man explores and gets a grip on become part of his life-world. In this study, the objective world comprises all the activities and procedures performed in antenatal clinics with which the pregnant woman is not familiar.

Subjective world or life-world
This is that part of the world that man has made his own. He knows it and has adapted it to meet his needs. It includes the following dimensions:
• Man’s immediate intimate personal world.
• Man’s his inner world – intrapersonal world.
• Man’s world of co-existence with fellow beings.
• The dimensions of time in which man exists.

The subjective world is dynamic, forever expanding as man’s knowledge of and grip on the external world expand. Thus, the subjective world of pregnant women in this study comprises all the knowledge and perceptions they have regarding antenatal care.

The personal world gives the woman the security of a firm base, a point of departure to meet the challenges of pregnancy. It is expanded through the accompaniment, guidance and assistance by midwives. An environment in which the woman is unconditionally accepted, and where she can communicate with confidence, allows the woman to find a home in this new world of antenatal clinics (Kotzè, 1998: 9).

1.7.3 Health
Health refers to the state of wellness or illness of an individual. It is a relative concept. Wellness and illness are affected by the quality of man’s relationships with the world, time, fellow beings and God. Health, in the context of this study, refers to the ability or inability of the pregnant woman to make decisions regarding the care she receives during pregnancy. The midwife, through the process of accompaniment, provides the opportunity for the pregnant woman to express her opinions regarding the care she needs (Kotzè, 1998: 12).

1.7.4 Nursing
Nursing is an interpersonal, comprehensive service to man at all stages of life, ill or well, of which accompaniment is an integral part. It entails a dynamic, systematic process to effect change that will facilitate the reaching of objectives based on the needs that initiated the process. Nursing, in this study, focuses on the midwife’s accompaniment of pregnant women towards experiencing physical comfort and security. Both the midwife and the pregnant
woman are active participants in this relationship, with the midwife bringing her knowledge and skills, while the woman accepts responsibility for her health (Kotzè, 1998: 13).

1.7.5 Accompaniment
Accompaniment in nursing is the planned, deliberate intervention by the nurse to enable the patient to overcome her needs for help and support. It is a two-way process, that is the nurse and the patient are in a collaborative relationship. The midwife, through accompaniment, directs the woman towards accepting responsibility for her health, as well as gaining self-reliance and self-confidence.

Implementation of accompaniment is possible if the following structures of accompaniment are observable and experienced in the nursing process:

- Relationship structures.
- Course structures.
- Actualization structures.
- Goal structures (Kotzè, 1998: 13).

Relationship structures
Experiencing a sense of security is a prerequisite for nursing accompaniment. The pregnant woman will only be prepared to cooperate and involve herself in her care if she feels she is in the safe hands of a skilled and knowledgeable midwife. The pregnant woman also needs to have insight regarding the importance of all the activities (examinations and tests) that are done to her. Hence, the midwife’s display of competence gives the woman a sense of security. A relationship of trust and mutual understanding where the midwife recognizes and understands the woman’s concerns and anxieties encourages the woman to open up and feel comfortable about expressing her feelings.

Course structures
The intensity of the relationship varies according to the degree of the pregnant woman’s dependence on the help and support of the midwife. Each pregnant woman presents for antenatal care with some knowledge and expectations.
The midwife needs to treat each woman as a unique individual and intervene with help and support as needed. The ultimate goal is for the pregnant woman to regain independence and self-reliance in making responsible decisions regarding her care during pregnancy, with the knowledge that the midwife is always available for consultation.

**Actualization structures**

In order for the aims of accompaniment to be actualized, both the midwife (accompanier) and the pregnant woman (accompanee) need to be active participants, each bringing inputs to the process of accompaniment. The midwife needs to be prepared and accessible in guiding the pregnant woman towards attaining self-confidence and self-reliance. On the other hand, the woman becomes aware of her responsibility and moves from being passive to accepting challenges associated with self-care during pregnancy.

**Goal structures**

The objectives of the accompaniment process will be realized when the pregnant woman comes to a responsible, realistic self-assessment, when she understands her situation (dangers associated with pregnancy) and her future potential in preventing complications. She accepts responsibility for her care and makes responsible decisions, identifying herself with the norms and challenges of this new pregnancy lifestyle (Kotzè, 1998: 20).

**1.8 RESEARCH DESIGN AND METHODOLOGY**

The design of the study as well as the methods used to collect and analyze data, will now be discussed.

**1.8.1 Research Design**

A descriptive, exploratory and contextual design will be used so that the researcher can explore and describe women’s perceptions of antenatal care. The researcher will use a qualitative, non-experimental approach that will allow women’s perceptions and experiences to be studied in terms of their
own definition of antenatal care (Schurink in De Vos, 1998: 240). A detailed discussion of the design will follow in Chapter 2 (see 2.4).

1.8.2 Research method
The research will be conducted in two phases. During the first phase women’s perceptions and experiences with regard to antenatal care they receive from midwives will be explored and described. The second phase will involve a description of guidelines and recommendations, based on the results of the study, with the aim of enhancing effective accompaniment of pregnant women by midwives. The first phase of the research method will now be discussed.

1.8.2.1 Research population and sampling
The researcher intends to explore how women with poor antenatal attendance view the antenatal care rendered by midwives. The focus of the study will, therefore, be on women who booked late for antenatal care, who had less than three visits prior to delivery. The target population will comprise women who:

- Are pregnant for the first time, so that their perceptions and experiences of antenatal care are not influenced by their previous experiences
- Started attending the antenatal clinic in Qumbu Health District after 20 weeks of gestational period, or
- Had recorded less than three antenatal visits at the time of delivery, and
- Are sufficiently literate to ensure that they understand the purpose of the study.

The sample will be chosen from the target population by means of purposive sampling. A complete discussion of the sampling method will follow in Chapter 2.
1.8.2.2  Data Collection
Data will be collected through unstructured interviews with individual participants. A predetermined, open-ended question will be used as a guide to allow each woman to respond in a way that reflects her perceptions and opinions, while at the same time opening up the number or type of potential responses (Tutty, Rothery and Grinnell, 1996: 56). The interviews will be conducted in Xhosa as all of the prospective participants are Xhosa speaking.

All of the interviews will be audio-taped after permission has been obtained from the participants (see Annexure E as an example of a consent form).

Data collection will continue until saturation occurs; that is when further interviews will elicit no new information (Tutty et al, 1996:56). The researcher will ask the participant to go through the transcribed interview to verify that it is a true reflection of her thoughts. The transcribed interviews will be translated into English before being analyzed. To ensure accurate translation from Xhosa to English, the translated interviews will be verified by a linguist expert. Field notes will be recorded during, or immediately after, each interview in order to describe the physical setting and non-verbal communication by the participant (Tutty et al, 1998: 70).

1.8.2.3  Data Analysis
The tape recordings of the interviews and field notes will be transcribed, that is typed word for word to facilitate content analysis. The interviews will then be translated into English to make the data accessible to non-Xhosa speaking members involved in the study. The transcribed data will be analyzed using Tesch’s eight steps of data analysis (Poggenpoel in De Vos, 1998: 343). These steps will be explained in detail in Chapter 2 (see 2.5.1.3). An external independent coder will be used to analyze the transcribed interviews and help with identification of the themes and categories. The identified themes and categories will then be used to support the conclusions of the study and to develop guidelines for practice (Poggenpoel in De Vos, 1998: 343).
1.8.2.4 Literature Control
A literature control will be done to verify if the findings support what is already known about the topic (Streubert and Carpenter, 1995: 46). Once data analysis is complete, the researcher will review the literature to identify similarities and differences with the existing literature.

1.8.2.5 Pilot Study
One pregnant woman meeting the criteria will be interviewed and the researcher will transcribe and analyze this interview to determine if the research questions, as well as the interviewing technique of the researcher, elicit the desired information. Modifications will be made if necessary to the method of data collection and analysis procedures.

1.9 TRUSTWORTHINESS

Trustworthiness in this study will be ensured by using Guba’s model for ensuring the trustworthiness of data; this model ensures that the data collected represents accurately the opinions of those who have been studied (Streubert and Carpenter, 1995: 25). In order to ensure trustworthiness, Guba’s four criteria, namely truth value, applicability, consistency and neutrality, will be used (Krefting, 1991: 214-222). A detailed description of these criteria follows in Chapter 2 (see 2.6).

1.10 ETHICAL CONSIDERATIONS

The rights of the participants and the professionals working at St Lucy’s Hospital, as the site where the study is to be conducted, will be protected. The researcher will adhere to the ethical principles that guide researchers, as explained by Brink (1996:39). These are the principle of respect for persons, beneficence and justice. A detailed description of these principles follows in Chapter 2 (2.7).
1.11 CHAPTER DIVISION

Chapter 1: Overview of the study
Chapter 2: Research design and methodology
Chapter 3: Discussion of results and literature control
Chapter 4: Conclusions, guidelines and recommendations

1.12 CONCLUSION

The researcher in this chapter has presented a general overview of the study, which includes the background of the study, research design and method, paradigmatic perspective, concept clarification as well as ethical considerations. Chapter 2 will present a detailed discussion on the research design and methodology of the study.
CHAPTER 2

RESEARCH DESIGN AND METHOD

2.1. INTRODUCTION

The research design and methodology of the study will be addressed in this chapter. The description of the rationale and objectives, as well as the principles of trustworthiness, will be presented.

The research design guides the researcher with regard to the implementation of the study. An appropriate design increases the probability of the validity and accuracy of the research findings. Qualitative research is the approach commonly used in Behavioral, Nursing and Social Sciences, as a method of understanding the unique, dynamic, holistic nature of human beings (Burns and Grove, 1993: 28). Qualitative methods describe human experiences and emotions like pain and caring, which are difficult to quantify.

2.2. RATIONALE

Effective antenatal care plays a major role in improving women’s health status and in reducing the maternal morality rate. However, for the antenatal care to be effective, women need to be active participants and accept responsibility for their health. Statistics indicate that pregnant women do not appear to be motivated with regard to utilizing antenatal services. The researcher has noted during student accompaniment that pregnant women either start attending antenatal clinic late (after 20 weeks of pregnancy), or have less than three antenatal visits at the time of delivery. The researcher presumed that poor antenatal attendance may be the result of the midwives not being able to meet the expectations of pregnant women.
Midwives tend to regard the way they organize maternity care as the best and the only way. They do not consider the opinions of pregnant women regarding what constitutes effective antenatal care. This may result in women being passive, accepting what they are told without question. The poor antenatal attendance has prompted the researcher to investigate the possible contributory factors from the pregnant women’s perspective and to identify what women view as effective antenatal care. Accordingly, this study aimed to provide pregnant women with an opportunity to express their opinions regarding the quality of services offered to them by midwives.

2.3. OBJECTIVES OF THE STUDY

The primary objective of this study was to explore and describe the perceptions and experiences that pregnant women have of the antenatal care that they receive from midwives so that utilization of services could be improved.

The specific objectives were to:

- Explore and describe the perceptions and experiences of pregnant women attending the antenatal clinic regarding the care they receive from midwives.
- Make recommendations to assist registered midwives in optimizing the accompaniment of women during their antenatal period.

2.4. RESEARCH DESIGN

A descriptive, exploratory and contextual design was used, since the researcher needed to explore and then describe women’s perceptions of antenatal care. The researcher used a qualitative, non-experimental approach that allowed studying of women’s perceptions and experiences in terms of their own definition of antenatal care (Schurink in De Vos, 1998:328).
• **Exploratory design:** The main purpose of an exploratory study is to discover new dimensions of the subject matter that have not been thoroughly researched before (Polit and Hungler, 1993: 11). It aims at exploring the dimensions of the phenomenon, the manner in which it is manifested and the factors related to it. In this study, pregnant women’s perceptions and experiences were explored with the aim of discovering the meaning they attached to antenatal care and how they viewed the services delivered to them by midwives.

• **Descriptive design:** A descriptive study examines relationships among variables through observation, description and classifying phenomena (Polit and Hungler, 1993: 22). The purpose is to gain more information about characteristics of individuals or groups and to provide a picture of situations as they happen naturally (Burns and Grove, 1995: 38). The researcher described the perceptions and experiences pregnant women have regarding antenatal care so as to formulate guidelines for effective accompaniment of pregnant women by midwives. A rich description of the findings was given, as well as the research methodology used to gain information regarding women’s perceptions and experiences of antenatal care.

• **Qualitative approach:** The qualitative approach is a way to gain insight through discovering meanings (Burns and Grove, 1995; 61). It emphasizes the dynamic, holistic individual aspects of human experience, and attempts to capture those aspects within the context of those experiencing them. Qualitative methods are used to describe and promote understanding of human perceptions such as pain, grief, hope or caring (Brink, 1996: 119). Accordingly, an accurate description of information provided by pregnant women was done in order to discover the meaning they attached to antenatal care and whether the services met their expectations.
• **Contextual design:** The study was contextual in nature in that pregnant women who attended an antenatal clinic at St Lucy’s Hospital were asked what their views were on antenatal care. The context of the study was to determine perceptions and experiences of pregnant women who visited an antenatal clinic in Region D (a rural area), the only source of antenatal care available to them (Polit and Hungler, 1993: 142; Streubert and Carpenter, 1995: 3). The setting in which the study was conducted was an antenatal clinic attached to a District Hospital in the Eastern Cape. This was the hospital where the researcher practised as a mentor of student midwives.

