

**STUDY OF HEALTH CARE SEEKING PRACTICES
OF PREGNANT WOMEN IN CAPE TOWN**

REPORT FOUR:

SUMMARY OF FINDINGS, CONCLUSIONS AND POLICY ACTION

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EXECUTIVE SUMMARY

Introduction

In the Western Cape, despite a system of primary obstetric units (MOUs) which have greatly reduced geographical barriers to access to services, women still book late or deliver unbooked. This report summarises the findings of a research project which set out to investigate why women book late through a qualitative study of women's health seeking practices in pregnancy and perceptions of quality of care.

Methods

The research was based on 103 minimally structured in-depth individual interviews and 4 group discussions held with patients and staff in the services (two MOUs and 2 Hospitals). Thirty women were recruited on their first antenatal visit at a Northern suburb MOU, Southern suburb MOU and a rural hospital in the Winelands area and reinterviewed repeatedly throughout pregnancy until after delivery. Two women who delivered unbooked were also interviewed. In addition, ten women participated in a narrative group discussion and three discussions were held with groups of nursing staff.

Key findings:

- the main reasons why women did not book early were: uncertainty about the usefulness of (particularly early) antenatal care, apart from its role in facilitating access (and preventing scolding and neglect) when in labour; "laziness" at the thought of having to get there at 3 or 4 am to ensure being accepted for booking; difficulties arranging childcare; relatively late diagnosis of pregnancy; perceptions that the "right" time to book was at 3-5 months; and anticipated rudeness of the staff.
- although some women at the Northern suburb MOU were satisfied with their antenatal care, many the experience was unpleasant and dissatisfying as they were not given the reassurance which they sought from the clinic about their pregnancy or information about many topics which they desired. In contrast, at the Southern suburb MOU women were for the most part fairly satisfied with their antenatal care but they expressed the wish to have more information and also not to be scolded. At the rural hospital problems of privacy in the consulting/history-taking area and verbal abuse of patients by staff were highlighted as problems.
- Staff working at the Northern suburb MOU had a considerably harder job than those at the Southern suburb MOU. The interviews indicated that patients using the Northern suburb MOU had substantially less bio-medical knowledge and understanding and so the important educational aspects of midwifery were much harder. The staffing data also

suggested that this MOU was understaffed compared with the Southern suburb MOU.

- Several women were satisfied with their experiences delivering at the Northern Suburb MOU as they had “nice” midwives. Others had had traumatising experiences of verbal abuse, beatings, arbitrary acts of unkindness and neglect. The manner in which staff responded to patients created situations of obstetric risk and five women delivered on their own in the MOU. Similar problems were reported at the rural hospital. The patients’ accounts were supported by the midwives’ interviews. In contrast most of the women at the Southern Suburb MOU were very satisfied with the care they received when in labour and none delivered unattended at this Unit. The narratives of the women suggested that this was because the midwives listened to the women and responded appropriately when they said they were about to deliver.
- The problems in staff patient relationships found in the study appear to stem from: a perception that staff have a duty to morally correct patients; poor staff communication skills; limited bio-medical knowledge on the part of patients and a failure of education to meet key information needs; a lack of skill amongst staff in dealing with difficult situations especially around birth through verbal communication rather than physical violence; a perception that beating patients is permissible; and, a lack of respect for patients, their autonomy and experiential knowledge.

Conclusion

Although perinatal and maternal mortality have been substantially reduced by the MOU system, this study suggests that there is considerable scope for improving other aspects of quality of care in the services. The finding of similar problems at the rural hospital demonstrates that this is not a problem unique to the Penninsular Maternity and Neonatal Services and indeed, accounts of dysfunctional staff patient relationships can be found from many parts of South Africa and internationally. Nonetheless, improving staff patient relationships is of great importance as the present situation and patients’ responses to it put patients at risk as well as infringing their human rights. The findings that, even in the more problematic units, some staff treat patients well indicate that change must be possible. The first three reports from this study contained recommendations for action arising from the research. This final report concludes with an action plan which has been developed by staff from the PMNS in response to these recommendations and as a result of several months of debate and discussion. This is a symbol of their determination to improve the quality of care and services for the women of Cape Town.

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1. INTRODUCTION

The provision of antenatal care and a safe birthing environment has been associated with a significant decline in peri-natal and maternal mortality and morbidity over the last few decades. In the Western Cape area around Cape Town a system of Midwife Obstetric Units (MOUs), which provide primary obstetric care to women within defined areas and refer those who have high risk pregnancies to secondary (Mowbrary) or tertiary (Groote Schuur) Hospitals according to defined protocols, have made services geographically accessible. They have reduced perinatal and maternal mortality and morbidity to the lowest levels in South Africa. Despite this innovative system, many women still book late in their second or third trimesters and some use services for delivery without booking at all. A study of women's health seeking practices in pregnancy and perceptions of the services was undertaken by the Medical Research Council with funding from the Health Systems Trust with the aims of understanding why women use the services in the manner in which they do, what other services or forms of health care they use in pregnancy and their perceptions of the role of the services and assessment of quality of care.

Several authors have investigated determinants of late or not booking in South Africa. Larsen and van Middelkoop (1982), Pattinson and Roussouw (1987) and Hamilton et al (1987) compared booked and unbooked mothers at King Edward VIII, Tygerberg and Coronation Hospitals respectively, and Westaway (1994) undertook a community-based survey of attenders and non-attenders at antenatal clinic, focusing on knowledge of health and health services and satisfaction with the service. The findings suggest that factors associated with late attendance fall within three main groups: social; health care; and, educational. The 'social factors' included unstable relationships with the child's father, an unwanted baby, difficulty getting time off work to attend, a low level of education, lack of social support and poverty (Larsen & van Middelkoop 1982; Pattinson & Roussouw 1987; Hamilton et al 1987). The 'health care factors' concerned the accessibility of services and perceptions of the quality care, in particular non-medical aspects such as waiting times and the politeness of staff (Larsen & Van Middelkoop 1982; Mphlanga 1985; Van Coeverden de Groot & Howland 1988). The 'educational factors' were identified as a "lack of knowledge about the importance of antenatal care" (Chalmers, 1990:35) (Loening & Broughton 1985) (Westaway 1994). Mphlanga (1985) also suggested that the timing of antenatal attendance may be affected by a desire to conceal early pregnancy to avoid the risk of 'witchcraft'. Larsen & Van Middelkoop (1982) did not find previous operative deliveries or the use of traditional healers influenced decisions to attend antenatal clinics. The main recommendations of Chalmers (1990) and Westaway (1994) focused on the need to educate women about the importance of antenatal care and the risks of not using it. International literature on health-seeking practices, however, increasingly emphasises the ways in which it is shaped by complex interplays of supply and

demand factors. MacCormack (1994) observes that “rural people” are “practised empiricists”, who make up their own minds about the benefits of an intervention and act accordingly. The influence of patient’s views of the quality of care in determining their service use is increasingly being recognised as important (Mensch 1993). With this in mind this study was undertaken in order to gain an understanding of how women make the decisions that they do about health care and in particular the impact of their assessment of and experiences with the services on these decisions.

The main findings of this study have been presented in three reports: the first (Jewkes *et al* 1997a), presents midwives perceptions of the services in which they work and the main problems which they encounter in their daily working lives; the second (Jewkes & Mvo 1997), focuses on women’s perceptions and use of the Northethn suburb MOU; and the third (Abrahams & Jewkes 1998), focuses on Coloured women’s perceptions and use of the Southern suburb MOU and the rural hospital in the Winelands area. This report is a summary document, drawing together the findings and lessons from the three parts of the study. The report has been prepared after consultations with members of nursing and medical staff of the University of Cape Town’s obstetric and midwifery services and also contains a summary of action which has been undertaken or is planned following from the recommendations of the other three reports.

