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Narratives of distress about birth in South African public maternity settings: A qualitative study

Rachelle J. Chadwick, MA PhD (Postdoctoral Researcher)*, Diane Cooper PhD (Associate Professor), Jane Harries, PhD (Director of Women's Health Research Unit)

Women's Health Research Unit, School of Public Health and Family Medicine, Falmouth Building, Medical Campus, University of Cape Town, Observatory 7925, South Africa

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ABSTRACT

Objective: to explore the factors associated with negative birth experiences in South African public maternity settings from the perspective of women's birth narratives.
Design: an explorative, qualitative research study using a narrative methodological framework and unstructured interviewing.
Setting: the city of Cape Town in South Africa.
Participants: 33 low-income women aged 18–42 years who had recently given birth to an infant in the public maternity sector.
Findings: more than half of the women ($n=18$) narrated 'narratives of distress' in relation to their birth experiences. One third narrated 'good' birth experiences and four women told minimalistic or neutral birth narratives. This paper reports only on factors associated with women's distress narratives. Narratives of distress were associated with poor quality of intrapartum care and characterised by the following four themes, namely (1) negative interpersonal relations with caregivers, (2) lack of information, (3) neglect and abandonment and (4) the absence of a labour companion.
Key conclusions and implications for practice: poor relationships with caregivers emerged as central to women's distress narratives. Interventions aimed at improving interpersonal communication, connection and rapport between caregivers and labouring women are central to improving quality of care in resource-constrained settings.

Introduction

South Africa is not faring well in relation to maternal health. Despite being a middle-income country with an established health care infrastructure, the maternal mortality rate (MMR) has reportedly increased from approximately 150 deaths per 100,000 live births in 1990 to approximately 625 deaths per 100,000 births in 2010 (Blaauw and Penn-Kekana, 2010). The MMR for developed world contexts is estimated as approximately 16 deaths per 100,000 births compared to the figure of 240 deaths per 100,000 births in the developing world (World Health Organisation, 2012). Sub-Saharan Africa is estimated to have a MMR of approximately 500 deaths per 100, 000 births (World Health Organisation, 2012). The MMR in South Africa is thus high even in relation to estimates from developing world contexts. There is however some uncertainty regarding MMR estimates in South Africa. For example, after adjusting figures from national census and community survey data using statistical modelling, Udjo and Lalthapersad-Pillay (in press) report a higher national MMR of 764 deaths per 100,000 births. The most recent national confidential report on maternal deaths, reporting only on deaths within health care institutions, cites a lower rate of 176,000 deaths per 100,000 births (Saving Mothers 2008–2012, 2013), while the mortality survey by Bradshaw et al. (2012) cites a figure of 333 deaths per 100,000 births without this distinction. Despite uncertainties regarding MMR estimates, there is however general consensus that maternal death rates are rising in South Africa (Bradshaw and Dorrington, 2012). This is surprising given that approximately 92% of South African women receive antenatal care and 89% give birth in a health care facility with skilled attendants (South African Demographic and Health Survey 2003, 2007). While HIV/AIDS is a significant indirect cause of maternal death (Abdool-Karim et al., 2010), approximately 59% of maternal deaths are due to direct causes (e.g. hypertension, maternal haemorrhage, maternal sepsis, obstructed labour and abortion) that are avoidable with good clinical and other quality of care (Saving Mothers 2008–2012, 2013).

Quality of intrapartum care is a significant but neglected factor shaping maternal health outcomes (Rattner et al., 2007; Van den

* Corresponding author.
E-mail address: rachellechadwick@yahoo.co.uk (R.J. Chadwick).

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Broek and Graham, 2009; Mathai, 2011; Fawcus et al., 2012). In South Africa, poor quality of intrapartum care is a contributing factor in poor maternal mortality and morbidity rates (Nzama and Hofmeyr, 2005; Fawcus et al., 2012). According to the 2012 report 'Saving Mothers 2008–2012', over 53% of maternal deaths in the public maternity system in South Africa are linked to avoidable factors (Saving Mothers 2008–2012, 2013). There has been little research on quality of care issues in South Africa (Nzama and Hofmeyr, 2005), with most research focusing on health systems factors (Penn-Kekana and Blaauw, 2002; Penn-Kekana et al., 2004; Parkhurst et al., 2005; Penn-Kekana et al., 2007; Thomas et al., 2007) and access to services (Tlebere et al., 2007; Silal et al., 2012). Limited studies have however found that poor quality of intrapartum care adversely affects women's use of maternal health services and may delay women presenting at health care facilities during labour (Tlebere et al., 2007; Dzomeku, 2011).