### 2.5. RESEARCH METHODOLOGY

The study was conducted in two phases, namely:

**Phase 1:** Data collection, interpretation and analysis.

**Phase 2:** Recommendations for midwifery practice.

#### 2.5.1 Phase 1: Data Collection, Interpretation and Analysis

The processes of data collection, interpretation and analysis will now be discussed.

#### 2.5.1.1 Research population and sampling

- **Population:** Brink (1996: 132) defines a population as a group of persons or objects that meet the criteria the researcher is interested in studying. A distinction is made between an accessible population and a target population (Burns and Grove, 1995: 236), whereby an accessible population is the portion of the target population to which the researcher has reasonable access. A target population, according to Rees (2003: 201), includes those people or objects that meet the inclusion criteria, namely the characteristics the researcher wants those in the sample to possess. In this study, the target population
comprised all pregnant women who attended an antenatal clinic in Qumbu Health District. This population was accessible to the researcher as she was working at the District Hospital that received referrals from all of the surrounding clinics.

- **Sampling:** The sample was chosen from the target population by means of purposive sampling. In purposive sampling, participants are selected because they are believed to be able to give the researcher access to a special experience that she wishes to understand, and are seen as a good representative of the target population (Yegidis and Weinbach, 1996: 122). The researcher used her judgement about which participants to choose and picked only those who best met the purpose of the research (Polit and Hungler, 1993: 444).

- **Sampling criteria:** Sampling criteria refer to characteristics essential for inclusion in the target population (Burns and Grove, 1995: 225). In this study, the target population comprised women who:
  
  o Started attending the antenatal clinic in Qumbu Health District after 20 weeks of gestational period, or
  o Had recorded less than three antenatal visits at the time of delivery, and
  o Were sufficiently literate to ensure that they understand the purpose of the study.

Initially the researcher intended to target primigravid women so that their views of the antenatal care of the present pregnancy would not be influenced by their experience of the previous pregnancies. After two weeks of not encountering a single primigravid woman in the antenatal clinic, the researcher decided to identify them from the antenatal attendance register. The data from the register revealed that almost all primigravid women were scholars from surrounding schools. The clinic staff explained that an arrangement had been made for scholars to be attended to quickly during
their school break times and then released for classes so as to cause the least possible disruption to their school day. This idea seemed to be addressing Ehlers, Maja, and Gololo’s recommendation (2000: 51) that strategies to improve accessibility of Reproductive Health Services to school-going adolescents need to be designed. However, the researcher is of the opinion that the quality and effectiveness of antenatal care provided to these teenagers needs to be further evaluated.

From those women identified from the antenatal register, the researcher could only contact five primigravid women in a period of two months. The researcher then resolved to interview all women who met the inclusion criteria, irrespective of the parity. Participants from different age groups and educational standards were included in the study. This ensured that the data collected represented pregnant women from varied backgrounds. The purpose of choosing these women was to explore whether their opinions regarding antenatal care were related to their reluctance to attend the antenatal clinic. The sample size was determined by the saturation of the data, that is interviews were conducted until a point of saturation was reached and no new information was being elicited. A minimum of ten interviews were conducted.

### 2.5.1.2 Data collection

Data were collected through unstructured interviews with individual participants. Kvale (1996: 14) defines an interview as an interchange of views between two persons conversing about a theme of mutual interest. Unstructured interviews are considered to be the best way to gain an understanding of people’s perceptions. They are used when the researcher wants to obtain an in depth, thick description and understanding of the participant’s world (Tutty, Rothery and Grinnel, 1992: 56). The interviews were conducted in Xhosa by the researcher herself, as all of the participants were Xhosa speaking.
Each participant was asked the following key question:

*(Khawundixelele ngokucingayo malunga noncedo othe walufumana koonesi eklini kubalukumgangatho obe uwulindele na?)* "Tell me about the care that you received from the midwives at the clinic during this pregnancy, and if it met your expectations?

**Preparation for the interview**

Tutty *et al* (1992: 60) emphasizes the need for the researcher to prepare herself first, before preparing the participants. The researcher needs to be prepared physically and mentally to handle any possible setbacks that may arise during the interview. The advice and guidance given by the research supervisors and the review of literature relating to the interviewing process equipped the researcher with the necessary interviewing skills. The researcher also needs to bracket all her experiences and rid herself of her own biases before talking to the participants (Beech, 1999: 45). Beech defines bracketing as a process by which the researcher resolves to hold in abeyance all preconceptions in order to reach experiences before they are made sense of. This enables the researcher to just see rather than to interpret according to her preconceptions. For the purpose of this study, the researcher bracketed all her experiences, readings and reflections about antenatal care prior to interviewing participants.

Appointments with the prospective participants at the antenatal clinic were made to coincide with the next scheduled antenatal visit to avoid any extra traveling to the clinic. Those who were admitted in hospital were approached an hour before the interview. A full explanation on the purpose of the study was given to the participant before she signed a written informed consent (see Annexure A). Participation was strictly voluntary. The participants were assured of confidentiality and that they were free to withdraw from the study without any threat to the care they received. The use of an audio-tape was explained to the participants and their permission obtained before using it.
Interviewing
A quiet, private room at the clinic or hospital was used to avoid disruptions. Each interview took approximately one hour. During the interview the researcher and the participant sat facing each other to promote eye contact. Maintenance of eye contact demonstrated the researcher’s interest in what the participant was saying. Various interviewing techniques were used to encourage the participant to continue talking, while at the same time avoiding biasing the participant’s responses (Burns and Grove, 1993:367). The following communication skills were used:

- **Minimal verbal response**: This involved the use of verbal responses like “mm-mm”, “I see”, “yes…?” by the researcher to indicate that she was listening to and following what the participant was saying (Okun, 1997: 76).

- **Reflecting**: The researcher communicated her understanding of the participant’s concerns, feelings and perspectives back to the participant in her own words (Uys, 1999: 190). The participant may not have stated explicitly how she felt and the researcher may have observed the non-verbal messages.

- **Paraphrasing**: Paraphrasing involves repetition of what the participant has said in order for the researcher to test whether she has understood the message correctly (Okun, 1997: 76). The researcher translated what the participant was expressing into more precise words, without adding new ideas to the message (Uys, 1997: 192).

- **Clarifying**: An attempt is made to understand what the participant means by making possible statements (Okun, 1997:76).

All the interviews were audio-taped once permission for this had been obtained from the participants (see Annexure A). Tape recordings produce the exact verbal response of the participant, which facilitates coding of the responses to identify themes and categories (Tutty et al, 1996: 67). Data collection continued until saturation occurred, that is until no new information
was elicited with further interviews. At the conclusion of each interview the researcher made another appointment with the participant to go through the transcribed interview to verify that this was a true reflection of her thoughts.

**Field notes**

Field notes were recorded during or immediately after each interview in order to describe the physical setting and the non-verbal communication of the participant (see Annexure B). Field notes are detailed reproductions of what activities occurred during an interview (Tutty *et al*, 1996: 70). They can also safeguard against mechanical problems like power failure. The researcher used the procedure of Schatzman and Strauss, as explained by Schurink *in De Vos* (1998: 285), in constructing the notes. According to this procedure, notes are categorized into observational, theoretical and methodological notes.

- **Observational notes:** Observational notes give an account of what happened with little or no attempt to interpret it. These notes tell who said or did what and under which circumstances (Schurink *in De Vos*, 1998: 285). The researcher in this study made written descriptions of what she observed during each interview.

- **Theoretical notes:** Theoretical notes entail the systematic attempts by the researcher to derive meaning from observational notes through hypothesizing or trying to identify some relation between observations from different interviews (Schurink *in De Vos*, 1998: 286). The researcher tried to identify repeatedly found patterns in the course of this study.

- **Methodological notes:** These are reminders or critical comments to the researcher herself. Methodological notes reflect the observations on the researcher herself, as well as the methodological process itself (Schurink *in De Vos*, 1998: 286). In this study, the researcher made methodological notes to remind herself of her role as well as of the research methodology itself.
Field notes were recorded on significant points from each interview (see Annexure B). The researcher also used a personal journal wherein she recorded her personal feelings, reflections, biases, insights and difficulties encountered during interviews. All this collected information was incorporated into the data base that was analyzed (Beech, 1999: 46).

2.5.1.3. Data analysis

The goal of data analysis is to identify persistent words, phrases and themes that could be grouped into categories. The tape recordings of the interviews were transcribed, that is typed word for word to facilitate content analysis (See Annexure C). The transcribed data was then analyzed using Tesch’s eight steps of data analysis (Poggenpoel in De Vos, 1998: 343).

Tesch’s steps can be described as follows:

- The researcher reads through all of the transcriptions to get a sense of the whole and then jots down ideas as they come to mind.
- She then selects one interview – it could be the most interesting – and goes through it while asking herself the underlying meaning in the information. She writes her thoughts along the margin.
- Having completed the above task for a number of transcripts, she lists the identified topics and groups similar topics into major topics, unique topics and leftovers.
- The topics are abbreviated as codes and written next to the appropriate segments of the text while checking if new categories emerge.
- The most descriptive wording for the topics is checked and turned into categories. Related topics are grouped together to reduce the total list of categories, and then lines are drawn between categories to show interrelationships.
- A final decision on the codes of categories is made and codes are alphabetized.
- A preliminary analysis of data belonging to each category is done.
- If necessary, recoding of the existing data is done.
An external independent coder was used for consensus discussion on the themes and categories identified. The researcher gave the independent coder a clean set of transcribed notes, as well as a guide with Tesch’s steps of data analysis (See Annexure D) to analyze and identify the themes. Thereafter, a consensus discussion was done by the coder and the researcher on identified themes and categories. The identified themes were used to support the conclusions of the study (Poggenpoel in De Vos, 1998: 343).

2.5.1.4. Literature control
In qualitative research, the literature is reviewed after data collection and analysis so that it does not influence the way the researcher views the phenomenon (Burns and Grove, 1995: 142). The researcher’s description of the phenomenon should include only what is seen in the real situation and not what is read in literature. Thus, a literature control is done to verify if the research findings supported what is already known about the topic (Streubert and Carpenter, 1995: 46). Once data analysis had been completed, the identified themes were compared with the existing literature to identify similarities and differences and to verify whether the literature supported the findings.

2.5.1.5. Pilot study
The pilot study involves pre-testing the key question to be used during interviews on participants similar to those who will be used in the study, as well as the researcher’s interviewing technique (Burns and Grove, 1995: 366). This allows the researcher to identify problems in the design of the question, and to test her ability to do an interview. One pregnant woman who met the inclusion criteria was interviewed and the researcher transcribed and analyzed the data to determine if the research question elicited the desired information. The researcher discussed the appropriateness of the data collection and analysis methodology with the supervisors and modifications were made as required.
2.5.2 Phase 2: Recommendations for midwifery practice

Recommendations for providing effective antenatal care were made, based on the results of the study, with the aim of improving antenatal services rendered to pregnant women. A literature review was used to verify whether the proposed recommendations were in line with the existing literature.

2.6. TRUSTWORTHINESS

Since qualitative research deals with people’s beliefs, experiences and perspectives, trustworthiness in this study was ensured by using Guba’s model (Krefting, 1991: 214) for ensuring trustworthiness of data. Use of this model ensured that the data collected accurately represented the opinions of those who had been interviewed, namely the pregnant women (Streubert and Carpenter, 1995: 25). Guba’s four criteria were used, namely truth value, applicability, consistency and neutrality. (Krefting, 1991: 214-222).

2.6.1 Truth value

Truth value refers to the researcher’s confidence that the findings for the informants and the context in which the research was done will be the truth (Krefting, 1991: 215). The truth value is ensured by the strategy of credibility. A qualitative study is credible when it presents such accurate descriptions of human experience that people who also share that experience would immediately recognize the descriptions. Thus, credibility establishes internal validity by taking into consideration criteria such as:

- **Prolonged and varied field experience:** This refers to the researcher’s experience in the context of research (Krefting, 1991: 217). The researcher has been a nurse educator for eight years, accompanying student midwives in the clinic where the study was carried out. Accordingly, she has insight into the quality of antenatal care that should be provided to a pregnant woman. Nevertheless, the researcher was aware of the need to bracket her experiences to avoid contaminating her thoughts. The processes of reflection and quieting
of the mind were carried out prior to all interviews (Beech, 1999:45). One of the researcher’s supervisors was an advanced midwife and both supervisors had extensive experience in qualitative research.

- **Triangulation.** This is a method used to ensure credibility of the study by using various data collection methods. The researcher achieved triangulation in data collection by using a variety of data collection methods such as interviews, field notes and a personal diary.

- **Peer examination.** This involves discussion of the research process and findings with impartial colleagues who are knowledgeable about qualitative methodologies. Peer examination in this study involved the use of an independent coder to verify identified categories during data analysis (Krefting, 1991: 219). The research process and findings were also discussed with the two research supervisors experienced in qualitative research as well as with colleagues in midwifery practice for their inputs.