2. METHODS

2.1 Study Methods

The research used ethnographic methods, including individual minimally-structured in-depth interviews, participant observation and group discussions. The interviews and discussions with Xhosa women were undertaken by Zodumo Mvo (mostly) and Rachel Jewkes; the interviews with Coloured women were undertaken by Naeema Abrahams; and the interviews and discussions with the staff were undertaken by Rachel Jewkes (mostly) and Naeema Abrahams. The interviews with pregnant women were undertaken in their preferred language (Xhosa, Afrikaans or English) and those with staff in English. They were audio-taped, translated (where necessary), transcribed into English and analysed using ethnographic methods.

The Xhosa women interviewed had all attended the Northern suburb MOU for at least part of their antenatal care, most delivered at the MOU but some were high risk patients who were referred for their delivery and part of their antenatal care to Mowbray and Groote Schuur Hospitals. The interviews were undertaken between February 1996 - April 1997. Most of the pregnant women were recruited on their booking visit at the Northern suburb MOU, but four were recruited at Mowbray. The women were chosen to include a range of age (17- about 40 years), socio-economic status (formal housing to very poor), duration of time in an urban area (transient - long established), parity (0-7), complications (or otherwise) and stage in pregnancy at which they booked (4 in the second trimester, 11 in the second, 2 were 'unbooked').

Seventeen Xhosa women were interviewed in the study, on between one and four occasions, giving a total of forty interviews. Two had delivered unbooked and so reported experiences of delivery but not antenatal care; four women were lost to follow up after the first visit, two of these left Cape Town and two were untraceable, and a fourth woman had an intra-uterine death, these five women thus reported antenatal clinic experiences by not those of delivery. Three women delivered at Mowbray, six at the Northern suburb MOU and one delivered at home. In order to gather more data on deliveries the Northern suburb MOU, one narrative group discussion (Maier 1994) was held with ten women living in the Northern suburb area, nine had delivered at the local midwife unit and the tenth at Karl Bremmer Hospital. These women were recruited through a women's health non-governmental organisation *Zibonele* and the recruitment criterion was women who had delivered in the previous year.

A total of fifteen Coloured women were interviewed of whom ten attended the Southern suburb MOU and Groote Schuur Hospital and five attended a rural hospital in the Winelands area. The women were recruited on their initial booking visit and were re-interviewed at intervals. Most of the women had four interviews of between 1 and 2-hour duration, resulting in a total of 50

interviews. In addition, a pregnant friend of one of the informants from Southern suburbs joined the discussions in all her follow up interviews.

The women attending the Southern suburb MOU delivered at the MOU, with the exception of three who were at high risk of complications and so were referred to Groote Schuur Hospital for continuation of antenatal care and delivery. The interviews took place between November 1995 - February 1997 (the researcher was on maternity leave during the study). The women were chosen to include both urban and rural (4 of the rural hospital women lived on farms), a range in age (17 - 38 years), and parity (0 - 4) and the stage of pregnancy at which they booked (4 in the 1st trimester, 9 booked in the 2nd trimester and 2 in 3rd trimester).

All first interviews with pregnant women were held in the antenatal clinic. All the follow-up interviews took place at the homes of the women and each built upon the previous interview with the final interview occurring after the birth of the baby. The scope of inquiry for the interviews with the pregnant women included symptoms and problems which they were experiencing, how they had made to decisions to attend a health care provider, their experiences with and perceptions of the quality of care provided and knowledge and perceptions of pregnancy and use of lay medications. The follow up interviews were usually relaxed occasions, often with lunch or tea and a considerable amount of “baby talk” and breaks for breast feeding interspersed the more focussed questioning.

The interviews with staff members were held at three sites in the Cape Town and Peninsula obstetric service: Groote Schuur Hospital antenatal clinic and labour ward; a Southern suburb MOU and a Northern suburb MOU. At Groote Schuur five interviews were held, four with midwives and one with an enrolled nurse. At the Southern suburb MOU four interviews were held, three with midwives and one with an enrolled nurse. At the Northern suburb MOU four interviews were held, two with midwives, one with an enrolled nurse and one with a family planning advisor. In addition one group discussion was held in the Northern suburb MOU with seven staff including two midwives, a nursing assistant, a family planning advisor and three general assistants (domestic workers). The interviews were held between November 1995 and July 1996. After which, a preliminary report was drafted and sent to staff at each study site. Group discussions were held with staff at the two MOUs to discuss the findings.

The interviews focused on staffs' perceptions of their working environment and problems which they encountered at work. They were undertaken using a brief aide memoire to assist probing around to problems and to facilitate inquiry about a range of areas in which problems could occur including study leave, relationships with other staff in the service, educational talks and patient

knowledge. The interviews were therefore semi-structured and interviewees were substantially free to determine their content and emphasis. The staff interviewed were chosen in order to represent a range of grades within the sites, in some cases they were staff who were particularly keen to be interviewed. They were assured confidentiality and anonymity and in order to assist this all the staff in the report are referred to as 'midwives' or 'sisters' even though some interviewed were not midwives. Data on activity and staffing levels at both the MOUs were also collected. The activity data were taken from the month-end statistics for 1996 and the staffing levels from the staff allocation document also for 1996. As the report was prepared in December 1996, only data from 1 January - 31 November are included in the analysis.

In order to gain a better understanding of ideas about pregnancy and childbirth in indigenous healing practices, seven minimally structured, in-depth interviews were also held with indigenous healers recruited through the Buzani Kubawo Inyanga's Association in the Cape Town area (4 Xhosa and 1 Zulu; 2 men and 3 women) and in the former Transkei (2 women). These interviews focused on healers perceptions of pregnancy, the types of problems which women experience in pregnancy and for which they seek help from healers, their causes and treatments.

Ethical approval for the study was given by the Medical Research Council's Ethics Committee and the Ethics Committee of Groote Schuur Hospital. Access was approved by Groote Schuur Hospital.

2.2 Organisation of obstetric services

Obstetric services in Cape Town are organised into three tiers. The primary tier comprises seven Midwife Obstetric Units (MOUs): Hanover Park, Gugulethu, Heideveld, Mitchell's Plain, Khayelitsha, Retreat and St Monica's; and Atlantis and False Bay Hospitals. These Units are managed exclusively by midwives and women attending most of them will not see a doctor during the pregnancy unless they have a problem. The Penninsular Maternity and Neonatal Services (PMNS) is divided into nine geographical areas and pregnant women within each are expected to attend their local MOU. The second tier is normally the first point of referral for women who have a history of or develop pregnancy complications. It comprises two hospitals, Somerset and Mowbray; the former three MOUs refer to Somerset and the latter four to Mowbray. The third tier is Groote Schuur Hospital. With the exception of residents of Mowbray who may use Mowbray Hospital, entry to secondary and tertiary level care is governed by protocols, which one MOU midwife described as 'rules and regulations'. Some women with serious medical problems receive all their care at the higher levels, whilst others commence antenatal care at MOUs and are transferred to hospital care at 36 weeks, a further group are transferred in labour if they develop complications. If a woman were to be transferred to another level, her folder would be there and

she would not be expected to attend the previous level again. Both the MOUs are on the same site as the areas' respective Day Hospitals. At the rural hospital all patients saw a doctor at each visit.

To ensure anonymity of the MOUs involved in this report they will be referred to the municipal region in which they are located i.e the Southern suburb MOU and the Northern suburb MOU. Similarly the rural hospital will also remain anonymous.

3. FINDINGS

3.1 Health-seeking practices

3.1.1 Pregnancy diagnosis

The women discovered that they were pregnant when they noticed that they had missed periods (described by a Northern suburb MOU woman as "*not washing*"). Usually they said they had noticed as soon as they missed the first period but it was only after missing two or three that they concluded that they must be pregnant, particularly when other signs were apparent such as kicking. Most of the women who had previous pregnancies described signs of pregnancy which they recognised, as a woman from the Southern suburb MOU explained "*I just felt the life inside of me... my breast was getting bigger... the nipples around it started to get black*". Those with no previous experience demonstrated markedly less knowledge.