Women's perspectives are critical in developing nuanced understandings of quality of care issues. Qualitative investigations are particularly important given that quantitative measures of birth satisfaction have been found to be skewed in South Africa towards positive evaluations. For example, while more than 90% of women reported satisfaction with obstetric services in a quantitative survey by Silal et al. (2012), the qualitative component of this study found that all but one woman expressed dissatisfaction with the quality of their intrapartum care and reported problems of shouting, verbal abuse, humiliation and lack of caring. Women might be reluctant to criticise health services in quantitative research or anticipate poor quality of care and might therefore indicate relative satisfaction with services as a result (Brown et al., 2007; Vivian et al., 2011). In-depth qualitative studies are thus needed to probe women's perspectives regarding their birth experiences and gain insight into quality of care issues.

In South Africa, there is limited research on quality of intrapartum health care from women's perspectives. The few studies that have been done point to serious problems in South African public sector obstetric contexts, including the verbal and physical abuse of labouring/birthing women, neglect and substandard care (e.g. Jewkes et al., 1998; Kruger and Schoombee, 2010; Human Rights Watch, 2011; Silal et al., 2012). Other research has found persistent barriers to the uptake of labour companions (Brown et al., 2007) and standard non-evidence based obstetric practices (Farrell and Pattinson, 2003; Vivian et al., 2011). Collectively these studies also indicate systemic problems in South African maternal health services, including a lack of accountability, resource constraints, emergency transport problems and problems with the supervision of maternity staff (Jewkes et al., 1998; Human Rights Watch, 2011; Moszynski, 2011).

The aim of this paper is to explore the factors associated with negative birth experiences in public health care settings from women's perspectives. A narrative methodological framework was used to allow women's perspectives of intrapartum care and their stories about their birth experiences to be foregrounded. There is a lack of research reporting women's stories of their care during labour and birth in the current literature about South African maternity care. While some research points to negative birth experiences as commonplace in South African public health care settings, there is very little research that explores these experiences from the perspective of women's birth narratives.

Methods

The study used a qualitative, narrative methodology to explore the birth stories of 33 South African women who had recently given birth in the public maternity sector in Cape Town, South Africa. Thirty-five women were interviewed but two interviews were not included in this analysis because the births did not take place in a public health facility. Those excluded were one home birth and a birth that occurred in transit to a maternity facility. Ethical approval was obtained from the University of Cape Town's Health Sciences Faculty Human Research Ethics Committee.

Participants were recruited in collaboration with a non-governmental organisation that offers primary preventive services, support and counselling to parents and caregivers. This organisation offers a home-visiting programme that supports pregnant women and new mothers via five antenatal and fifteen postnatal visits by a trained community counsellor. The home-visiting programme runs in 11 peri-urban and impoverished communities in the broader Cape Town area. Women participating in this home-visiting programme who had given birth in the preceding four weeks were approached by community counsellors and asked whether they were interested in participating in the study. The study's interest in women's birth stories, and that it would involve a once-off interview with a researcher in their home or another venue of their choice, was explained to them. If a woman signalled willingness to participate in the study, the researcher (first author) was contacted by the community counsellor and an interview was set up. Before the start of the interview, the nature of the research project was explained again to potential participants and informed consent was obtained. Women were assured that they could elect not to participate or withdraw at any stage without any negative repercussions, that the interview would remain confidential, that their names and identities would be protected throughout the research project and that pseudonyms would be used in all reports, articles or presentations based on the research. A consent form was read to each woman and her signature was obtained to indicate consent to participate in the study. Consent forms were provided in English, Afrikaans and translated into isiXhosa where necessary. Women who understood and spoke English and Afrikaans could elect to be interviewed in the language of their choice. As the researcher is not proficient in isiXhosa, interviews with first-language isiXhosa speakers who agreed to this, were conducted in English.

Following consent, participants engaged in a face-to-face unstructured interview which began with the broad question, 'Can you tell me what happened with your birth experience?'. The researcher had a set of questions to pursue if needed but most interviews took place as conversations in which the researcher asked spontaneous questions arising from what the participant narrated. This is appropriate in a narrative methodological framework as narratives are more likely to be elicited by an open-ended and unstructured interviewing style (Riessman, 2008). Interviews were digitally recorded and transcribed verbatim by the first author. Afrikaans interviews were transcribed into Afrikaans and then translated into English by the first author. Most of the interviews ($n=32$) took place in women's homes. One interview was conducted in a women's shelter. Women lived in 10 different informal settlements in the wider Cape Town metropole. Homes consisted of backyard sheds, shacks, council flats and in some cases, small freestanding houses. One woman was homeless. All of the women lived in peri-urban informal settlements marked by overcrowding, high rates of violence, gangsterism and poverty. Approximately 1.2 million South Africans out of a population of 51 million are estimated to live in informal settlements (Statistics South Africa Community Survey 2007, 2008). Seventeen women lived in very poor conditions and resided in backyard sheds or tin shacks without running water or electricity. Fifteen women lived in council flats or small freestanding houses. Four women were extremely poor and lived in tin shacks with virtually no furniture or basic possessions.

Participants ranged in age from 18 to 42 years. Most of the women had given birth to their first ($n=18$) or second baby