### 2.6.2 Applicability

Applicability refers to the degree to which the findings can be applied to other contexts and settings or other groups (Krefting, 1991: 216). In qualitative research the ability to generalize is impractical as the study is conducted in the naturalistic setting with the purpose of describing the experience of a particular group of participants. Hence, the applicability of data was ensured by a strategy of transferability, that is checking whether the findings could be compared with contents outside the study situation (Krefting, 1991: 216):

- The researcher provided a **complete description** of the research methodology, the findings and the verbatim quotes from individual interviews to ensure applicability of the study to other contexts.

- The **sampling criteria** also ensured transferability in that only the participants who met the eligibility criteria (as described in Chapters 1 and 2) were chosen for the study.
2.6.3 Consistency
The consistency of data refers to whether the findings will be consistent if the enquiry were replicated with the same participants or in a similar context (Krefting, 1991: 217). As explained previously (see 2.6.2.), the findings may not be consistent in repeated enquiries as the emphasis in qualitative research is on the uniqueness of human experience. Thus, consistency is defined in terms of dependability whereby the sources of variability can be explained, for example participant fatigue or increased insight on the part of the researcher (Krefting, 1991: 217). Dependability was attained by applying the following:

- **Dense description** of the research methods used in the study. The detailed description of data collection and analysis methods used produced an auditable trail for another researcher to follow.
- **Peer examination** by research supervisors promoted reliability of the study. An independent coder was also used to independently assess the study and analyze the data.
- **Triangulation** of data collection methods and sources, as explained previously (see 2.6.1. above), also ensured dependability of data.

2.6.4 Neutrality
Neutrality of data refers to freedom from bias in the research procedures and results. Lincoln and Guba in Krefting (1991: 217) suggest the strategy of confirmability to ensure neutrality of data. Confirmability suggests that another researcher could arrive at comparable conclusions given the same data collection methods and research context. Confirmability enhanced the objectivity of the study through criteria such as the following being met:

- **Triangulation** of data collection methods and sources, as explained under truth value (see 2.6.1).
- **Reflexive analysis**, which refers to the assessment of the researcher’s own background and her experience in the field of study. The researcher’s experience as a nurse educator for midwives and the expertise of her supervisors ensured the provision of comparable conclusions from collected data (Krefting, 1991: 218).
• **Literature control**, which involves the process of finding, reading and critically analyzing published research studies on a given topic, with the aim of identifying similarities and differences and verifying whether the literature supports the findings (Burns and Grove, 1993: 366). Literature control was conducted to identify similarities and differences with the existing literature.

2.7. **ETHICAL CONSIDERATIONS**

The researcher observed the following ethical principles underlying the protection of research participants as explained by Brink (1996: 39):

• **Respect for persons**: This is concerned with the right to self-determination. Participants were informed of their right to decide voluntarily whether or not to participate in the study and that they could withdraw their consent and discontinue participation at any time without fear of intimidation.

• **Principle of beneficence**: This principle involves the protection of participants from discomfort or harm. The researcher needs to ensure that the risks involved do not exceed the benefits of the study. According to Strydom in De Vos (1998: 25), emotional harm to participants has more far reaching consequences than physical discomforts. Madsen (1992: 79) emphasized scrupulous honesty as the moral principle that should guide researchers in the conduct of their research. Therefore, the researcher explained fully the aim of the study to the participants so that they understood explicitly the role they were to play. Honesty and openness promoted the development of a trusting relationship between the researcher and the participants. The participants were informed beforehand about the potential impact (benefits and risks) of the investigation. Since the researcher was not part of the clinic staff, the participants were free to voice their opinions without fear of being victimized.
• **Principle of justice:** This involves the right to fair selection of participants from the target population. All participants meeting the inclusion criteria had an equal chance of being selected. The principle of justice also involves the right to privacy.

• **Informed consent:** Strydom in De Vos (1998: 23) maintains that adequate and accurate information on the goal of the investigation and the procedures that will be followed during an investigation be given to potential participants to allow them to make an informed decision regarding participation:
  
  o Written permission was requested from the relevant Health Authority and from St Lucy’s Hospital management before commencing the study (see annexure E). A copy of the research proposal was sent to both the Member of the Executive Council and St Lucy’s Hospital management to inform them fully of the nature and purpose of the research.
  
  o A full explanation concerning the purpose of the study was given to the participants prior to obtaining verbal and written consent (see annexure A). Informed consent is the prospective participant’s agreement to participate in a study as a participant, which is reached after assimilation of essential information (Burns and Grove, 1993: 104). The participants were given the opportunity to choose whether or not to participate in the research and were informed about their right to withdraw from the study at any stage. The nature, risks and benefits of the study were explained to each participant to enable her to make an informed decision (see annexure A).

• **Right to confidentiality and anonymity:** Individual rights to confidentiality and anonymity were guaranteed in that no information received from the participants was divulged to other individuals. All participants were assured that information in the report would not
identify them personally. Other than in the consent forms, no identifying data such as names and addresses were required during the study. The researcher made sure that the transcribed notes to the independent coder contained no biographical data that could link the participants to the information provided. The researcher also explained to the participants the reason for using the tape recorder and that the audio-tape recordings would be destroyed after completion of the study. Therefore, the participants were assured that their identity could not be linked, even by the researcher, to the individual responses (Burns and Grove, 1993: 99).

- **Right to privacy**: All possible means of protecting the privacy of participants were applied. The individual participant was free to determine when, where or with whom private information would be shared or withheld (Strydom in De Vos, 1998: 25). The audio-tapes of interviews were kept under lock and key, to be destroyed on completion of the study.

### 2.8. **CONCLUSION**

A detailed description of the research design, methodology and trustworthiness of the data, as well as ethical considerations, has been provided in this chapter. In chapter 3 the researcher will discuss the actual research findings.
CHAPTER 3

PHASE 1: DATA COLLECTION, ANALYSIS AND INTERPRETATION

3.1. INTRODUCTION

The previous chapter included an outline of the research design and method. This chapter contains the analysis and interpretation of data collected by means of the interviews and field notes. The identified themes and sub-themes are also presented. A literature control was done to verify whether the findings support what is already known about the topic.

3.2. PRESENTATION OF RESULTS

The study was conducted in a district hospital in the Qumbu Health District. The district hospital that was included in the study receives referrals from all of the surrounding clinics. A total of ten women were interviewed in this study before saturation of data was reached. No further interviews were conducted thereafter since no new information could be elicited. Five participants were selected from the antenatal clinic and five were interviewed post delivery.

3.2.1 Target Population and Sample

The target population consisted of pregnant women who attended antenatal clinic in Qumbu Health District. Due to time constraints and the vastness of the area, an accessible population of the most readily available participants who visited one district hospital in Qumbu Health District was approached by the researcher. The initial target population of primigravid women could not be accessed as the majority of them was high school learners who had a special
Participants who met the following inclusion criteria and were purposively selected from the target population were women who:

- Started attending the antenatal clinic after 20 weeks of gestational period (late booking visit) at Qumbu Health District, or
- Had recorded less than three visits at the time of delivery, and
- Were sufficiently literate to ensure that they understood the purpose of the study and could read the information on the consent form.

3.2.2 Characteristics of the Participants

Participants who met the set criteria were interviewed as they became available. The target population was sufficiently representative of different groups with regard to age, parity, socio-economic status, marital status and level of education. Some of the participants were interviewed after delivery and this provided a wide variety of experiences being examined, including the influence of age and previous experiences concerning the current perceptions and experiences of antenatal care.

Age

The sample included women aged between 16 and 37 years. Three participants were between 16 and 19 years, four were between 20 and 24 years, two were between 31 and 34 years and one was 37 years of age.

Differences in parity of participants

Five of the participants interviewed were in their 1st pregnancy; two were in their 2nd pregnancy and three were in their 6th, 7th and 9th pregnancies respectively.
Gestational age at the time of booking
One participant started attending antenatal clinic at 20 weeks gestation, but had only two visits prior to delivery. Six participants started attending antenatal clinic between 24 and 28 weeks, while three started at 30 weeks gestation.

Financial support
Nine participants were unemployed, while one was employed as a domestic worker. Four of the unemployed participants were married housewives. The husbands of two of the housewives were unemployed and the children’s grants were their only source of income. Four participants were learners in either grade 11 or 12, while one was in her 2nd year at a technicon. The researcher assumed that these women made use of free antenatal services provided at the clinics, due to inability to pay for alternative antenatal services.

3.2.3 Data Collection
Data were collected by conducting unstructured interviews with individual participants. The purpose of the study was explained again to each woman and the informed consent was signed. The interview time was set to suit the needs of each participant. Data collection stretched over 4 months. Data collection continued until saturation was reached. A total of ten unstructured interviews were conducted with the participants. The following predetermined open-ended question was used:

“Khawundixelele ngokucingayo malunga noncedo othe walufumana koonesi ekliniti njengokuba ukhulelwe, nokuba belukumgangatho obe uwulindele na?” (Tell me about the care that you received from the midwives at the clinic during this pregnancy and if it met your expectations?)

The interviews were conducted in Xhosa by the researcher herself, as all participants were Xhosa speaking. Each interview lasted between 40 minutes and one hour. The interviews were audio-taped, and transcribed verbatim
within 24 hours after the interview. They were then translated into English before being analyzed. In order to ensure quality and to minimize loss of meaning, the translated interviews were read and verified by a linguistic expert from the languages Department at the Nelson Mandela Metropolitan University. Field-notes were also written immediately after each interview to describe the physical setting and the activities which occurred during each interview (Annexure B). An independent coder was provided with a clean set of transcribed interviews to help identify themes and categories and discussions were held to reach consensus about these. The collected data were analyzed using Tesch’s eight steps (Poggenpoel in De Vos, 1998: 343) and the following major themes were identified:

- Women perceive midwives as considerate and knowledgeable.
- Women perceive midwives as lazy and rude.
- Through their experiences, women identified certain needs in the services and care they received at the clinic.
- Women experience mixed emotions about the care they received from midwives.

The identified themes and their sub-themes are tabulated in table 3.3.
Table 3.3: Identified Themes Related To Women’s Perceptions and Expediencies of Antenatal Care

<table>
<thead>
<tr>
<th>THEME</th>
<th>SUB-THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Women perceive midwives as considerate and knowledgeable.</td>
<td>1.1 Women perceive midwives as considerate when they give priority to those staying far from the clinic.</td>
</tr>
<tr>
<td></td>
<td>1.2 Women perceive midwives as knowledgeable when they execute their duties.</td>
</tr>
<tr>
<td>2. Women perceive midwives as lazy and rude.</td>
<td>2.1 Women perceive midwives as lazy when they see them sitting having tea or lunch while women are waiting.</td>
</tr>
<tr>
<td></td>
<td>2.2 Women perceive midwives as rude when they shout at them.</td>
</tr>
<tr>
<td></td>
<td>2.3 Women felt that their needs were ignored at times by midwives.</td>
</tr>
<tr>
<td>3. Women experience mixed emotions about the care they receive from midwives.</td>
<td>3.1 Contented: Women felt content about the care they received from the midwives.</td>
</tr>
<tr>
<td></td>
<td>3.2 Frustrated and angry: Women felt frustrated and angry when turned back home for being late.</td>
</tr>
<tr>
<td></td>
<td>3.3 Embarrassed: Women felt embarrassed when being palpated by a male nurse.</td>
</tr>
<tr>
<td>4. Through their experiences, women identified certain needs in the services and care they received at the clinic.</td>
<td>4.1 Women expressed a need for adequate information about pregnancy.</td>
</tr>
<tr>
<td></td>
<td>4.2 Women wanted the midwife to give reasons and explanations about procedures performed on them by midwives.</td>
</tr>
<tr>
<td></td>
<td>4.3 Women expressed the need for a doctor at the clinic for deliveries.</td>
</tr>
<tr>
<td></td>
<td>4.4 Women expressed the need for pregnant women to be dealt with separately from other clients.</td>
</tr>
<tr>
<td></td>
<td>4.5 Women expressed the need for a clinic closer to their homes.</td>
</tr>
</tbody>
</table>
3.3. DISCUSSION OF RESULTS

The participants expressed both negative and positive views and experiences of antenatal care rendered by midwives. The fact that midwives were seen as considerate on one hand and rude and lazy on the other hand could be attributed to the behavior of individual midwives. Some midwives appeared to respect women as individuals while others apparently failed to give them the respect due to them. A detailed discussion of the identified themes with regard to women’s perceptions and experiences of antenatal care by midwives will now follow.

3.3.1. THEME 1: WOMEN PERCEIVE MIDWIVES AS CONSIDERATE AND KNOWLEDGEABLE

The Concise Oxford Dictionary (Pearsall, 2000:170) describes the word ‘considerate’ as *taking care not to inconvenience or hurt others*. A ‘knowledgeable’ person is described as a *well informed* person (Pearsall, 2000: 315). This implies that midwives are seen by women as well informed and that they take women’s interests into consideration when executing their duties. Pregnancy is a time of physiological change and psychological adjustment for a woman; hence considerate midwives are highly valued by women. A pregnant woman’s initial encounter with midwives leaves a lasting influence on the way she will respond to future pregnancies.