Most of the women attended a private doctor for pregnancy confirmation. Two of the the Northern suburb women went there after having been told they were '*not pregnant*' after tests at the Day Hospital. Some of the Northern suburb women indicated that they would visit different practitioners until one agreed with their assessment that they were pregnant (if they wanted to be) or to see if one would say that they were not (if they did not want to be). Dr John of Belville was mentioned by several of the Northern suburb women. One explained that he was popular because he was "*really helpful*", "*explains everything*" and gives medicines to drink so "*you shouldn't just stay unprotected*". This was a reference to his practice of giving women medicine which they perceived to resemble indigenous '*strengthening*' medicines known as *isicakathi* (see later). As special expenditure was involved in these private consultations and pregnancy confirmation was an important and usually happy event, the Northern suburb MOU women mentioned that in each case their husbands or boyfriends had suggested the visit and provided the money for it or sanctioned the expenditure. Several of the Northern suburb MOU women did not confirm pregnancy through bio-medical means, but went directly to the MOU to book at quite an advanced stage.

At both the Southern suburb MOU and at the rural hospital most of the women knew that they had to have a pregnancy test before being accepted for booking and most had already attended a

private doctor for this. Those who did not, were sent away and were not booked until they returned with results. Two women reported having some difficulty getting confirmation from a private doctor or clinic, and had to struggle to persuade staff to do a pregnancy test. In one case three visits had to be made just to get the pregnancy confirmed.

3.1.2 Role of antenatal care, place and timing of booking

Pregnancy, and perhaps mainly birth, were generally perceived by the Northern suburb women to be times of uncertainty and vulnerability, but most were vague about the role of antenatal care in reducing this apart from its role in facilitating access to care in labour. It was usually described in terms which were linked to an idea of being able to get “help” in case problems developed (such as stomach pains or premature labour) and to make sure that you “deliver nicely”. The Southern suburb MOU and at the rural hospital women differed from the Northern suburb women in that they were more convinced of the value of antenatal care, although not more able to describe why it was important. This was a reflection of their generally much greater ‘bio-medical literacy’ and concomitant trust of bio-medicine, and may also have reflected the greater amount and higher quality of information given to them by the staff. The Southern suburb and the rural hospital women indicated that the attitudes of the staff towards them, the friendliness of the clinic and the degree to which the clinic met their perceived needs were critical in determining their assessment of their time in the clinic and its usefulness to them.

The women who booked the earliest in both groups had a specific bio-medical concerns. The earliest of the Northern suburb MOU women in the study, booked at 14 weeks. She said that she went in order to get checked for STDs. The earliest woman from the Southern Suburb MOU booked at 12 weeks because her previous child had Down’s Syndrome and she was concerned about the risk to the present pregnancy. In general women who had had problems in this or previous pregnancies had a clearer idea of the help they wanted from antenatal care, but the stage at which the help was necessary depended on when problems had been detected. For example a woman from the Northern suburb who had been found to have a breech, said “*you don’t know the position of your baby so you have to go to at least in your seventh month*”.

Several women from the Northern suburb mentioned that it was important to book in order to get care in labour, as one who booked at five months explained “*it’s good to go to the clinic because when you are in labour they...ask for your card first. Some people do not get cards until they have to deliver and they don’t get attended soon when in labour, no one cares for them. They start with those who have cards, even if you have a serious problem you don’t get attended to*”. This was the reported experience of one of the older women, who had not booked on her previous delivery. She decided to book earlier this time because of it, despite not thinking antenatal care was very

useful.

All the women interviewed who booked antenatally did so between three and eight months. Some women perceived that they booked at the 'right' time, but several of the Northern suburb MOU women discussed in the interviews when this might be and indicated that they did not really know. For example, one suggested times between five and nine months before asserting that the main thing was to book before going into labour. Some of the health sector staff also apparently were uncertain about when women should book. Three Northern suburb MOU women who had their pregnancies diagnosed at the Day Hospital were told to book at 3 months, at five months, and one was told to wait two months, which made her seven. Women who had had more pregnancies were more likely to book later, perceiving the main purpose of this to be to get access for delivery.

Most women had had little choice of where they could book as the MOUs served defined geographical catchment areas and they did not have the money for private care. Some women were prepared to make considerable sacrifices and travel considerable distances in order to use services which they perceived to be better. Four of the Northern suburb MOU women interviewed described travelling or making plans to travel long distances in order to choose their site for delivery. Two women said they travelled from the former Transkei because the staff in the local services did not "care", whilst one went to Worcester to deliver because she had been told the nurses in the Northern suburb MOU were "*very rough, they even beat you*". This was not the only reason for travel, as one woman explained she had come from "*Xhosaland*" because it is "*hard work*" and she wanted to sleep. One of the Southern suburb MOU women also made plans to deliver at a hospital in her rural home because she was upset by the care she received at the MOU, although in the end she did not go there.

3.1.3 Reason for delaying a clinic visit

Some women booked in their second and third trimesters because they did not know that they were pregnant as they were using Depo Provera and had amenorrhoea, some were advised to book late and some perceived that later booking was 'right'. Many, however, booked later than they thought they should have.

Several of the women gave reasons for booking late, not booking at all or missing follow up visits. The women indicated that their patterns of health service use were influenced by considerations of time, perceptions that booking was important if a person is sick or near to delivery, the weather, lack of motivation due to the pregnancy being unwanted, spending time searching for an alternative place to attend because of fears of poor care, economic factors such as not having

transport money or delaying to accumulate the user fees (although these were not necessary), difficulty getting transport during busy times on the farms, effort to be expended in terms of travel to the services, waking early and making arrangements for childcare as related to perceived benefits and anticipated experiences in the services. The importance which they gave to one over others varied from woman to woman and even at different stages in a narrative of one event. It was apparent that the women loosely weighted up the cost and benefits of attending bookings and the follow-up visits with a greater effort being made to attend for booking compared with overcoming similar barriers for the follow-up visits. The follow-up visits were perceived, by many women, as less important.

A Northern suburb MOU woman who had booked at eight months with her previous pregnancy said it was because the experience of attending the clinic was not a very pleasant one, she said she was “*lazy*” to wait in the “*long queues*” and “*they touch your stomach disrespectfully*”. Another said she booked late as she had not known that she was pregnant. The two women who were unbooked gave different reasons for this. The older woman said that she had intended to book (late) but she “*didn’t realise she was so far gone*” and could not arrange for someone to look after her other children at the early hour at which she would have to leave in order to be able to book. The teenager said it was because she had heard about the Northern suburb MOU booking system from a friend and she was “*lazy to wake up*”.

The booking system at Northern suburb MOU did make access to the MOU difficult although the most of the women interviewed had been accepted for booking the first time they attended. Four women had only managed on their second (1), third (2) or fourth (1) attempt. Those who succeeded first time reported arriving between 12 midnight and 6.35 am. In order to get there so early they either had to get someone to accompany them, which several mentioned was difficult, come very late at night and sleep over or walk alone, risking meeting thugs [*izikoli*] on the road. Those who had not succeeded reported being turned away between 5 am and 7.00 am. Most of the women said that they had been told that the clinic had a quota and it was necessary to be in the first thirty to get taken, although two women (booking in October and December 1996) reported that the quota was fifteen.

Access to Southern suburb MOU, by comparison was much easier and usually women said they just had to be there by 8.00 am. Even though this MOU only booked three days a week, only one of the women interviewed had the experience of being turned away. She was a teenager who only managed to book at the MOU on her third occasion (due to a public holiday and then being told the clinic was full). During the course of the study the policy at the Southern suburb MOU was said to have been changed and thereafter women were allowed to book all day, surprisingly this

women tried to book after the said change of policy.

The Southern Suburb and rural hospital women booked later in their second or third trimester had some different constraints on booking from the Northern suburb MOU women, mainly because many worked. Work was a problem for women who either were paid only for work done, or were discouraged or not allowed by their employers to take time off to attend at particular times such as busy times on the farms or when children being minded were ill. All the women described problems with arranging care of their own children during visits.

