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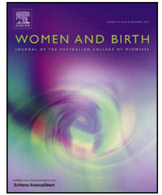

Original Research – Qualitative

Birth stories from South Africa: Voices unheard

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ABSTRACT

Background: The manner that birth events unfold can have a lasting impact on women. Giving voice to women's experiences is key in the creation of care that embodies humanistic, family-centred service.
Aim: The aim of this research was to describe the experiences of women receiving care during childbirth.
Methods: The design was qualitative and descriptive using thematic analysis to analyse women's birth stories. A purposive sample of women (N = 12) who had recently given birth in South Africa was selected. Participants were recruited who had delivered across a variety of settings: public, private, and maternity hospital, as well as at home. Data were collected using in-depth interviews and field notes.
Findings: Four themes were noted: cocoon of compassionate care, personal regard for shared decision-making, beliefs about birth, and protection. Themes demonstrated both caring and non-caring behaviours including feelings of sadness, loneliness and being unwanted, being scared and uncertain, and overall dissatisfaction with the birth experience. Irrespective of setting, patients felt the absence of shared decision-making; the exception was where care was with midwives in an independent maternity hospital or at home.
Discussion: A period of high vulnerability, birth is often met with care perceived as non-caring and lacking in compassion. Many women reported failure to be included as a partner in decision-making where birth occurred in private or public hospital settings. Where a midwifery model of care was in place, experiences were uniformly positive.
Conclusions: Fundamental change is needed in midwifery education and scope of practice, with overhaul of health system resourcing.
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Statement of significance

Problem or issue

Little is known about the birth experiences of women in health facilities where midwifery roles may vary.

What is already known

Efforts to reduce maternal mortality have led to increased numbers of women giving birth in health facilities but with escalating reports of disrespect and abuse of women.

What this paper adds

Efforts to move childbirth into health facilities in South Africa have been largely successful; however, failure to provide midwifery-led, woman-centred care has resulted in growing reports of non-caring behaviour by midwives. The need to reconsider birth setting with midwifery-led care is urgent.

1. Introduction

A middle-income country, South Africa faces many health care challenges. With approximately 1 million births each year,[1] obstetrical providers are challenged by high caseloads and inconsistent availability of resources. Providing care between private and public systems, resources are stretched perilously thin with demands from increasing numbers of illegal immigrants moving into the South African healthcare system, as well as large numbers of South Africans seeking care in public hospitals. A two-tiered system, there are over 216 public hospitals with

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approximately 28,000 beds; private hospitals number 342 with over 100,000 beds.[2] And not unlike Apartheid times, childbirth continues to be divided along racial lines with black and coloured women giving birth primarily in public facilities and white women giving birth with specialist physicians in private hospitals.[3,4]

There has been emphasis on persuading women to give birth in a health facility with close to 90% doing so, and with the public system providing care for 83% of the population,[5] it is important to examine the nature of obstetrical care across settings. A growing shortage and maldistribution of obstetricians has placed the greatest challenge on midwives. Midwives provide the bulk of services in public settings and carry a disproportionate burden in care of the poor and underserved — a phenomenon noted across the globe.[6] In the private sector in South Africa, midwives typically function as an obstetrical nurse with patient management — including the birth, performed by the physician and where intervention rates are exorbitant.[5] Few midwives work independently providing birth services at home or in a maternity hospital.