3.3.1.1. Sub-theme 1.1: Women Perceive Midwives as Considerate When They Give Priority to Those Staying Far From the Clinic

The participants expressed their appreciation for the midwives considering their needs. Midwives were described as either giving priority to those pregnant women staying far from the clinic or seeing pregnant women before attending to other clients at the clinic. Participants also verbalized that midwives did not turn them away when they arrived at the clinic in an advanced stage of labour even if they were supposed to deliver in hospital. These perceptions are reflected in the following quotes:
‘Sikude nalandawo, bekuthiwa sawubon’ukuba sikhona ngoku kudediswe aba bakufutshane kufakwe thina, senzel’ukuba sindedakale sihambe kwangoko’
(‘We are far from that clinic ---- they used to attend to us first once we arrive, before the ones who stay nearer the clinic, so we are helped and leave early.’)

‘Bayatsho bathi ungeza ekliniki xa unamasu amabini, hayi ukuba uneliso lesihlanu nelesithandathu. E kliniki bayasindeda xa sisengxakini, basithumele esibhedlela. Phofu xa sewuqond’ukuba uyalunywa kukude esibhedlele uyaya e kliniki’ (‘They say you can come to the clinic if you are pregnant for the second time, but not if it is for the fifth or sixth time. They help us at the clinic, if we have a problem they send us to the hospital. But when you realize that you are in labour pains and the hospital is far away you do come to the clinic.’)

The study revealed that midwives’ attitudes and behaviours play an important part in how women perceive the antenatal care they receive from them. They determine whether antenatal care is seen by women as effective or not. A similar observation was made by women in the study by Mathole, Lindmark, Majoko and Ahlberg (2004: 123) on women’s perspectives of antenatal care in a rural area of Zimbabwe. In this study women considered midwives as being personally interested in them. Seibold (2004: 179), in her study on young single women’s experiences of pregnancy, adjustment, decision making and ongoing identity construction, observed that women appreciated being taken care of by sympathetic health professionals. These women explained that access to sympathetic and expert midwives played a major role in their adjustment to pregnancy and motherhood. Antenatal care needs to be made as attractive as possible to the woman and this may be achieved by the way in which she is treated during this time. Regarding the management of emergency deliveries by the midwives: this is in line with the National Health Act of South Africa, 2003 (Act 61 of 2003), which states that a health care provider may not refuse a person emergency medical treatment.
3.3.1.2. Sub-theme 1.2: Women Perceive Midwives as Knowledgeable When They Execute Their Duties

Midwives were seen as possessing the requisite knowledge and skills needed to assist the woman through pregnancy. This seemed to increase client confidence in the midwife. Participants expressed feelings of trust in midwives’ knowledge and expertise and accepted their interventions without question. They actually verbalized that midwives know their work, as illustrated by the following statement:

‘Ayisihluphi lo nto ngoba amanesi ayawazi umsebenzi wawo, ayasinceda’ (‘We usually don’t mind because nurses know their work, that they are helping us’.)

One woman commented as follows about her perception of the midwife’s competence:

‘Bebendiqhuba kakahle kakhulu, kangangokuba ngoku sendiya okokugqibela ude watsho uSister ----- (calling her name) wathi uyakrokra inoba ndizobeleka nge ‘operation’, wathi umntwana wam mkhulu ---- uggira yena khange ayibone loo nto---‘ (‘They took great care of me, in so much that on my last visit Sister----(calling her name) even said she suspects that I will deliver by an operation, she said my baby is big---the doctor did not see that---.’)

Thus, the participants saw midwives as having special knowledge about mother–child care. Theron (1999: 66) maintained that one of the measures required to reduce maternal and perinatal mortality rates in South Africa was the improvement in the knowledge of practising midwives, especially those practising in remote areas. In his study on the cognitive knowledge of midwives practising in the Eastern Cape Province of South Africa, Theron (1999: 66) observed that knowledge of these midwives improved after the introduction of the Perinatal Education Programme (PEP). Midwives’ confidence and attitude towards their work also improved. Thus, all midwives
need to be empowered with the necessary knowledge and skills to accompany pregnant women effectively.

Proficient, informed and skillful midwives are trusted by women. Feelings of trust put women at ease when they are in the hands of midwives and women become more cooperative and responsible for their care. A feeling of confidence in staff and a conviction about their competence were also supported by Bluff and Holloway (1994: 161) in their study on women’s perceptions of midwifery care during labour and birth. According to this study, women were satisfied with the care received from midwives, and the main reason they gave was that midwives know best. A study on women’s opinions on antenatal care in four developing countries (Cuba, Thailand, Saudi Arabia and China) revealed that women believed in the expertise of their midwives and that, as the midwives had been educated to help pregnant women, they were capable of doing so (Nigenda, Langer, Kuchaisit and Romero, 2003: 3).

3.3.2. THEME 2: WOMEN PERCEIVE MIDWIVES AS LAZY AND RUDE

The word ‘lazy’ is described as unwilling to do work, or doing little work (Pearsall, 1995: 251), while rude means being impolite, showing no respect or consideration for other people (Pearsall, 1995: 383). Participants described midwives as being lazy regarding their work and said that they would continue with their conversations without showing consideration towards women who had been waiting for attention for a long time. They also made impolite remarks when they were approached by women while conversing.

3.3.2.1. Sub-theme 2.1: Women Perceive Midwives as Lazy When They See Them Sitting Having Tea or Lunch While Women are Waiting

Some participants described midwives as lazy regarding their work, especially after lunch-time. One participant specifically expressed her dissatisfaction when she was made to wait while nurses were conversing long past lunch hour:
'Enye into endingayithandiyo kukuhlaliswa phaya--- ufik’abanye--- iinesi zihlale--- ubone--- njengokuba niyalazi ixesha le lunch, ukuba badla ngokuthath’ihour---- bendikhe ndathetha neny’inesi ixesha le lunch ligqithile ihlel’egate’iniNdaya kuyophya ndathi Sister awusilibalanga na, yancuma yathi hayi khawuphole sisese’lunch’ ini, ngelo xesha uhleli uyancokolaNdaqaphel’ukubaiinesi ziyonqen’ukusebebza’ ('Another thing I do not like is being made to stay there--- you find out some of them--- nurses sit, you see--- as you know the lunch-time, that they used to take an hour--- I once talked to another nurse, the lunch-time had already passed, she was sitting at the gate. I went to her and said ‘Sister, have you not forgotten us?’ She smiled and said ‘No, cool down, we are still at lunch’ meanwhile she was conversing. I've noticed that nurses are lazy to work.')

Midwives were observed as not only taking extended lunch-times, but as making women wait outside even if it was not lunch-time, as reflected in the following quotation:

‘Basuke benze abo babini bathathu, bathi yhuu hayi nisenzel’intloko thina siyahamba sifun’ukuyotya, okanye bathi, nokuba akuloxesha le lunch, bathi khanibe nihlala pha phandle’ ('Then they will attend to two or three mothers, and say ‘No, you are causing us a headache, we are going to eat now'. Even if it's not lunch-time they will ask you to go and wait outside.')

It is the fundamental responsibility of the midwife to provide the highest possible standard of care for her clients within the prevailing circumstances (Searle, 1997: 158). The way a midwife uses her time affects the quality of care she provides for women in the antenatal clinic. The midwife, as a practitioner, is expected to provide a full day’s work for a full day’s pay. From the participants’ responses it could not be ascertained clearly whether the midwives were late in going to lunch; however, if this was the case, it should have been communicated to the women in order to gain their cooperation.
Communication is the basis of all human relationships and it is likely that the women would have understood and not complained if they had been provided with an explanation regarding late lunch-times. Women, as individuals, have the right to health care; this is violated when they are made to wait for long periods before receiving attention. Denial of access to health care is one of the aspects of human rights abuse (Bennett and Brown, 1999: 69).

Nokwe’s study (2003: 66) on the quality of antenatal care in an Eastern Cape Hospital identified staff shortage as one of the causes of poor quality of care. Hence, the lack of interest in the work and staff shortage could be closely related. Booyens (1998: 136) described lack of interest in work as one of the consequences of burnout syndrome due to exposure to work-related stress factors. Walker (2000: 162) identified the stress factors leading to burnout in midwives as being due mainly to trying to balance the pressures between home and work. It is virtually impossible to meet the responsibilities associated with being a wife, a parent and a midwife who provides the best possible care to all her clients, especially when coupled with staff shortages. The problem of staff shortage is longstanding in this region of the Eastern Cape. Most clinics are manned by two midwives; this means that only one midwife is on duty for four days when her colleague is weekend off. Nokwe (2003: 66) recommended the presence of at least one advanced midwife in any midwifery unit, because her advanced skills and knowledge enable her to teach others to cope with the workload.

3.3.2.2. Sub-theme 2.2: Women Perceive Midwives as Rude When They Shout at Women

The behaviour of midwives was an important aspect raised by participants in this study. Participants verbalized that midwives harassed them. Some midwives were described as harsh, rude, unfriendly and unable to handle people properly:
‘Amany’amanesi akanasiphatho ebantwini, ku worse kubantu abakhulelwayo--- basoloko bebangxamela bathi uzohlukuhla ngexesh’elithile ---‘Other nurses are unable to handle people properly, worse with pregnant women. They are always angry towards them saying, saying you come for palpation at a certain time---.’

Some of the midwives were described as insulting and dehumanizing to pregnant women:

‘Abalifuni ixesha lasemini bathi hayi siyanuka (laughing) sesinuka ngoku, bekufanel’ukuba size ekuseni’ (‘--- they do not want the midday time--- they say we are already foul smelling (laughing)--- we are supposed to come in the morning.’)

Participants also described midwives as disrespectful when addressing women, even those women older than the midwife herself, as indicated in the following quote:

‘Ubon’ukuba lo mntu amngxamelayo u pregnant, kodwa mdala kunaye, afike abe em ‘shout’ (a) athethe nje nakanjani’ (‘You find out this pregnant person they are harassing is old, even older than the nurse who is shouting and talking anyhow to her.’)

The code of conduct for nurses stipulates that a nurse should maintain a standard of ethical behaviour that does credit to her profession, even in her private life (Uys, 1999: 20). The welfare of the client should always be her first consideration. Midwives’ attitudes towards women during pregnancy, delivery and post delivery have been a matter of longstanding concern. In a study among teenagers in the Free State Province, Heunis, Van Rensburg and Ngwena (2000: 56) concluded that judgemental and moralizing attitudes among health workers influenced the health-seeking behaviour of teenagers.
These researchers suggested a multi-function centre for youth only, because health workers either refused to provide adolescents with services like contraceptives or only gave them after long embarrassing lectures, as they feared that these might encourage premarital sexual relationships. The idea of hostile midwives was also shared by women in the study by Mathole et al, (2004: 123) on women’s perspectives of antenatal care in a rural area in Zimbabwe. Women in this study described midwives as abusive and humiliating, asserting their control over pregnant women. This has been observed to affect the way women use and accept antenatal services. Diale and Roos (2002: 138), in their study on perceptions of sexually transmitted diseases among teenagers, also observed that women cited negative attitudes of the nurses in Midwifery Obstetrical Units (MOU) as one of the reasons for underutilization of MOU’s. Women in Benn’s study (1994:147) also cited a change in the attitude of the midwife as a recommendation for improving antenatal services. Knowing and respecting the client are key support activities, which in turn build closer relationships.

The Department of Health, in the White Paper (South Africa 1994: 94) for the Transformation of the Health System in South Africa, stresses that the health workers need to develop a caring ethos and improve their attitudes towards their patients. The midwife’s negative attitude has an impact on the midwifery profession and leaves a mark on its image that cannot easily be erased. As the first contact person for most pregnant women, the health of the latter depends on her. She is in an ideal position to influence and assist women and refer them to other support services; consequently, her response to her clients could have lasting effects on maternal morbidity and also on the psychological health of the pregnant woman.

3.3.2.3. Sub-theme 2.3: Women Felt That Their Needs Were Ignored at Times by Midwives

Participants perceived midwives as unapproachable and tending to ignore women’s concerns. Feelings of frustration were expressed by participants
when they could not ask questions because the midwives appeared to be in a hurry:

‘Ndaske ndabhideka nje ngoba zazininzi izinto endandingaziqondi----qond'uba awukwazi kuzibuza. Wayekugxagxamisa ngemibuzo nje ,afune uphendule ngokukhawuleza---- ngokungathi kukho apho aleqa khona’
(‘I was very frustrated because there were lots of things I did not understand, that I was unable to ask. She was impatient, asking questions and expecting quick answers, as if she was in a hurry.’)

‘uthi ukuze ukwazi ukubuza umntu abe open’ (for you to be able to ask a person needs to be open.)

These responses reflect that some of the participants would have asked more questions than they actually did had the opportunity been provided. Missed opportunities during the antenatal period contribute to incorrect diagnoses and, subsequently, incorrect management of pregnant women. Accordingly, active listening and effective communication play a major role in reducing maternal morbidity and mortality. It is important for the midwife to be intuitive about the woman’s needs and to be of assistance to her in meeting those needs. Listening to women is the means of ensuring that antenatal policies and practises address their felt needs.