3.1.4 Health maintenance and responses to problems

3.1.4.1 Use of the bio-medical sector

The women from both the MOUs and from the rural hospital responded in quite different ways to symptoms which they encountered in pregnancy. The women from the Northern suburb assessed their symptoms against knowledge of ‘normal’ problems encountered in pregnancy which they had gathered in educational talks or when consulting a midwife about a problem, as well as through listening to friends and relatives and experiences in previous pregnancies. Very few women consulted private doctors. Self-medication almost exclusively was with indigenous medications. Only one woman reported having consulted a private doctor during pregnancy for symptoms, she had “*wind at the bottom [of her stomach]*” and said ‘*dirty blood*’ was diagnosed and she was given some ‘cleaning’ medicines. Two women attended the Day Hospital with flu, but all the other women reported symptoms to the clinic. The only products bought from a chemist, which were mentioned were Grandpa powders and Panados for pain. Several reported having been told by staff about medications pregnant women should not use, one specifically identified Grandpa powders.

In contrast the Southern suburb and rural hospital women were much more likely to discuss seeking formal care or taking medication for symptoms. They also responded in different ways depending on their perceptions of the severity and nature of the problem, but often spoke of attending the after hours clinic, a pharmacy, a private doctor or followed self-healing practices, which included taking non-prescription medications, indigenous herbs, Cape Dutch remedies and a variety of other non-medicinal products (see Tables 1-4). Receiving medication was in fact an important criterion by which the satisfactoriness of care was judged, even though they too were aware that they should be cautious about taking medication during pregnancy. Not being given medication was perceived to be tantamount to not being given care, and this influenced women’s choice of health care provider. An exception was, however, made for iron tablets which were not popular.

After pregnancy confirmation, the Southern suburb and rural hospital women usually attended private doctors for problems during pregnancy which they perceived not to be pregnancy complications. One woman explained that she perceived that it was “safer” to do this because the MOU would not provide medication and the doctor would examine her. One woman who attended the rural hospital at night with asthma and a chest infection and was very dissatisfied with her treatment as she was not given the antibiotics which she expected. Eventually she went to her private doctor who immediately gave her the desired medications. From the narratives of the rural women it was evident that they were very attached to the “farm” doctor who is a GP operating in the “dorp” and referred to him as “good” and someone they could “trust”. This doctor had an arrangement with the farmer who allowed the women and her family to attend while the payment was subtracted from their salaries at the end of the month. This arrangement suited the women because they do not need cash to attend the doctor. Some women reported trying to get advice from a pharmacist before visiting a private doctor.

All the women seemed to perceive that they should consult the MOU with possible pregnancy complications. Several of the women from the Northern suburb MOU reported receiving quite a negative reception when they did so if the midwife did not agree that they ‘really’ had a problem. In several cases this led to conflict between staff and patient as patients did not think they were listened to properly and staff were dismissive and even rude to patients who did not understand why they were being told their problem was not serious. Women felt disempowered as having perceived that they were acting on the ‘danger signs’ information they were given in the clinic, they were told that they had got it ‘wrong’ and their knowledge was undermined. Not surprisingly several said they found this ‘confusing’, as one who was told her baby was only “stretching” or “turning” explained “*they told us to go whenever we feel pains and tell your problems. But now I get confused when they say I'm supposed to have pains so I shouldn't go*”. Her reaction was to assume that the midwife was mistaken (“*I don't believe that*” she asserted) as she assumed that quite severe pain must be abnormal. The three patients who reported similar experiences all interpreted them as due to ‘ignorance’ on the midwives’ parts.

Women who contacted the Southern suburb MOU and the rural hospital reporting problems also complained about the reaction of the staff. One who attended the Southern suburb MOU at night with vaginal bleeding said the staff were “*very rude*” and told her that she “*wasting their time*” because she had forgotten her card in the panic and they did not observe blood in her vagina. Another woman reported rudeness from staff when her friend phoned into the same MOU to check what she should do as her waters had broken. Similarly a woman from the rural area was “*scolded*” when she called the clinic to ask advice about lack of foetal movement. Such experiences may well discourage women from seeking advice which could be important for their

health and that of their babies.

3.1.4.2 Use of Xhosa medicines and practices

Roughly two-thirds of the Northern suburbs MOU women followed indigenous healing practices for themselves, their babies or reported having done so in previous pregnancies. Others said they knew little about “traditional matters” or did not use traditional medicines because they were church goers (and would pray instead for protection against sorcery). Some women suggested that they were protected from sorcery in a township. None the less, many had been advised about indigenous practices by friends and relatives. The chief concerns which women looked to indigenous practices to address related to the need for “strengthening” of the womb against sorcery, the prevention of the childhood illness *umoya mdaka* [dirty wind] and treatment of symptoms which had not been helped by the bio-medical services. The indigenous healers interviewed suggested that women might consult at any stage of pregnancy, but one said this was commonly after the sixth month.

The indigenous healers explained, and many of the women agreed, that pregnancy was a "delicate" time, one when women have "lots of problems" and, in particular, unpredictable ones, which could lead to the death of the mother or child. Women and their babies were said to be vulnerable to "evil" sent by another person (directed sorcery), particularly a neighbour or a girlfriend of the child's father, who has a "grudge" or is "jealous" or just to ‘spells’ which a woman might step over in the environment (non-directed sorcery). The women described using medicines during and after pregnancy for “strengthening”. Some medicines were drunk, mentioned by name were “baboon’s urine” [*uchamo wemfene*] and *isicakathi*; others were put on a fire “to make smoke where you live” and another form was called *intambo*. This was described as material which the healer twists and smears with medicines and gives to a woman to wear around her waist until the baby is born, another said her father made one from part of a cow’s tail. The *intambo* protects a woman against “jumping over dirty things. One of the healers said he protected mothers “from the outside” by making two small incisions and putting power into the wound, and by giving her something to use when she baths and to sprinkle in the house. Most women bought their treatments from indigenous healers (‘Coloured’ or ‘Xhosa’) themselves or were given them by concerned relatives. One explained how she would prepare *isicakathi* herself in rural areas from roots called *inkunzane* which she would cook and give to the baby, but she was embarrassed to “take her spade and dig for herbs” in town. Another asserted that “most pregnant women start taking those medicines at four months until delivery” to ensure an easy and safe delivery.

Women described practices to protect their babies against *umoya omdaka* after birth much more

often than taking something themselves. The healers explained that *umoya omdaka* is a childhood illness which can affect children of any age, although it can cause problems for pregnant women as well. Its symptoms include green diarrhoea, restlessness, crying, stopping sucking, fits, grey tongue, constipation and a sunken fontanelle. They indicated that all children are vulnerable to it but most said that not every child developed it. *Umoya* was said to have several causes, it may be transmitted to a child in the womb by a mother who has 'stepped over' something which has made her womb dirty; it may be spread by *impendulu* [the lightning bird] through witchcraft; it could be determined by ancestors and indicated by the child being birth with the membranes around him or a cord around the neck. Two healers indicated that it could be infectious with transmission either through *impendulu* or just by being in a house with a child who had *umoya*. Since the period of vulnerability for the baby was long, treatment was often said to be continued for two years. Commonly the arrangement was a one off payment (R50 in the case of the Apostolics) which would entitle the baby to a full course of this. Treatment was described as involving medicines to drink, the use of herbs injected anally ['spading'], creams or ointments which could be rubbed on or herbs in a tiny wallet on a string. One woman said she had been given a bottle of Xhosa medicine for herself and the baby to take a teaspoon of each day, a rubbing medicine mixed with vaseline and a wallet for the baby. Whilst another explained that she had been advised in the hospital to go to the Apostolics for *umoya* protection or to get a wallet, rather than giving the baby medicines because "some people do not know how to prepare the correct mixtures and the baby dies". She said that "as soon as she could" she took him to be rubbed twice a week and got him a wallet. Other things which women reported giving included gripe water and *umthombothi* [indigenous medicine given to babies].