Such system constraints have led to a glut of reports of compassion fatigue[7,8] and a failure to rescue patients from unnecessary intervention.[9] Concomitantly, there has been an exponential increase in patient complaints about substandard care[10,11] that lacks compassion, is abusive, and fails to promote core values of midwifery practice and use of the midwifery model of care. The importance of a skilled birth attendant has been identified as a crucial factor in reducing perinatal mortality and morbidity.[12] However, access to such personnel typically engenders birth in an institutional setting, removed from supportive family and friends, and with uncertainty regarding quality of care. Such uncertainty can serve as a deterrent to seeking skilled care, fuelled by fear of encountering abuse.[13]

There has been little systematic inquiry into women's birth experiences *across* healthcare settings, though there is widespread report of variable quality of care.[14–16] Variability in care during childbirth, including disrespect and abuse and the lack of quality care in maternity facilities, has been a more recent concern across the globe.[17–28] With increased recognition, there is now growing demand and global effort to both understand and reduce disrespect and abuse in maternity facilities.[29]

Though substandard, disrespectful care has been recognized as a problem in South Africa, there is relatively limited research on the quality of care during childbirth.[11,15,30,31] There is an even greater paucity of research examining childbirth experiences in varied settings (i.e., private hospitals, public hospitals, private maternity hospitals, home) and by different maternity care providers (i.e., gynaecologists, midwives). Given the tremendous healthcare system demands and need for professional support in childbirth, this research sought to give voice to the birth experiences of women receiving care in varied birth settings in South Africa. Such information has the potential to provide powerful evidence for creating change for improved care of women during a crucial period in life that is of profound significance for women — that of the childbirth experience.[32]

The primary aim of this study was to explore and describe the experiences of women giving birth in varied birth settings in South Africa with care provided by midwives and obstetrical physicians. There was particular interest in two key aspects related to the experience of childbirth, positive and negative care practices impacting the woman's desired childbirth experience, and the influence of midwifery care across diverse settings.

2. Method

A qualitative descriptive approach served as the framework for this study,[33] allowing for description and interpretation of the narrative stories told by participants of care received during childbirth. The consolidated criteria for reporting qualitative research (COREQ) guidelines were used to guide report of findings.[34]

2.1. Design

A qualitative approach using semi-structured, in-depth audiotaped interviews and field notes were used to better understand women's experiences of care from obstetrical providers during childbirth in one of three institutional settings: private hospital, public hospital, and private maternity hospitals, as well as at home. Interviews took place in the first two quarters of 2013. Each interview lasted 1 h, on average, and was conducted at either the participant's home or in a small conference room at a local guest house — depending on the participant's preference. Only the researcher (MHT) and the participant were present for interview though 9 participants brought their infants with them as well. There were no repeat interviews. Only the research team had access to the data, which was de-identified upon transcription.

To fully understand women's childbirth experiences in varied settings, interview questions were broad, encouraging participants to share perceptions and feelings relevant and meaningful to them.

2.2. Participants

A purposive, convenience sample of women (N = 12) who had recently given birth in South Africa in one of three institutional settings (private, public, or private maternity hospitals), or had given birth at home, were recruited using snowball or chain-referral sampling technique. Fourteen (14) women expressed interest in study participation though one cancelled due to a family crisis and one did not show with an inability to reach her for further follow-up; both had experienced birth in the home setting. The sampling criteria were birth with a midwife or physician within the past 6 months in an institutional setting or at home, over 18 years of age, and able to communicate in English. Written informed consent was obtained following approval from the University of Colorado Multiple Institutional Review Board (12-1458) and the Ethics Committee of the University of Johannesburg (AEC51-01-2012).

2.3. Measures

2.3.1. Demographic information

All participants were verbally queried about the same set of demographic questions by the researcher. Questions related to age, marital status, race/ethnicity, education, employment outside the home, parity, type of birth, place of birth, and labour and birth obstetrical provider.

2.3.2. Semi-structured interview questions

Interview questions were developed based on the focus of the study. All participants were asked the same standard questions with probing, as necessary. The key interview statement was: "Describe your recent birth experience at [name] facility." Additional interview statements included: "What were the best things about having your baby at [name] facility? The most difficult?" and "Was the midwife caring for you helpful in making your birth experience what you had hoped? Why or why not?" The same researcher conducted all interviews (MHT) and interviews were conducted until saturation was found. The interviewer made field notes during the interview including behavioural observations.

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