Poor communication has a negative effect on the quality of care provided by midwives. Coffman and Ray’s study (2002: 542) on African American women’s support processes during high risk pregnancy and postpartum revealed that active listening allowed the midwife to get to know the woman and to be open to the ideas and beliefs expressed. Mathole et al (2004:123) maintained in their study that rural developers perceived the rural poor as ignorant and, therefore, did not even bother to listen and learn from them. These researchers observed that the major role of a midwife was to ensure that pregnant women complied with the established routines and nothing else. They recommended that a conscious effort be made to reach out to women to
discover their concerns and opinions, so that these can be incorporated into relevant policies. Moyo (2003: 10), in her paper entitled ‘Midwives and women: together for the family of the world’, advocated for a true midwife women partnership, where there is interactivity rather than just one-way information giving from midwives to women. Kwast (1998: 134), in her study on the quality of care in reproductive health programmes, identified six determinants of quality improvement, of which the provider-consumer relationship was one; according to her, the midwives of Tanzania and Botswana have undertaken initiatives to establish partnerships between the mother, her family and the midwife. The purpose of partnership is to provide appropriate care where the woman not only feels safe, but provided for and protected as a person who is valued.

According to Benn (1994: 28), feelings of powerlessness on the part of the midwife have a negative impact on the midwife-client relationship. The midwives strive for recognition and tend to use terms that are not understood by women with the hope of dominating the midwife-client relationship. Therefore, the recognition of midwives as competent and capable practitioners, particularly by medical practitioners, has a potential for improving midwife-client relationships.

The concept of listening to mothers is in line with one of the Batho Pele principles, namely consultation. Batho Pele is the White Paper on transforming public service delivery, through the establishment of a culture in which all state employees put the public first and are accountable for the service they give (Department of Health, 1999: 16). Women are more aware of their rights and need to be consulted in decision-making with regard to their health. The South African Constitution Act 108 of 1996 (South Africa 1996: 18) governs every facet of life, including the practice of midwifery. The Constitution spells out clearly the rights of individuals, including the right to complain about health care services, to have such complaints investigated and to receive a full response on such investigation (South Africa, 1996: 18). Patients have rights as citizens to participate in decision-making on matters
affecting their health, and every citizen has the right to participate in the
development of health policies. Thus, women’s opinions of antenatal care
need to be considered and incorporated when policies on antenatal care are
formulated.

3.3.3. THEME 3: WOMEN EXPERIENCE MIXED EMOTIONS ABOUT THE CARE THEY RECEIVE FROM MIDWIVES.
The participants expressed varied emotions about the type of care they
received from midwives; these ranged from feelings of content to those of
frustration and embarrassment. Initially all participants indicated that the care
they received was good, but when questioned about specific issues they
reflected dissatisfaction.

3.3.3.1. Sub-theme 3.1: Women Felt Content about the Care They Received From the Midwives
The participants expressed feelings of satisfaction about the way their
problems were attended to. One participant stated that she received attention
from one midwife throughout the day. Participants also felt that the midwives
cared when they took time to talk to them:

‘Ndiphatheke kakuhle kakhulu phaya (ubuso butyhilekile)--- Xa
ufik’ekliniki uyichaza ingxaki yakho, iyabhalwa apha ekhadini, uthi xa
uyobeleka ufi ke amanesi sele yazi ingxaki yakho’ (‘I have observed very
good care there (lighting up) --- When you come to the clinic and explain
your problem, it is written in your card so that when you go for
childbirth, nurses already know your problem…’)

The participants also expressed their appreciation of the individualized
attention and patience shown to them by some of the midwives. These
midwives seemed to demonstrate genuine concern for the woman by going
beyond what was expected of them:
‘Wathi uSister uza kuba ‘open’ athethe yoke into---- wandicacasela ke izinto ezininzi.’ (‘Sister said she was going to be open and speak everything, she explained a lot of things to me.’)

‘Kwakusithiwa iipilisi zase klinik i zezona zona zenza ukuba ube nengxaki, kodwa wath’u Sister ekliniki ziyanceda. U Sister waba nomonde, endicebisa ukuba ndizithathe’ (‘People used to say clinic pills are the very ones that bring problems, but Sister at the clinic told me that they are helpful. Sister was patient with me, encouraging me to take them (the pills’)

Women seemed to relate good antenatal care to the assurance given regarding the baby’s health. They appeared to be more concerned with the fetal well-being and knowledge about the fetal condition seemed to motivate their antenatal attendance. This is reflected in their definition of good antenatal care in terms of being able to find the fetal heart. They even referred to antenatal attendance as *going for palpation* (*ukuhlukuhlaha*) to ensure that the baby was healthy and lying in the correct position. Thus, the participants evaluated the midwives’ competence in relation to their ability to assess the baby’s well-being. The following statement reflects this belief:

‘Umntwanam bekumana kuthiw’akabonwa ukuqala kwam, so baye bandihoya ke bendihoya bade bayibona intliziyo yomntwana ebebesithi abayiboni. Babendihoyile ke kakhulu’ (‘They used to say they did not see the baby during my initial visits, so they observed me now and again until they found the fetal heart. They took great care of me.’)

The midwife is the key provider of maternity services in South Africa. De Kock and Van der Walt (2004: 4) maintained that a caring attitude by midwives contributed to the improvement of quality maternity care. In terms of their ethical code (Searle, 1987: 233) midwives must always act in the interests of the client.
3.3.3.2. Sub-theme 3.2: Women Felt Frustrated and Angry When Turned Back Home for Being Late

Participants expressed their frustration when they were turned back on arrival at the door and told that they needed to wake up and come to the clinic earlier. In some clinics they were turned back as early as 08:00 if the stipulated number of palpations per day had been reached:

‘Azange senziwe ngale gem yesibini safika kwathiwa si late ----sabe ke thina sikhalazela ukuba zange sayixelelwa into kuba kubekw’ixesha----. ('On the second visit we were not attended to, we were told that we were late when we arrived. Our complaint was that we were never told to arrive at a specific time.‘)

‘Abanye ke babesithi sebefikile bajikwe sebesemnyango kuthwe e kliniki kuyavelka akufikwa late’ ('Others were turned back at the door on arrival, and were told that you need to wake up when you come to the clinic, you do not come late.‘)

The researcher has not been able to locate any literature supporting the idea of women being turned away from the clinic for being late. However, the researcher is aware that the number of women palpated per day is stipulated in a number of clinics within the Eastern Cape, due to limited human resources that can barely cope with the large numbers of pregnant women. Nevertheless, this is against the goals of the Department of Health, as stipulated in the White Paper for the Transformation of the Health System in South Africa (1994: 98). According to this document, the government aimed at increasing access to integrated health care services for all South Africans. Providing equal access to health services is also one of the principles of Batho Pele (Department of Health 1999: 16). The Batho Pele initiative aims to enhance the quality and accessibility of government services by improving efficiency and accountability to the recipients of services. Turning women away who have made the effort to come for antenatal care is definitely not putting people first.
3.3.3.3. Sub-theme 3.3: Women Felt Embarrassed When Being Palpated By a Male Nurse

Participants expressed the view that they did not feel happy exposing their bodies to male nurses:

‘Le yokuhlukuhlwa ngumntu oyindoda – yho, hayi ke leyo! La bhuti ohlukuhlayo kaloku sasikrotywa nguye apha ngaphantsi! Futhi watsho ngoku sisezawuya phawathi sizawukhulula sishiyeka ngonondrokhwe qha. Hayi, singamaXhosa thina asiqhelanga kukhulula phambi kwendoda esingayazi!

(‘Being palpated by a man, oh, that was worse! That gentleman who was palpating us was actually inspecting our private parts! In fact he frankly told us before, that we have to undress and leave only the petticoat---. No, we as Xhosa women are not used to undress in front of a male stranger.’)

Although only one participant verbalized her embarrassment on being palpated by a male midwife, gender could be an important issue here, as there are very few male midwives in this area. All of the other participants stated they had never been palpated by a male nurse. A similar observation was noted among Thai women in Australia (Liamputtong, Rice and Naksook, 1997: 77) in a study on the experiences of pregnancy, labour and birth. These women expressed their embarrassment about vaginal examinations being conducted by male doctors because they were not familiar with their private parts being examined by other people. Accordingly, midwives need to be aware of, and be sensitive to, the cultural specifics of the particular group with which she is working. The midwife needs to seek out ways of learning about accepted cultural responses and also to understand the influence of a client’s culture on her compliance and experience of pregnancy. Dickason and Schult (1998: 3) described the characteristics of the culturally competent practitioner as the one who is non-judgemental and who demonstrates flexibility and tolerance in meeting the needs of clients from diverse communities.
3.3.4. THEME 4: THROUGH THEIR EXPERIENCES, WOMEN IDENTIFIED CERTAIN NEEDS IN THE SERVICES AND CARE THEY RECEIVED AT THE CLINIC

Inadequate teachings, distance from the clinic, transport problems, financial constraints, lack of safety and difficulties in crossing rivers during the rainy season were all among the needs identified by the participants in the services and care they received at the clinic.

3.3.4.1. Sub-Theme 4.1: Women Expressed a Need for Adequate Information about Pregnancy

One of the aims of antenatal care is to prepare the woman for delivery, both physically and emotionally, and that is possible mainly through health education. Early detection of pregnancy-related conditions can be done by the well-informed woman herself. With increased knowledge, women can do much to prevent problems during antenatal, intra-partum and post-natal periods. Although all participants indicated that health education was done at the clinic, some expressed concern about lacking adequate information with regard to pregnancy. Participants expected to be given lectures about caring for themselves during pregnancy, as reflected in the following quote:

‘limfundiso nge pregnancy asibinazo ngokupheleleleyo’ (‘We do not get adequate teachings about pregnancy.’)

The following statement indicates that some individualized health education was done, either during history taking or when findings were recorded in the antenatal card:

‘Asikaze sifundiswe, ngaphandle kokuxelelwa ngoku, xa ikhadi lakho ligcwaliswa’ (‘We are never taught except being told now, when your card is filled (when information is recorded in the card.’)
However, individualized education seemed to deal with specific problems of the individual concerned and did not provide information on pregnancy care adequately. One participant’s comment suggested that the health education content on pregnancy care was presented at a level above her own understanding:

‘Hay’inobandaphoswa siskolo nje, kuba kuye kuthethwe------uyacaciselwa ukuba yenzelwa ntoni yonke into’ (‘I suppose it’s because I did not go to school, for something is usually said... it is explained to you why anything is done.’)

Poor quality of antenatal education has been identified by several researchers (Nokwe, 2003: 59; Gordon, 2005: 3). Nokwe’s study (2003: 59) on the quality of antenatal care in an Eastern Cape Hospital revealed inadequacies in the health education content provided by midwives in antenatal clinics. According to this study, no health education or advice was recorded on patients with a haemoglobin of less than 10g/dl of blood and only half (50%) of antenatal cards audited reflected health education topics in the space provided for health education. This could indicate either that no health education was done or that the health education given was not recorded.

Expectant women and their families need to be empowered with relevant information on pregnancy care. Well informed women are in a better position to make reasonable choices and decisions. It is of vital importance that women be knowledgeable about pregnancy care and complications that may arise. Kumbani’s study (2002: 48) on knowledge of obstetric complications among Malawian primigravidae revealed that women were unaware of any pregnancy problems that might require immediate intervention. They tended to cite minor disorders of pregnancy as complications that could arise. Lavender, Stephen, Walkinshow and Walton’s study (1999: 43) revealed that women identified the information provided during pregnancy as one of the factors contributing to a positive birth experience.
Van Huis (2000: 161) described appropriate midwifery care as one of the six pillars of safe care and antenatal education as forming the core of midwifery care. One of the issues raised by women in the study by Nigenda et al (2003: 4) in all four developing countries was the issue of increased access to information given by midwives. According to women’s views in this study, providing adequate information and communication skills were central issues that needed to be improved by midwives. Inadequate antenatal education was also observed by Liamputtong, Rice and Naksook (1997: 83) among Thai women in Australia, whereby women of a low socio-economic background received short consultation time and were not given detailed information about pregnancy care. However, lack of adequate information about maternity care in these women was related to language limitation, which was not the case with the sample of this study as both midwives and participants were Xhosa speaking.