As well as for strengthening, some women reported consulting indigenous healers with symptoms. The women informants described doing so after being dissatisfied with the clinic, but one of the healers mentioned that women sometimes came to them first and they might then refer them to be checked by a "doctor". One woman described getting medicines because she was having stomach pains and hardness. The clinic had given her an ultrasound ("Xray") and iron tablets, but she didn't perceive the pills worked and so returned to report this, only to be told that the baby was "stretching". Then she went to a healer who gave her medicine which helped her. Another woman was given medicines for *umoya* during her eighth month of pregnancy because of waist pains which the doctor could not cure. She complained that it was expensive, but spoke admiringly of the healer when she described the process, saying the if you go and say you want medicines for pregnancy and how far you are "he will automatically know which medicine to prepare for you".

The healers indicated that in the last month of pregnancy they would give women medicines

[imbelekisone] to ease birthing. Some of the healers, of both sexes, said that they used to assist mothers in birth when they lived in rural areas but did not do so in the urban areas because they were not allowed to. They described, however, circumstances in which some women gave birth on their premises and strongly implied that healers did occasionally assist in the birthing. Both the healers and one of the women mentioned that healers had, and used, medicines which would make women who had had a Caesarian section deliver normally next time. One woman said she “would like to use them” but didn’t think she should trust them when she was near “doctors and hospitals”.

Several of the women indicated considerable overlap between concerns of indigenous health care and bio-medicinal service use, notably in a perceived need to know how the baby was “sitting”, in perceptions of the benefit of massage and palpation, in (unmet) desires for something for “protection” from the clinic, and general perceptions that this was a vulnerable time. The woman who delivered at home also suggested that she had not told the Groote Schuur staff that she thought she was in labour as they should “see” this, which is also resonant of the practices of patients when they attend indigenous healers as they also do not express their concerns verbally.

3.1.4.3 Self medication by Coloured patients

Given the emphasis that women from Southern suburbs and rural hospital placed on receiving medication from health services, it is not surprising that self-medication was a common practice of both the rural and urban women. They described a variety of ways in which they treated their minor ailments during and after pregnancy as well as prophylactic treatment for health maintenance for their new born babies. Often they followed the advice of older women.

The indigenous herbs used by the Southern suburbs and rural hospital women are described in Table 1 and were locally available herbs known for the treatment of common reproductive health problems. Herbs and Dutch remedies were predominantly used to treat indigenous illnesses, particularly associated with womb ‘dirtiness’ or “*baarwind*” [winds in the womb], which was perceived to be the cause of the “*10 day attack*”, a wind from the womb which goes to the head. Womb dirtiness was perceived to be a problem after birth, for which cleansing with herbs was required, “*to allow all the old blood and things to come down*”, and thus these were used exclusively after the birth. Mothers, grannies, aunts and elderly women in the community were mentioned as the most common sources of information about herb use and were frequently consulted. Often the herbs were prepared by the older woman after they had been bought or picked from the garden. One woman described how her granny was “*angry*” when she discovered that she had been bleeding continuously for nine months after the birth of her previous baby. The granny had treated her with “*home remedies*” which “*worked immediately*” and caused the

passing of “*massive pieces of blood*”. Women were only instructed on their use when they were pregnant for the first time and several mentioned being warned about not buying Dutch remedies or making herbal preparations too early because they could be used in witchcraft. Sometimes the Dutch remedies and the herbs were combined.

The Cape Dutch remedies have a long history of use in the Cape and their popularity stems from their low cost reputed efficacy for the treatment of minor health problems (see Table 2). Both urban and rural women had similar knowledge and used the Dutch remedies during their pregnancies as well as after the birth which included oral preparations and massaging oils for the babies. During pregnancy women described using it to improve their “*energy*” levels; to treat high blood pressure, to relieve tension, stress or induce calm. The reasons for their use for babies included to “*help them to sleep*”, “*to relax*” and to “*loosen the winds*” and to ensure tone in the neck muscles to prevent a “*floppy*” neck. The babies had to be massaged in a particular technique and the women were instructed how to do this by elder women such as mothers grannies and aunts. One woman reported that the “*old people believed that the smell will keep the devil away*” and that this was the main reason why the babies are rubbed with the Cape Dutch remedies.

The women most often used over the counter medication for the treatment of minor ailments (see Tables 3 & 4). Food substances were also used, for example, women reported “*eating salt quickly*” or putting “*dry coffee*” on the tongue to treat nausea due to reflux and one woman mentioned that they use these because they do not receive “*heartburn tablets*” from the clinics. More than one woman reported the smoking of cigarettes to relief symptoms, using “*continuous smoking*” as a way to help the “*turning pain to subside*”. The interviews suggest that women, particularly from the farms, perceived that ‘loosening’ the baby was a necessary stage in child birth and some reported receiving advice to rub sunlight soap and Vaseline onto their stomachs to prepare the child for birth. During the narratives of delivery, it was apparent that some were told by nursing staff that they should walk around when in labour for the same reason.

Table 1: Indigenous Herbs

Herb	Taken by	Used for
Buchu	Mother	Fever associated with the “10 day attack” after the birth
Dassie pis	Mother	Combined with Bakbos for the cleansing after the birth
Lilly leaves	Mother	Combined with paraffin for treatment of the “10 day attack” after the birth
Bakbos	Mother	Combined with Dassie pis for the cleansing after the birth
Moerbossie	Mother	Cleansing of womb after the birth
Perde pis	Mother	Combined with Dassie pis for cleansing after the birth

Table 2: Cape Dutch Remedies

Remedy	Taken by	Used for
Versterk Druppels	Mother and baby	To give energy / to “calm” down / to deal with “stress”/ to keep “ blood low” / to treat a “bitter” mouth / to massage baby / to treat after birth “cramps”
Saccheroi syrup	Baby	Mixed with oils to massage the baby to relax / promote sleep / prevents “floppy” head of baby.
Behoedmiddles	Baby	Mixed with Entress Drupples to massage baby
Entress Drupples	Baby	Mixed with Behoedmiddles to massage baby
Kramp Drupples	Mother	Combined with Wonderkroon, Versterk drupples and herbs for the cleansing after the birth
Wonderkroon Essens	Mother	Combined with Kramp drupples, Vesterk drupples and herbs for the cleansing after the birth
Lewens Essens	Mother	To drink after the birth to “clean” the womb
Sinkens	Mother	To prevent the “10 day attack” / to cleanse after the birth

Table 3:Non-prescription Medication

Medication	Taken by	Used for
Suncodin	Mother	For headaches during pregnancy
Gripe water	Baby	To treat winds
Dolorol	Mother	For headaches during pregnancy
Panado	Mother	For relief of tuming pains and headaches
Filibon	Mother	To give energy
Supa-tabs	Mother	To treat constipation during pregnancy
Eno	Mother	To treat heartburn
Friars Balsam	Baby	For the treatment of a bleeding umbilical cord
Vicks	Mother	Applied to the chest to treat an asthma attack
Rennies	Mother	To treat heartburn

Table 4:Other Products

	Taken by	Used for
Oils	Baby	Combined with others to massage the baby
Salt	Mother	For the treatment of nausea / heartburn
Coffee	Mother	For the treatment of heartburn / to promote labour
Ginger beer	Mother	To enhance the production of breast milk
Sunlight soap	Mother	Applied to the abdomen to loosen the baby before birth
Paraffin	Mother	Combined with Lilly leaves and applied to body to treat "10 day attack"
Onions	Mother	Placed in bath water to help remove caesar stitches
Vaseline	Mother	Massaged into abdomen to loosen the baby before birth
Cloves	Mother	To treat toothache during pregnancy
Cigarettes	Mother	To relieve turning pain / to treat insomnia

3.1.5 *Attending services when in labour*

Women's decisions about attending the MOU or a hospital when in labour (when they "got sick") were influenced by a variety of factors including the time day or day of the week. Southern suburb women who had given birth before often expressed an unwillingness to spend a long time "walking around" in the facility and so tried hard to stay at home until as near delivery as possible, although transport arrangements did not always permit this. Women near the rural hospital could call an ambulance to take them to the hospital, whereas those attending the Southern suburbs MOU had to arrange their own transport, which could be costly and awkward if needed at night. Whilst many women said they would walk or take a taxi to the clinic for antenatal appointments most would try to get a car or van when in labour. They often made prior arrangements with a neighbour who owned a car and paid between R20 and R30 for the trip. When labour started in the afternoon or early evening, some women decided to go to the clinic early to avoid the inconvenience of looking for transport in the middle of the night. Similarly, when labour started late at night the women would usually wait out the night at home, instead of waking the driver, and so arrive in advanced labour.