Gordon (2005: 3), in her study on the application of Health Promotion Programmes (HPP) in Community Health Centres, maintained that severe staff shortage had cascading effects on patient care, especially with regard to talking and listening to patients. She advocated the use of Health Promotion Officers (HPO’s) for group health promotion, so that midwives would do individual health education only. The HPO could motivate for a healthier lifestyle like stopping smoking or alcohol intake to improve health, as well as explain to women how certain medical procedures were done and why. Group health promotion would, thus, equip women with knowledge to improve their health status and that of their unborn babies. Gordon (2005: 2).also recommended that health promotion programmes be evaluated regularly to verify their effectiveness

All participants demonstrated correct and adequate information about HIV and AIDS. This reflects that HIV/AIDS education is integrated into antenatal care as recommended in the White Paper for the Transformation of the Health System of South Africa (South Africa, 1997: 98). This document recommends
that the Maternal and Child Health Services be comprehensive and integrated, so that services are rendered on a one-stop ‘supermarket’ basis. The Academy for Educational Development (AED)/LINKAGES (Ntombela, 2005:15) also advocated for the PMTCT programme to be integrated into the existing antenatal services. The aim of the integrated antenatal care package is to ensure effective implementation of strategies to reduce the risk of mother to child HIV transmission. The National Minister of Health, Dr Tshabalala-Msimang, in her 11th annual report on the status of HIV prevalence in South Africa (Department of Health, 2000b: 1), stated that antenatal surveys are regarded internationally as the most reliable tools to estimate HIV prevalence in populations. Integration of services allows multipurpose use of resources and permits more outputs to be achieved (Mashazi and Roos, 2000:103).

However, the women’s lack of knowledge regarding pregnancy care revealed that the health education content seemed to concentrate mostly on HIV teachings rather than on pregnancy care, as reflected in the following statement:

‘limfundiso abasinika zona ngoku sikhulelwe, ukuba masizame ukuba si ‘testelwe’ i AIDS - I HIV, ukuba si ‘negative or positive na’ (‘The lessons they give us now that we are pregnant, that we try to be tested whether we are negative or positive for AIDS, HIV.’)

Even the involvement of the fathers during pregnancy is directed specifically towards HIV counseling rather than antenatal education, as expressed in the following quote:

‘Bayasicebisa ngokuthi xa ukhulelwe uze nalo mntu okukhulelisileyo, sitsalise igazi, ukwenzel’ukuba sifundiswe soba yi-2, nokuba sinaso esisifo, nokuba siyaqhubeka sithandana siphathane ngendlela eyiyo, sixelelw’ukuba funeka nenze kanje, umntu atye uku noku’ (‘They also advise that when you are pregnant, bring the person who made you
pregnant, so that blood may be taken to both of you----- so that we are both given advice, so that even if we both have the disease, even if we continue being lovers we take good care of each other, that we are told how to behave, what to eat.’

It seems as if the strategies used to bring about HIV awareness are more effective than those used for antenatal education. Kwast (1998b: 133), in her evaluation of quality of care in reproductive health programmes, expressed the concern that Maternal and Child Health services seem to suffer because midwives are overburdened with HIV prevention and treatment services. A training manual that focuses on women’s preparation for pregnancy and childbirth needs to be developed.

3.3.4.2. Sub-theme 4.2: Women Wanted Midwives to Give Reasons and Explanations about Procedures Performed on Them by Midwives

The majority of participants verbalized their concern that some procedures were performed on them without explanations as to why they were being done; they were also not informed about whether the findings were normal or not. Several references were made regarding the lack of information on blood tests and medications given at the clinic. Participants said they did not know the purpose of these tests and examinations. The following statement explains women’s expectations in this regard:

‘Azange bandixelele ukuba litestelwa ntoni igazi lam’ (‘They did not tell me why they tested my blood.’)

The indications for the medications given to the women were also not explained to them:

‘ nesa stofu sitofw’egxalabeni---yaqonda--- ndicing’ukuba sifanel’ukuxelelwa ukuba sesantoni’ (‘—about that injection given on the shoulder too--- I think we need to be told -you know - what it is for.’)
According to participants, midwives seem to concern themselves with established routines of pregnancy care rather than the effect of their care on the women. Among others, Fryer in Hinchliff, Norman and Schober (2003:38) proposed the following guiding principles that reflect the personal accountability each midwife has in caring for her clients:

- Respect the client as an individual.
- Obtain consent before you give any treatment or care.

Explanation is essential before all actions and procedures are done to clients to gain their cooperation. Women have a right to be informed why anything is done to them. The permission to do the procedure needs to be granted by the woman, based on informed choice. The registered practitioner must not practice in a way which assumes that she knows what is best for the client (Fryer in Hinchliff et al, 2003:39).

The code of professional conduct sets out principles of professional conduct. It provides the midwife and the public with the picture of what is expected of someone registered and has a license to practice nursing (Neal in Hinchliff et al, 2003: 109). Neal in Hinchliff et al (2003:102) described respect for the client and her decisions about her health care as one of the principles underpinning professional practice. This means identifying the woman's preferences for nursing care and respecting those preferences where possible. Part of respect is recognizing the worth of the woman as an individual, and maintaining her dignity.

3.3.4.3. Sub-theme 4.3: Women Expressed the Need for a Doctor at the Clinic for Deliveries

Distance from the referral hospital was the only reason stated by the participants for a need for doctors at the clinics. Participants verbalized their
dissatisfaction that they had to be referred to a hospital about sixty kilometers away because there were no doctors at the clinic or at the nearby District Hospital:

‘Bendirhalela----- moss kuthwa apha abantu abakhulelwyo abaqalayo ababelekeli apha--- ngoku ke nantso into endihluphayo. Kuthwa bathunyelelw’eMtata , abantu bathi baye baxelelwe ukuba akukho gqira. Mna bendingavuya ukuba kubelekelwa apha’ (I so wished that—you know it is said that women pregnant for the first time do not deliver here, that’s what worries me. They say they are transferred to Umtata--- People say they are told that there are no doctors. I for one would appreciate it if they do deliveries here.’)

Participants seemed to be satisfied with the care provided by midwives as stated before. However, the participants’ choice of midwifery care could have been influenced by financial constraints as all of the participants were unemployed and could not afford alternative antenatal care. On the other hand, women in Benn’s study (1994: 147) preferred doctors to midwives for their antenatal care, as they regarded doctors as more knowledgeable and more skilled than midwives. Thai women, in the study by Liamputtong et al (1997: 84), preferred midwives to doctors for their antenatal care because of their experience. The fact that midwives were themselves mothers and had experienced pregnancy made them more capable of understanding women’s needs.

3.3.4.4. Sub-theme 4.4: Women Expressed the Need for Pregnant Women to be DEAL with Separately from Other Clients

Some of the participants expressed their frustration that they were combined with other clients at the clinic while procedures requiring some privacy, like urine testing, were performed:

‘Into yokubakuthiwe masichame size nomchamo uzo testelwa phandle, apha kube kugcweleabantu abaninzi abagulayo yenzi iintlioni--- ingathi kungakho
indlu yabakhulelwayo bodwa’ (‘The fact that we are told to pass urine and bring it for testing outside, whereas there are so many sick people there, is rather embarrassing. I so wish that there may be a separate room for pregnant women only.’)

Participants also verbalized that the clinics were frequently too crowded and that they had to wait five to six hours before they were attended to. The participants associated the problem of overcrowding with the way in which the services were organized, particularly in combining clients with differing needs so that the period of queuing was prolonged:

‘Amaxesh’amaninzi bayanidibanisa nonke—bayalibazisa xa abantu benziwe ngexesh’elinye, kuvela kuqhutywe(kukalwe) qha wonk’umntu okanye ke kungathiwa makuqale aba bakhulelwayo kulandel’abantwana’ ‘Mostly they combine everybody---they delay us when they (the clients) are done at the same time, when they just weigh everybody, or when they don’t say those pregnant must start then children to follow.’

‘Basebenzisa umnyango omnye nab’abazocwangcisa,... Nabazis’abantwana, Lo nto yenz’ukuba sihlale phandle ixesha elide.” ‘--- they use one entrance with those for family planning and those bringing their children, so we are made to stay outside for a long time.’

Reviewed literature confirmed that combining clients with different needs prolonged duration of contact rather than enhancing quality care. Kunene, Ndzimande and Ntuli (2001: 70), in their study on service delivery issues in provision of antenatal care in South Africa, assessed the time spent by the clients at the antenatal clinic. They observed that although each client spent more than four hours at the clinic, very little time (less than 30 minutes) was spent in contact with nurses. They also discovered that not all clients received all services scheduled to be received per visit. Richter’s Standards for Perinatal Education (2002: 11) spelled out that different groups of mothers needed to be approached differently rather than combining them. Heunis, Van
Rensburg and Ngwena (2000: 56) also proposed that the reproductive health services of adults and youths be separated in order for their needs to be optimally fulfilled. Women in Benn’s study (1994: 151) explained that they had to wait for over an hour for attention and recommended that waiting time be reduced to improve antenatal utilization.

### 3.3.4.5. Sub-theme 4.5: Women Expressed the Need for a Clinic Closer to Their Homes

The majority of women expressed the need for a clinic within walking distance from their place of residence, as reflected in the following quotes:

‘Siyanqwenela ukuba nathi ngaske sibe nekliniki elaph’elalini, ngoba ikliniki esiyisebenzisayo ikude’ (‘We would like that we also have a clinic here in our location, because the clinic we use is too far.’)

Apparently even the few clinics and the hospital that were nearby did not provide all antenatal services. Participants verbalized that women had to be sent to Umtata for emergency deliveries and that transport was always a problem:

‘Xa bekunokuthiwa sisibhedlele bendizakunwenela ukuba kubekho ne'theatre' apha noogqira, kuba siyabetheka yile nto yokungabikho koogqira’ --- asinamali yokuya e Mtata apho kukho oogqira’ (‘If it was a hospital I would like it if there was a theatre as well as doctors, because we do suffer due to unavailability of doctors------ we don't have money to go to Mtata where there are doctors’)

‘I mobile iyeza yona, kodwa ayihlukuhli…. Iza namayeza kuphela’ (‘The mobile clinic comes but it does not do palpation, it only brings medicines.’)

The distance to the clinic makes the services unaffordable in terms of cost. Women either travel long distances on foot, or pay dearly for transport:
‘Sikhwela ngemali, kukude ukusuka ku Malephe uye e town….. ngamanye amaxesha sewuse town unesi akuggithisele esibhedele …. Yenye imali ke leyo. Abasebenzi abayeni bethu …. Awunayo naloo mali nokuba sewufun, ukuy’ekliniki’. (‘We use money to travel, it’s far from Malephe to town… sometimes from town the nurse refer you to the hospital and again it’s another money… our husbands are not working, you don’t even have that money even if you want to go to the clinic.’)

Women also felt unsafe when traveling on foot:

‘Sihamba umgama omde, nokuba sewuhamba ngenyawo kuyaleqwa, kuba sihamba kwindawo enamasimi’ (‘We travel a long distance, even if you travel on foot people are being chased as we walk through the farms’)

The findings in this study support previous literature on women’s perceptions and experiences of antenatal care, particularly those women from rural areas. Lieve (2003: 80), in her paper entitled ‘The impact of inequality on the health of mothers’, identified access to adequate obstetric care services as the important determinant of high maternal mortality. She observed that women most in need of these services have least access to them. Distance from the clinic, transport problems, financial constraints, difficulty in crossing rivers during the rainy seasons, negative attitudes of service providers, long waiting hours and poor quality of care were all mentioned by women in Benn’s study (1994: 151) as some of the reasons for late booking. Heunis et al (2000: 56) confirmed in their study that inequity in access to effective Mother, Child and Women Health (MCWH) services exists particularly in previously disadvantaged rural areas. In her study on antenatal care utilization and perinatal outcome, Benn (1994: 151) recommended that reduced cost as well as more clinics in easily accessible areas would improve antenatal utilization.
Currently, in this region the unavailability of adequate and accessible antenatal services remains a problem and women have to travel long distances for these services. The Eastern Cape Triennial Report (1999 – 2001) by the National Committee on Confidential Enquiries into Maternal Deaths (Department of Health, 2002: 199) revealed that 21.6% of maternal deaths were associated with transport problems to referral institutions, while the delay in getting the patient from home institutions was attributed to 13% of cases.

However, in a study on women’s opinions on antenatal care in developing countries (Cuba, Thailand, Saudi Arabia and Argentina), distance from home was not viewed as important by Cuban pregnant women if they received care in a hospital (Nigenda et al. 2003: 1). They preferred to travel far from their homes to be sure that they would receive the attention they needed. They argued that they felt more secure attending the hospital because of all the equipment available there. Thus, improvement in their socio-economic status may influence women’s views regarding accessibility of antenatal services.

3.4 CONCLUSION

In this chapter, data collected during interviews were analyzed. Themes and sub-themes that described women’s perceptions and experiences of antenatal care were identified. Review of literature was done to verify whether the findings supported what was already known about the topic. The discussion reflected both positive and negative views of women regarding antenatal care and revealed that antenatal services fail to provide some of the needs of pregnant women.

Chapter four will address the guidelines for assisting midwives in optimizing the accompaniment of women during their antenatal period. Conclusions and recommendations for practice, education and further research will be made.
CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

4.1. INTRODUCTION

The previous chapter dealt with data analysis, discussion of results and literature control. The aim of this chapter is to describe the guidelines to assist midwives in optimizing the accompaniment of women during their antenatal period. Guidelines for practice in the clinical field will be developed and recommendations for nursing education and further research will be made, based on the conclusions reached during data analysis.

4.2. OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Explore and describe the perceptions and experiences of pregnant women attending the antenatal clinic regarding the care they receive from midwives.