For women from the Northern suburb MOU, attending the labour represented a major cost and many saved carefully for some time for this. A lift to the MOU was reported to cost R80- R100 at night and R10-40 during the day. For Mowbray or Groote Schuur the prices were said to be R150 - R200. Often the process of raising a driver at night was complicated, as one woman explained she had to wake a relative who woke a neighbour who woke another neighbour in order to get a car. The complicated process of getting transport at night would sometimes be described as taking several hours, particularly if arrangements had not been made beforehand. One woman, who delivered unbooked, said it had taken her five hours from the time she realised that she was in labour until she had got ready, got transport and been driven to the MOU. Only one woman reported using the ambulance service and she said it had taken five hours for the ambulance to arrive but was impressed that it came at all. She lived in a formal housing area and was the only one who was in a position to call an ambulance as she had a telephone. Cost was identified as one of several considerations for the two women who delivered where they were not supposed to as both had attended their place of booking and had been turned away 'not in labour' earlier in the day. They were reluctant to pay again to have the experience repeated and so they then waited until they were certain they were in labour, by which time one could only reach the MOU and the other decided to deliver at home.

3.1.6 *Post-natal care*

Apart from contraception, post-natal care at the Northern suburb MOU related entirely to cord care for the baby. Women explained that they were told to either see a community health worker

or to return to the clinic for this until it dropped off and were told to buy white spirits and cotton wool to clean the cord. Even this small expenditure was difficult for one particularly poor mother, who had spent her last money on her taxi when she was in labour and was going to have to borrow money to buy spirit to clean the cord. The unbooked Northern suburb teenager said she was not told about cord care but she planned to visit the community health worker. Postnatal care for the Southern suburb women was easier. They were expected to attend the clinic every second day with their babies for cord care. A few, also spoke about the district sister that visited their home after the birth of the baby.

3.1.7 Sterilisation

During the antenatal period women with several children were encouraged to be sterilised and some perceived that some staff tried to coerce them into agreeing. It was an option which ultimately few women pursued even though most of the multiparous women at the Southern suburb said at the first interview that they are planning to have it. All but one changed their minds after discussing it with friends and hearing of the “*terrible experiences*” of female relatives. They indicated that they feared additional pain and incapacity after the pain of child birth, not being able to look after the new baby and their other children properly and having a general anaesthetic. One woman complained that the staff advocating sterilisation did not really consider the women’s position, “*it is quick for them but they don’t know because they do not feel your body*”, she felt that she would “*already have lots of pain after the birth and your body is still raw and painful*”. One woman was put off as after the birth she shared a ward with a woman who had a sterilisation done and saw her “*curling around with pain*” and soiling herself after the operation. Seeing this and speaking to this woman confirmed that she should cancel her own sterilisation. One woman explained that she would have a sterilisation, but preferred to delay it as she had been told that it is less “*painful*” and “*better*” to have a “*dry sterilisation*” [done a few months after the birth] than to have a “*wet sterilisation*” [immediately after the birth of the baby]. It would seem that women consent to have a sterilisation when they are confronted by the staff to make a decision about family planning during the first booking visit, but develop fear and concerns after talking with other people, which are not addressed by the services.

One of the Northern suburb informants had a sterilisation at Mowbray Hospital. She said she had been very fearful of the operation, fearing dying and leaving her children. She explained “*in the olden days people would be doomed [given a general anaesthetic] and a person would go, some of them wouldn't come back*”. She explained the change by saying “*Nowadays I think they decided to make a plan [i.e. by dooming some parts of the body]. It is actually a better plan that only your abdominal parts gets killed and your brain is all with you.*” This fear of general anaesthesia was also expressed by the two other women who had Caesarian sections at Mowbray

and may have influence the choices of other women vis a vis sterilisation.

3.2 Women's perceptions of quality of care

3.2.1 Over all care in the antenatal clinics

The process of booking involved, at each site, women spending many hours in the antenatal clinic. The longest periods were spent in Northern suburb MOU and at the rural hospital. At the Northern suburb MOU this was because the booking system meant that women had to arrive 3 or 4 hours before the staff, whereas in the rural area it was because they were seen by midwives in the morning and only saw a doctor at 2.00 pm. Women complained bitterly about the waits at the Northern suburb MOU and particularly about rising early, whereas they did not mind so much at the rural hospital as most were reliant on farm transport which always took people to hospital in the morning and collected them at the end of the afternoon. The Northern suburb MOU teenagers also complained of being verbally harassed by other patients during this wait. After the clinic staff arrived, the '*business*' of antenatal care at both the MOUs took an average 4 or 5 hours.

The booked women in the study had between one and six antenatal visits, depending on the duration of pregnancy at booking, the health risks of each woman and whether women attended all of those arranged. The follow-up visits at the two MOUs were shorter (2 - 3 hours) but this depended on the staff levels and number of women attending for the day. At the rural hospital, women coming for follow-up were seen by a doctor in the morning but many had to spend the rest of the day at the hospital waiting for their farm transport to collect them in the afternoon. Doctors visited the MOUs once a week and saw patients referred to them. Women with complications or in need of investigation had to be referred to Mowbray or Groote Schuur Hospital for antenatal care and delivery.

At all the antenatal clinics booking involved opening a folder, history taking, taking blood, weight and height measurement, urine testing and measuring blood pressure. Women also discussed future contraception plans and received some form of health education. Most of these tasks were performed by different staff members but at rural hospital, family planning advice and health education were integrated into the history taking stage. Women were also examined physically, but at the Southern suburb MOU this was done only on the second visit. All the rural hospital patients were also given a Pap smear. The fragmented and task-orientated nature of care meant that women had few opportunities to develop a relationship with a single staff member. Those at the Southern suburb MOU and the rural hospital complained that this made it harder for them to speak to the staff and so they hesitated to express their feelings and concerns. This problem at the

Northern suburb was additionally compounded by the general fear of the nursing staff.

The booking system at the Northern suburb MOU had a tremendous impact on the women, most of whom were extremely angry about having to get there so early to get care and sometimes still being turned away. Many of the patients perceived it to be primarily a display of staff power and they felt that the staff were mocking them when they said they should be there at 3.00 or 3.30 am to book. It certainly gave them opportunity to reflect upon their own vulnerability and most concluded that they did not really have another option. As one explained: *“It is something that is necessary. We are supposed to accept it because that is beneficial to us. If we cannot be patient about it, it is not their problem. If a person can be cheeky to the nurses and go home, she would be digging her own grave not [one] for the nurses”*.

The early experiences with the service at the Northern suburb MOU may well have contributed to the expectation voiced by all the patients that they did not expect to be treated well by staff. The interviews demonstrated that it was clearly the norm in popular discourse in the area was to report bad experiences in the MOU. Some women in fact were satisfied with their care but in the interviews were almost apologetic about saying this as it was not in line with the usual views expressed.

Although some women attending the Southern suburb MOU feared being treated badly by staff, this fear was nothing like as commonly expressed by these patients as those at the Northern suburb MOU. Communication between staff and patients and the related question of continuity of care (or lack of it), in turn, were critical in influencing these perceptions. This was well illustrated in patients constructions of ‘nice’ nurses which were visible in their narratives, these were sensitive to their needs, treated them as *“human beings”*, were respectful, warm, friendly and provided them with information. The more educated patients, at all the sites, met more nice nurses. They reported being given more information by the staff and were less likely to have negative experiences. Many of the women attending the Southern suburb MOU on a Tuesday morning remarked about how much they appreciated the tea and sandwiches served by Friends of the MOU and the accompanying talk on breast feeding. This undoubtedly contributed considerably to creating a better atmosphere in the MOU on that morning.

At all sites patients complained about staff scolding and shouting at them in the antenatal clinic. As a Northern suburb patient asserted *“[they] don't know how to talk to a person...they shout, they shout, they scold you too much”* and, to make matters worse, they complained to the patients about the patients saying that the staff are rude. Particularly at the Northern suburb MOU, individuals were shouted at for *“talking softly”*, moving slowly after being called to a room or

going too early to the a room after mistakenly thinking they had been called. Many of the Southern suburb and rural hospital women also mentioned that they knew that if they did not follow the “rules”, for example by booking late, being late for or missing appointments or, at the Southern suburb MOU, forgetting to bring urine specimens, they would be shouted at or scolded by the nurses. Some of this scolding, particularly at the Southern suburb and the rural hospital was perceived, to be well intended, for example scolding about smoking in pregnancy and booking late, and women suggested that they accepted this and it did not particularly bother them. Other forms of scolding were not excused, they were perceived as unpleasant, humiliating and “rude”. The latter forms made women feel very “upset” and “angry” and, particularly when others could hear, it made them feel they were being treated like children.

From participant observation and interviews at the rural hospital it was apparent that certain (deviant) groups of patients were ritually scolded, apparently as punishment since the scolding would not have contributed towards ensuring a safer pregnancy and delivery. Women who were unkempt and dirty and teenagers were two of these groups, as is illustrated by the following extract in which a woman describes treatment of pregnant teenagers by some of the antenatal sisters:

“They scold them really ugly. They ask funny things. They want to know ... things that the people cannot answer. So these children remain quiet and look at them as if they are dumb. For example they would ask ‘who is the father of this child’, ‘is he still at school’, ‘were you still at school when you got pregnant’, ‘does the child’s father work, ‘how much money do you have to raise this child’, ‘will this child be able to eat every day’, ‘can this child go to school one day and can he go to university one day’ and they just sit there. The nurses continue to talk and some of them sit with their heads facing the ground. Then she lift their chins and say ‘look at me, look at me, don’t just stare into the ground - I am speaking to you....look at me, how do you look at a man -you know about lying with you bums open and now you can’t even look at me”

Some women reported strategies to avoid being scolded for example, one woman from the rural area attended a private doctor on the Saturday before her antenatal clinic visit to check her urine for sugar in an attempt to defend herself if she was told off for poor diabetic control. Another explained, “I make sure that I do not walk out of the ‘spoor’”. Unfortunately the strategies did not always work as at times all the assembled patients were collectively scolded in an effort to deter those who might consider doing something wrong in future, or a woman would be scolded particularly loudly so that everyone waiting could hear her misdemeanour, detection and

punishment so that this could be an example to the others. The overall effect of scolding at the Northern suburb MOU was to make patients afraid of the staff.

3.2.2 *Communication between patients and staff*

There were quite substantial differences in the amount and nature of communication between patients and staff in the clinics. The interviews at the Northern suburb MOU suggest that there is particularly little explanation given to patients and several women remarked that they were never told their results unless they were abnormal. As a consequence, none of the women could explain why they were weighed and had their urine tested and some of the first time mothers found the physical examinations mystifying and even frightening. As one explained *“I didn’t know about palpation of the abdomen, how it is done... they just held my stomach...they filled me with air...in my arm....I was scared because I didn’t know how the palpation is done”*. Another commented *“they didn’t do anything strange except that they put that sucking thing and they did something on my stomach, that pipe”* she didn’t know why this was done and did not like to ask. There were very substantial differences between the terms which the Northern suburb women used when talking about their bodies and pregnancies and those used by bio-medical staff. This undoubtedly reflected the limited exposure of these women to bio-medical language since the staff, reportedly, explained little to them and that which was explained often avoided bio-medical terms (e.g. talking of “going to the TV” rather than ‘ultrasound’), and none of those interviewed had read anything on pregnancy.

The women from the Northern suburb MOU generally indicated that they wanted much more information from staff about procedures in the clinic but were reluctant to ask for it. As a result, they were pleased that they were being “checked” but were uncertain of the importance of what was being done and some women said they “expected more”. Only one woman reported having been told her baby was “fine” after palpation and being offered a Pap smear, she was notably one of the more educated and articulate of the women interviewed which might have explained why she was given more information. None the less she remarked about not being told why a Pap smear was done (*“they just said they will extract the [womb’s] juice”*) and not being told what the blood test was for at the time blood was taken.

The interviews suggested that there was substantially more communication between staff and women at the Southern suburb MOU although there were still complaints about information, for example about due dates and how the baby is getting on, not being volunteered. None the less the Southern suburb MOU and the rural hospital women complained that they could not communicate equally well with all staff. As one from the Southern suburb explained: *“there are some sisters that give you nice advice and they talk nicely with a person...they explain what the*

problem is etc.” Communication with the staff was said to be pleasant and satisfactory when the staff allowed them to ask questions and answered them in a “friendly” and obliging manner, for example a woman attending the Southern suburb MOU described her booking visit and said that she found the “nurse was friendly” because she [the informant] “could ask her if my blood pressure is normal”. ‘Niceness’ was thus both definitive of and a prerequisite for good communication. Two Southern suburb women expressed satisfaction when nurses acknowledged their concerns and took time to explained symptoms. One of these described phoning the MOU when she “was experiencing difficulties” and was told that the pain is “normal and is caused by the baby pressing down.” In these positive experiences the women were able to use the information to understand what is happening to their bodies and in this way the staff helped them to allay their fears.

In contrast to the Northern suburb, many of the Southern suburb and rural women utilised bio-medical discourse to a considerable extent, for example they spoke of “cms” of cervical dilation, “advancement” of the baby, methods of inducing labour including breaking waters, and gave explanations of difficulties or things which happened to them which resembled bio-medical explanations. The narratives suggested that much of this terminology they had learnt from the midwives explanations of, for example, their progress in labour. The more educated women tended to have more knowledge and had acquired it from reading books and magazine articles about pregnancy and child birth. Rural women most closely resembled the women of Northern Suburb MOU in their familiarity with bio-medical discourse.

Some Southern suburb women described situations where they were ignored when they asked questions and reported minor ailments. A woman attending the MOU explained that she had not asked the staff about her swollen ankles, about which she was concerned, because “you can tell them, but they do not take note of you”. She had asked them advice twice before for the treatment of heartburn and felt she had been ignored. Perceptions of poor listening by staff, often resulted in women deliberately deciding not to volunteer information, which the women felt might be relevant to their care. In another example, a woman described having a “3 hour test” for diabetes. She tried to tell the sister that she had “lots of sweets the night before” but the sister seemed to ignore her. In response, she decided not to tell “them we have sugar in our family ...I thought they must find it out for themselves”. There was considerable criticism of the doctors at the rural hospital both in the clinic and in the wards for not explaining things to patients. In particular they complained about doctors discussing them with colleagues in English which they could not understand and, as well as excluding them, made them feel ignorant.

3.2.2.1 Dates

Most of the Southern suburb and rural women had knowledge of the expected length of pregnancy and often spoke in terms of 'weeks'. Most of these calculated their own expected date of delivery from their last period and this was often in conflict with the date that the sister gave at the clinic. Women's confusion over their expected date of delivery was compounded by their seeing different staff members at each antenatal visit, with the result that their given dates changed from one visit to the next. The women expected that the dates would be easy to determined and thereafter fixed, but found that they were negotiated and shifted continuously taking into account new information on abdominal size, body parts or ultra sound scan findings. Many women ultimately stopped believing the staff and resorted to calculating their own dates (which from the researchers' assessment were even less accurate than the shifting ones given by the staff). The confusion over the dates was often so considerable that it suggested that most women and health providers only had a fairly rough idea of the duration of the pregnancy.

In all cases the errors in the calculation of dates meant that women actually booked earlier than they had intended to. Accurate prediction of the date of delivery was perceived to be important to the women (as it clearly was to the staff) and confusion over dates was frustrating for most women who wished to plan household arrangements and work schedules around the delivery. Uncertainty in some cases was compounded by the practice at Southern suburb MOU of not examining women on their first visit, which prolonged the period of waiting for a clinical assessment of dates. Several women indicated that they would have preferred to have been examined on their first visit. Others asserted that if the staff were unsure of the dates they should refer a woman for an ultrasound, which they thought would clarify the matter, although some of the women discovered that repeated ultrasounds often produced their own set of differing dates.