- Make recommendations to assist registered midwives in optimizing the accompaniment of women during the antenatal period.

The first objective of the study was pursued by asking the following question:

‘Khawundixelele ngokucingayo malunga noncedo othe walufumana koonesi apha ekliniti njengokuba ukhulelewe, nokuba belukumgangatho obe uwulindele na’. (Tell me about the care that you received from the midwives at this clinic during this pregnancy, and if it met your expectations.)

The researcher believes that the first objective was achieved as the perceptions and experiences of pregnant women were explored and adequately described. With respect to the second objective, the identified
themes will serve as a basis in the development of guidelines to assist midwives in their accompaniment of pregnant women.

4.3. DISCUSSION OF FINDINGS

From the discussions and analysis of results it can be concluded that:

- **Women Appreciated Care Given by Considerate and Knowledgeable Midwives**: Women felt at ease in the hands of proficient, informed and skilful midwives.

- **Midwives Provided Pregnant Women with Correct and Adequate Information about HIV And AIDS**: Through their responses, all participants demonstrated adequate knowledge on VCT, PMTCT and safe sex practices.

- **Although Health Education Plays a Major Role in the Prevention and Management of Pregnancy-Related Conditions, Information Provided on Pregnancy was Inadequate**: Women expected to be given more information about pregnancy-related issues. They verbalized that no explanations were provided by midwives regarding the significance of some tests and examinations done to women. Women also expressed the need for their concerns to be considered by midwives. Women did not feel free to ask questions about things that they did not understand because midwives were either unapproachable or seemed to be in a hurry.

- **Antenatal Services Failed to Meet Some of the Needs of Pregnant Women, particularly in terms of Accessibility and Affordability**: Women had to travel long distances to get to the clinic and to the referral hospital when they needed tertiary care. They could also not afford transport costs as they were unemployed. Travelling on foot proved to be unsafe and some accessible mobile clinics did not provide antenatal care. Women were also frustrated by long waiting times, especially after lunch-time, and being turned away when they arrived late at the clinic.
The Midwife-Client Relationship was Compromised by Insulting and Humiliating Remarks Made by Midwives Towards Pregnant Women: Midwives were described as harsh, rude, unfriendly and disrespectful when addressing women, even those women older than the midwives themselves.

Most Emotions Expressed by Clients were Negative: These emotions were related to the care they received from midwives and included anger and frustration.

4.4. RECOMMENDATIONS FOR CLINICAL PRACTICE

The following recommendations for practice in the clinical field are suggested based on identified themes during data analysis:

- Recommendations to empower midwives with health education skills.
- Recommendations on the health education content that should be given to pregnant women.

4.4.1 Empowering midwives with health education skills:

Midwives need to be empowered on how to guide and assist pregnant women and their families through client education. According to Kotzè (1998: 13), accompaniment in midwifery should be planned and deliberate with the aim of assisting the pregnant woman to overcome her needs for help and support. Through accompaniment, the midwife should direct the woman towards accepting responsibility for her own health.

Troskie (1996: 192) emphasized the importance of creating a learning atmosphere before implementing any educational programme. This includes:

- Determining the values and norms of women;
- Identifying and eliminating any impediments to the learning process.
Both the physical and psychological climate should be ideal to promote learning. The physical climate includes:

- The venue for antenatal education; this should be spacious and well-ventilated but warm.
- The seating arrangement; this should include comfortable chairs arranged in a circle so that everybody is visible.
- The group should not comprise more than sixteen members; this is to allow face-to-face communication (Perelson, 2002: 35).

The psychological climate involves the positive attitudes of midwives which promote a climate of pleasure and humaneness (Neal in Hinchliff et al, 2003: 100). The essential positive attitudes will be discussed later in the text.

Women’s contributions should be welcomed and considered: The midwife should ask what the women expect of health education, and their expectations should as far as possible be incorporated in the education programme.

4.4.1.1 Principles of adult learning

The health education approach for pregnant women as adult learners should consider the principles of adult learning. Fowler in Hinchliff et al (1988: 46) explained the following assumptions about adult learners which indicate how best they can learn:

**Self concept** – Learners have developed a self concept of being responsible for their own decisions and their own lives. They need to be seen and treated by others as being capable of self direction (Olds, London and Ladewig, 1996: 61). The midwife should avoid the ‘teacher knows best’ attitude and be willing to negotiate with women regarding the process and focus of learning (Fowler in Hinchliff et al, 2003:399)

- **Experience** – adults can draw on a wide field of experience to the educational activity. They are learning about childbirth from their mothers and other female relatives The midwife thus needs to assess women's previous knowledge and experience to build upon what is
already known by women. If women’s experiences are ignored or devalued, they may perceive that as being rejected as people (Olds et al., 1996: 61).

- **Readiness to learn** – adults see the need to learn based on real life situations, thus they take responsibility for their learning.
- **Orientation to learning** – adult learning is task centred rather than subject centred
- **Motivation to learn** – Learning is largely motivated by intrinsic factors like improved quality of life, enhanced self esteem (Olds et al. 1996: 61).

### 4.4.1.2. Appropriate teaching principles

Troskie (1996:192) mentioned the following principles which can be adapted for patient counselling and education:

- **Establishing a trusting relationship:** This relationship develops when the midwife identifies and considers the woman’s emotional needs. Genuine interest and willingness to listen to women’s needs form the basis of a trust relationship.

- **Declaring both parties’ expectations:** Both parties must agree on mutual expectations. Conflicting expectations of women and midwives may result in failure to achieve the objectives of the health education programme.

- **Focus on problem-oriented learning:** Adult learners like to apply what they have learnt in real-life situations, so they should be given opportunities to do so. Since pregnancy is a real life situation, problem solving and task oriented methods of teaching should be used during antenatal education.

- **Recognise woman’s individuality:** All women should be regarded as persons in their own right.
4.4.1.3. Methods of presenting the subject matter
A variety of methods can be used when the subject matter is presented to women, particularly those methods which allow open communication and participatory learning:

- **Demonstration** cultivates cognitive and psychomotor skills, for example antenatal exercises can be demonstrated to women, while their importance is emphasized.

- **Group discussions** will harness the women’s past experience.

- **Active participation** can be in the form of role play or simulation. (Troskie, 1996: 193).

4.4.1.4 Evaluation of learning
Evaluation of information gained can take the following forms:

- Ongoing: Monitoring of women’s responses to instruction, during the course of the lesson.

- Evaluate the behavioural changes brought about by the learning experiences, that is, the extent to which the information gained is used by women for their benefit.

- Antenatal exit interviews can be done to explore women’s opinions of antenatal education (Troskie, 1996:196).

4.4.1.5 The recommended health education content that should be given to pregnant women

According to the National Maternal Guidelines (Department of Health, 2002: 24) the following are the aspects that need to be covered in the health education of all pregnant women:
4.4.1.5.1 Interventions to reduce mother-to-child transmission of HIV:

- Benefits and sources of voluntary, confidential counselling and testing (VCCT) Women need to be made aware of the significance of knowing their HIV status.

- Counselling and advice on the prevention of HIV infection through safe sex practices (abstinence, being faithful and using condoms).

- Empowering women with negotiation skills regarding safer sex practices.

- Antiretroviral (ARV) prophylaxis: Nevirapine given at 32 weeks to be swallowed at the onset of labour.

- Infant feeding options

- Demonstration of appropriate breastfeeding techniques (correct positioning and attachment of the baby to the breast).

- Expression and storage of breast milk

4.4.1.5.2 Information on pregnancy, labour and newborn care:

- Importance of antenatal care

- Physical and psychological changes of pregnancy

- Self care in pregnancy:
  - Diet and exercise
  - Personal hygiene and breast care
  - Use of medications
  - Abuse of alcohol, tobacco and recreational drugs (Department of Health, 2002: 24).
4.4.1.5.3 Danger signs of pregnancy:

The woman must contact a health care worker immediately she experiences the following signs:

- Severe headache
- Epigastric pain
- Vaginal bleeding
- Drainage of liquor from the vagina
- Reduced fetal movements (Department of Health, 2002: 24)
- Temperature above 38°C
- Blurring or double vision
- Persistent vomiting

4.4.1.5.4 Indications of medications and vaccines given during pregnancy and childbirth, for example:

- Ferrous sulphate tablets 200mg daily, to prevent anaemia.
- Folic acid tablets 5mg daily, in the first trimester to prevent neural tube defects.
- Tetanus toxoid immunization 0,5ml to prevent neonatal tetanus. (Department of Health, 2002: 23).
- Mebendazole for de-worming in the second trimester.

4.4.1.5.5 Significance of essential screening investigations:

The midwives should discuss with women the significance of the following screening investigations, as identified in the Maternal Guidelines for maternity care (Department of Health, 2002: 23):

- Syphilis serology - rapid plasmin regain (RPR).
- Rhesus blood group and haemoglobin level.
- Human immunodeficiency virus, following accepted principles of voluntary counselling and testing.
- Urine testing for protein and glucose
Information sharing should start first in large groups, then small specialized group discussions (e.g. teenagers, married couples) to address common needs. The teaching strategies that are used for HIV/AIDS awareness could also be used for pregnancy-related issues as they seem to be effective, judging by the improved knowledge on HIV/AIDS observed by the researcher in the participants.

4.4.2. Improving Midwife-Client Relationship

Accompaniment is a two-way process whereby the midwife and the pregnant woman are in a collaborative relationship (Kotze, 1998: 13). The midwife needs to listen to the concerns of pregnant women and not dominate the relationship. Understanding the actions that pregnant women have reported as important to them can guide the practice of those who provide antenatal care.

Women should be allocated to a specific midwife during pregnancy so that they can build a strong relationship of trust and understanding. Women's cultural issues would, thus, be better understood and respected by the midwife. According to Neal in Hinchliff et al (2003: 101), the relationship between the midwife and the pregnant woman is based on the woman’s need for care, assistance and guidance. It is established solely to meet the woman’s needs, and therefore it is therapeutic in nature. The above authors identified the basic concepts that shape a therapeutic nurse-patient relationship as:

**Power:** The balance of power within the relationship is not equal. The midwife’s knowledge and skills place her in a position of authority. The appropriate use of professional power must therefore ensure that the process is adapted to be acceptable to each woman. The midwife needs to consciously relinquish some power and take on more of a partnership role with the woman, in order to give choice and to accept the choices the woman makes.

**Trust:** The woman’s trust in the midwife is based on the assumption that midwives have unique knowledge and skill, and that they will use their
knowledge and skill to provide proper care. The midwife needs to demonstrate behaviours and attitudes that justify the woman placing trust in her. Building a trusting relationship greatly improves care and helps to reduce stress for the patient.

During the early stages of the relationship, the midwife needs to ensure that the woman knows that information will be treated as confidential, but will be shared with others involved in the delivery of care. The woman’s wishes will be respected regarding the sharing of information with her family.

**Respect:** Respect for the woman and her decision about her health care is fundamental to the midwife client relationship. This means identifying the woman’s preferences for nursing care and respecting those preferences where possible. Respect for the woman’s decisions means respecting their ability to make decisions about themselves, and ensuring that they have choices. Recognising the worth of the woman as an individual and maintaining her dignity is part of respect (Neal in Hinchliff et al 2003: 102).

**Intimacy:** Intimacy in the professional nurse patient relationship relates to activities that the nurse performs with, and for, the patient. These activities may be physical, psychological, emotional, spiritual or social, but they are not sexual in nature. However, they do require a closeness and understanding between the midwife and the woman (Neal in Hinchliff et al 2003: 102). This requires the woman to have confidence in the midwife and her ability and willingness to treat the woman’s interests as paramount.

The midwife needs to engage in a professional relationship with the woman through the use of **appropriate communication and interpersonal skills.** Engagement in a midwife client relationship demands the following concepts: (Neal in Hinchliff et al 2003: 102)

- **Love:** A demonstration of care and concern towards another person.
• **Empathy:** The ability to feel ‘with’ and ‘for’ the patient. Empathy enables the nurse to sense, to share in, and to accept the patient’s emotional point of view.

• **Sympathy:** Recognition of the discomfort, pain or distress experienced by the client, which evokes on the midwife an immediate response to alleviate the cause of discomfort.

• **Understanding:** The ability of the midwife to accept and show appreciation for another person’s thoughts, feelings and actions.

• **Acceptance:** This refers to receptivity of the woman’s opinion without judgement.

Interpersonal skills are a prerequisite for effective communication. The **principles of effective communication**, as described by Neal in Hinchliff *et al* (2003: 105) include:

- Being greeted warmly
- Being listened to
- Receiving clear explanation
- Being reassured
- Being able to express fear and concern
- Being respected
- Being given enough time
- Being treated as a person, not just a disease

**Developing a positive attitudinal approach to client care**

The nurse or midwife, as a change agent, has a potential to bring about a positive change in the midwife client relationship. To achieve this, the midwife needs to know herself first, both as a person as well as a professional. She needs to examine her reactions, her capabilities, her limitations and her degree of commitment to her profession. When the midwife is aware of her strengths and weaknesses, she will use the acknowledged strength or weakness constructively. She will be honest, genuine, open and flexible, able to share her feelings of sadness, happiness and loneliness, rather than mask them. The personal awareness, knowledge and understanding, when put into
operation, results in a positive experience for the client, her family and community, and is referred to as the therapeutic self (Neal in Hinchliff et al 2003: 102).

Six positive attitudes are essential in the delivery of client care:

- **Personal worth**: An attitude of personal worth is the viewpoint the midwife holds about self and others. It involves acknowledging and accepting cultural differences, recognising the autonomous rights of others, showing respect for humanity and acknowledging the client as an individual (Neal in Hinchliff et al 2003: 102).

- **Personal integrity**: An attitude of personal integrity means that the nurse maintains honesty towards herself in her dealings with herself and with others. It implies that the midwife needs to be:
  - Just, fair, honest, dependable.
  - Willing and able to acknowledge commitment to the profession, to women and to self.
  - Accepts challenge and committed to a willingness to take risks.
  - Accepts responsibility and accountability for her actions.

- **Open mindedness**: This attitude stems from the sincere desire to learn from others, and to make use of the knowledge thus gained. It demands flexibility and receptiveness to modify existing belief systems. It is conveyed through acceptance, respect and understanding. With regard to midwife client relationship, open mindedness is accepting the right of women to hold values and make decisions that may differ from hers as a midwife. The midwife needs to understand that what is right for one woman may not necessarily be right for another. Open mindedness is an essential attitude if free and effective communication is to exist between the woman and the midwife. (Neal in Hinchliff et al 2003: 102).
• **Advocacy:** Advocacy is an attitude of support that safeguards the rights and integrity of the patient. It includes standing up or fighting for the good of the patient. The midwife supports the woman in those decisions she feels are right and necessary for the maintenance of the woman’s personal integrity. Advocacy demands that the midwife provides the woman with the necessary information to reach an informed decision, and ensuring that the decisions made are carried out according to the woman’s wishes (Neal in Hinchliff et al 2003: 102).

• **Hopefulness:** Hopefulness means looking at a situation from the bright side. The midwife needs to feel within herself that in the most hopeless situations she can use her knowledge and skill to be of support, and assist the client to find meaning in life. Hopefulness is conveyed through touch, bright shining eyes, a warm smile and a kind, interested word (Neal in Hinchliff et al 2003: 102).

• **Involvement:** The attitude of involvement means that the midwife places priority first on the practice of midwifery and last on the self. The midwife functions to the best of her ability regardless of the personal circumstances in which she finds herself (Neal in Hinchliff et al 2003: 102).

The Government also has a role to play in improving midwife-client relationship, in that it needs to reconsider aspects relating to staff allocation, with the aim of reducing the workload of practising midwives. Staff shortage contributes to strained midwife–client relationships.

4.4.3. **Recommendations for improving accessibility to antenatal services**

Accessibility of antenatal care involves both bringing services closer to the women and women closer to the services. A balance is essential between upgrading services and mobilizing women to utilize the services (Ross, 1998:
14). The Health Authorities need to improve accessibility of antenatal services by:

- Improving transport and communication facilities between health centres for easy referral from one centre to another.

- Building clinics within walking distance of all women; this will curb the problem of transport costs and make antenatal services affordable for pregnant women with low or no income.

- Midwifery care also needs to be appropriate in terms of quality. The services must ensure that both human and material resources are available, accessible, acceptable and affordable to pregnant women. Midwives can also improve accessibility of antenatal services for pregnant women, through modifying clinic organization. The barriers that hinder utilization of antenatal services need to be eliminated, particularly with regard to reducing the waiting time at the clinic. Appointment dates can be spread throughout the week for even distribution of the workload, so that women do not have to wait longer than necessary for attention.

4.5 Recommendations for Nursing Education

The researcher wishes to make the following recommendations with regard to nursing education:

- The Health Authorities need to empower midwives through organized workshops and short courses. The topics to be addressed for practising midwives should include interpersonal skills, principles of customer care, patients’ rights and the value of community participation in midwifery care. The purpose of these short courses will be to change the midwives’ attitudes towards pregnant women so that they will be more caring, supportive, patient, kind and understanding.

- A training manual outlining the health education content to be given to pregnant women needs to be compiled to ensure that midwives provide women with adequate, up-to-date information.
Midwives need to be encouraged to update themselves with current evidence-based information regarding pregnancy. This will enhance confidence in themselves, assertiveness and sympathy in caring for their clients.

### 4.6 Recommendations for Further Research

The researcher wishes to make the following recommendations with regard to further research:

- A further study needs to be done on women in urban areas to evaluate if the findings are not influenced by geographical constraints in rural areas.
- The effectiveness of antenatal care in school-going children needs to be evaluated in this region, as the concern seemed to be more on uninterrupted school programmes than on the welfare of both the mother and the baby.

### 4.7 LIMITATIONS OF THE STUDY

The study took longer to complete than anticipated due to the following circumstances:

- The initial target group of primigravid women could not be accessed as the majority of them were high school learners who had a special time arranged for palpation. The researcher later decided to interview some of the participants post delivery, irrespective of parity.
- The change in the job allocation of the researcher interfered with the progress of the study, as the current place of work is far from the area where the study was conducted.

### 4.8 CONCLUSION
The results show that the antenatal care provided by the midwives is inadequate, particularly with regard to health education on pregnancy care. The antenatal services are inaccessible and unaffordable due to transport and financial constraints. The midwives’ attitudes and behaviours also have a negative impact on the midwife-client relationship. These findings highlight the need for the midwives to improve their knowledge on pregnancy care and to increase their efforts in developing good midwife-client relationships. The researcher has developed guidelines on pregnancy care to assist practising midwives during antenatal education. Recommendations have also been made to improve midwife-client relationships and to increase accessibility of antenatal services.
BIBLIOGRAPHY


KUNENE, PJ; NDZIMANDE, PN & NTULI, PA 2001: The image of the nursing profession as perceived by the community members of three adjacent residential areas of Empangeni in Kwazulu-Natal. *Curationis*. 24(2) 35-41.


NIGENDA, G; LANGER, A; KUCHAISIT C & ROMERO, M 2003: Women’s opinions on antenatal care in developing countries: results of a study in Cuba, Thailand, Saudi Arabia and Argentina. 17-10-2006 @ 08:56 am. http://www.biomedcentral.com/1471-2458/3/17


SOUTH AFRICA (REPUBLIC) 1990: Regulations relating to the conditions under which registered midwives and enrolled midwives may carry on their profession. Regulation R2488, in terms of the Nursing Act, 1978 (Act 50 of 1978, as amended). Pretoria: Government Printers.


TUTTY, ML; ROTHERY, MA & GRINNELL, RM (JR) 1996: Qualitative research for social workers: phases, steps and tasks. London: Allyn and Bacon.


FIELD NOTES

Interview one

The participant was selected among other pregnant women who were waiting to be attended to at the antenatal clinic, as she met the inclusion criteria. She had started attending the antenatal clinic at 24 weeks. The appointment with the researcher was made to tally with her third visit to the antenatal clinic.

The Sister in charge of the antenatal clinic offered one of the offices to be used by the researcher for interviews. The interview took place during her third antenatal visit. The participant was seated comfortably in a chair facing the researcher. The purpose of the study was explained to the participant and the informed consent form was signed. Apart from a crying baby now and again in a nearby room for under-fives clinic, the office was reasonably quiet.

The participant is a single 21 year old standard 10 student. She stays with her mother and grandmother, her father died. The only source of income is the grandmother’s old age pension. The participant is soft spoken but calm, maintains eye contact and makes no nervous actions. She verbalized her appreciation of the way she was handled at the clinic. She maintained that she started attending the antenatal clinic early because of painful breasts, which implies that she would have started later than 24 weeks if there were no problems!

Interview two

The researcher identified the participant from the antenatal attendance register at the clinic. An appointment with the participant was made through her mother, who is a hospital worker. The participant came to see the researcher at work. The researcher explained the purpose of the study to the participant, and obtained a written permission from her. The participant explained that she was going to write an examination paper that day, and offered to come for an interview after writing.

The interview took place during her third antenatal visit in an office at the antenatal clinic. The participant is an unmarried, 16 year old standard 10 scholar. She started attending the antenatal clinic at 30 weeks. She is young, inexperienced and anxious, very co-operative and willing to participate though unable to express her views accurately.
Interview three

The participant is a 19 year old, single woman in her second pregnancy. The gestational age at booking visit was 30 weeks, so she met the inclusion criteria. She visited two different clinics during this pregnancy. The policy of weekly visits after 36 weeks gestation enabled her to have 4 antenatal visits prior to delivery. She is a standard 10 scholar, un-employed.

The appointment was made with the participant at the postnatal ward on the day of delivery. The participant showed interest on the topic and was very willing to participate. The interview was conducted at about 18h00 on the same day, in a quiet, empty nursery unit. The researcher started by a thorough explanation of the purpose of the study. An informed consent was signed and a copy of consent given to the participant.

The participant was sitting facing the researcher, and was holding her baby to the breast. The need to use the tape recorder was explained to the participant before commencement of the interview. The participant was calm, confident and maintained eye contact as she stated her facts. The interview took about 30 minutes, and was interrupted by electricity cut off as it was already dark. The noise from the incubator alarm was switched off, and winding up of the interview was done in darkness.

Interview four

The participant is a 19 year old single, standard 10 student in her first pregnancy. She started attending the antenatal clinic at 30 weeks. She stays with her mother and her two sisters are already working. The mother is also receiving a social grant, so they are comfortable financially. She had delivered on her way to the hospital, a live female infant with a birth mass of 3100 grams. She was admitted for observations.

The interview was done post delivery, in a side ward of the postnatal unit. She was a determined lady, sure of her facts. She seemed to evade the question of why her blood was taken. To respect her privacy, the researcher did not probe her.
Interview five

The participant is a 37 year old housewife in her ninth pregnancy. She stays with her un-employed husband and eight children. The only source of income is the children’s grant for three of her children, of which one is epileptic. She started attending the antenatal clinic at 28 weeks. She was admitted in maternity ward in mild labour at the time of the interview.

The interview took place in a pre-heated side ward in the antenatal unit which was reasonably quiet. The participant was seated on a comfortable chair facing the researcher. Apart from a mild contraction that kept on coming now and again, she seemed cheerful and amused by the questions the researcher was asking.

Interview six

This is a 24 year old, single lady who was pregnant for the first time. The gestational age at booking visit was 26 weeks. Her antenatal card indicated three recorded antenatal visits before delivery. Her mother died in 1998 and she, together with her brother, is staying with her married sister. She passed standard 8 and could not continue with her studies as there was no money. She is working as a domestic worker, but verbalizes her desire to continue schooling. The father of the baby is supporting her financially, and she intends going back to work after delivery.

Interview seven

The participant was a single, 22 year old 3rd year scholar at a Technicon. She stays with her widowed mother, but the brothers and sisters are already working. This was her second pregnancy, the first one ended up with an early neonatal death at one week. She started attending antenatal clinic at 20 weeks, but had only two antenatal visits prior to delivery. At the time of the interview she had already delivered a female infant with a birth mass of 2800 grams.

The interview took place in a pre-heated side ward of the postnatal unit where it was nice and quiet. The participant was sitting on a chair facing the researcher. She seemed relaxed and very eager to express her opinions regarding the care she received at the antenatal clinic.
Interview eight

The participant is a 22-year-old single standard 9 student in her first pregnancy. She started attending the antenatal clinic at 24 weeks. She stays with her mother and is the second born out of seven children. The only source of income is the social grant towards the youngest child. During the time of the interview she had already delivered by Caesarean section a male infant who died within 24 hours due to meconium aspiration. She was admitted eight days post delivery for septic suture line.

The interview took place on the 10th day post delivery, in the maternity side ward. The participant appeared confident, calm and relaxed, maintaining eye contact. Though outwardly she seemed to have accepted the loss of the baby, the researcher could detect that her opinions were influenced by feelings of guilt for not taking the advice given at the antenatal clinic.

Interview nine

The participant is a 32-year-old married woman in her sixth pregnancy. Because of twin pregnancy, she has six children already. The husband is not working and the only source of income is the social grant for the last three children. She started attending antenatal clinic at 24 weeks, and was referred to the hospital for confirmation of yet another twin pregnancy.

The interview took place in a quiet maternity side ward, during her stay at the hospital. She was 28 weeks pregnant at the time of the interview. She was sitting on a chair facing the researcher. Apart from the discomfort due to the large abdomen, she seemed relaxed, even passing jokes about her un-employed husband and the number of children.

Interview ten

This is a 34-year-old housewife in her seventh pregnancy. Out of eight children (she had triplets), only three are alive, and only two were delivered in hospital. She started attending antenatal clinic at 28 weeks, in spite of her bad obstetrical history. She was admitted for painful oedematous vulva during the time of the interview, and was on antibiotics after incision and drainage of Bartholin’s abscess.

The interview took place in the maternity ward, in a quiet side ward of the antenatal unit. The participant was lying on her bed with the researcher sitting on a chair next to the bed. She seemed calm and relaxed though she had difficulty in expressing herself. A lot of probing had to be done to get her facts straight.