At the Northern suburb MOU there was almost no discussion of expected date of delivery in the interviews. Some of the women were particularly dissatisfied about not being told by the MOU midwives when they should be delivering. Several of the women interviewed expressed considerable uncertainty about when they were due, often having got quite different dates from their last menstrual period, assessments by private doctors and by the MOU staff. Only one woman reported being sent for ultrasound to try and confirm her dates and she had not learned from this what they were. None of the women indicated that they had closely anticipated the date of the start of labour based on calculations and it is possible that this was because the midwives did not tell when they estimated they might deliver. This was one of the substantial differences between bio-medical perspectives and those of the Northern suburb women. This group did not discuss their pregnancies in terms of weeks, but it was not clear whether this was because they did not think of their pregnancies in terms of a set number of 'weeks' leading to a predictable delivery date or whether they just considered their delivery date to be 'private'. The interviews

with Xhosa indigenous healers suggested that both may have been factors.

3.2.3 Health promotion

The first time mothers at all the sites had distinct need for health information and were often “scared”. They specifically mentioned not knowing “*what was happening...when pregnant*”. “*how must I open my legs*” and about “*pushing and such things*”. Those from the Northern suburb MOU and rural areas complained that when they had asked other women about this they had just been told that it was “tough”, “painful” or “difficult” without being given any details, which led one to conclude that it must be “very scary”. During participants observation the researcher observed the women exchanging information about their pregnancy, the clinic, the staff and procedures. In this way women gained knowledge on common experiences and also received advice on how to deal with symptoms.

The staff at the Northern suburb MOU recognised the substantial gaps in the knowledge of many women about pregnancy and regarded the health educational talks as particularly important, much more so than those at the Southern suburb and rural clinics. The focus, however, was on providing patients with information so that they could become extensions of the staff’s surveillance system, rather than eliciting and meeting patient needs. Thus the main emphasis was on the ‘danger signs’ of pregnancy which if women develop they should attend the Unit. Women explained that these included: headaches with swollen feet (without having gone a long distance on foot); “*when your water comes out*”; *if the baby is moving “too much”, “too little” or “in an unusual manner”*; (yellow) discharge; menstruation; stomach becoming “*hard*”; stomach pains; and, “*labour pains*”.

Women were expected to learn these by heart but some complained of difficulty concentrating due to tiredness and hunger from rising early to book, and fear of the staff, as one young woman explained: “*When we come here to the clinic we are always in fear because it is said that the nurses are ‘silly’ so by the time they start talking to you, you start wondering what will they say to you, as a result you can’t absorb what they are telling you.*” She added that fortunately they had not shouted at her. On follow up visits, patients reported that the whole group was detained in the clinic if some could not remember the danger signs. This, reportedly, made the patients “*angry*” and “*frustrated*” and they felt like shouting at the staff but did not as they feared victimisation when labour started. The educational strategy did not appear to meet its goals as in the interviews most women could only name one or two danger signs.

In addition the Northern suburb patients were given ‘*education covering ‘normal’ changes* (i.e. when not to come to the clinic), what pregnant women should eat, breast feeding, what to bring when in labour, STDs and avoiding traditional medicines. There were considerable differences

in the types of information which women reported having been given as it depended a lot of the talk of the day.

Education of women at the Southern suburb MOU and the rural hospital was not given as much priority as at the Northern suburb. At the Southern suburb MOU the women were given a group talk during their first antenatal visit which mainly dealt with the clinic's "rules" such as its hours, the after hour facilities including the reasons why a woman might attend after hours service, items to bring when coming for delivery for example sanitary pads, baby clothes, food and money for the public phone. They were also provided with an appointment card which contained information such as when to attend in labour, attending the after-hours facility and a list of danger signs. Few women reported receiving educational information during the follow-up visits at Southern suburb MOU, although it was apparent that issues were addressed on a one to one basis during palpation and three mentioned discussing the danger signs of pregnancy in this context.

At the rural hospital there were no group health promotion activities. Women were given an information pamphlet at the time of their booking (which covered the signs of labour, danger signs of pregnancy, when to attend for the above and list of items to bring), but for the most part health education, such as it was, was provided individually, integrated into the process of taking the obstetric history. Whilst this could have provided an excellent environment for tailored communication, it did not as there was no privacy. Histories were taken in a room shared by two sisters who talked to their respective patients simultaneously within easy hearing distance of the rest of the women waiting in the corridors. The researcher was able to observe the content of several of these discussions just by sitting in the corridor listening. It was apparent that the interviewing style was interrogational and frequently focussed on topics which the women found sensitive such as their economic status or sense responsibility, for example when asking "*who will care for this child?*" and "*how many nappies do you have?*". Most of the women reported that they experienced these sessions as hostile and formidable encounters. This was not an environment conducive to learning and it resulted in the women becoming fearful and angry at the staff which further discouraged the asking of questions.

Not surprisingly the educational information was met with a mixed response from the women. At all the sites, some of the more experienced women said they had heard to all before, but others had not and expressed considerable appreciation of it. One explained that she had received care in Transkei and Gauteng for a previous pregnancy and had not been "taught" any "lessons". Another Northern suburb woman, who developed symptoms which concerned her, said that although she knew most of it she still had found the health education useful as the nurses had said women should attend the clinic outside their normal appointment if "something strange happens"

as otherwise she would expect to be shouted at.

Some of the women were quite dissatisfied with the information which they were given in the clinic, particularly the younger ones who had greater needs. One complaint was that women were not given any information “about pregnancy” or “how to look after the pregnancy”, but only about what to do when problems arose. One woman said she wanted to know “*things that happen to you when you are pregnant like the fact that the baby turns...when and how it happens, so you don't panic when it happens*” and what to expect in labour. The two women who mentioned advice and support after delivery said they were “not told anything” except to breast feed, this itself was communicated in a ‘lesson’ and the women were not shown how to breast feed. At each of the Units some of the patients complained about their preparation for labour and about how the labour areas were organised and where they were supposed to wait and to deliver.

Many of the Southern suburb and rural hospital women smoked during their pregnancy and all of them had good knowledge of the effects of smoking on their babies. The staff at the Southern suburb MOU were described as “*hammering on the smoking*”, being “*strict*” and “*scolding*” women about it both antenatally and when they caught patients smoking in the toilets after delivery. Although most of the women perceived that they should stop smoking or cut down, they complained about how hard it was to stop. Nonetheless many of them did alter their smoking practices during pregnancy or after the birth in response to a number of pressures or concerns. These changes included stopping for periods, for example during a chest infection in response to pressure from the father of the child, or not allowing anyone to smoke in the same room as the baby.

3.2.4 *Care during labour and delivery*

The group of patients who were generally most satisfied with their care during labour and delivery were those who delivered at the Southern suburb or Groote Schuur. Of the ten women recruited from the Southern suburb antenatal clinic, three gave birth at Groote Schuur Hospital, and seven at the MOU. All delivered vaginally. Most of the women described most of the nursing staff who helped them with their deliveries as “nice” or “really nice” and as very “helpful” and all were overall very satisfied. All but one of the women, however, complained of being scolded by staff they came into contact with at some stage. An informant explained that a friend of hers who worked at the MOU had told her “*they were not allowed to scold the mothers any more*”. It did appear from the interviews that this was not being followed.

Of those who were recruited from the rural area, two had Caesarian sections and three delivered vaginally. Those with Caesarians were generally satisfied but two of the women who delivered

vaginally were distressed or angered by aspects of their experiences, particularly episodes when the staff shouted at or scolded them and the third was distressed by the way in which staff treated a woman who was delivering with her.

Women who delivered in the Northern suburbs similarly had very mixed experiences. Of the original group of seventeen patients who were recruited for this study from, five were not followed to delivery as one had an intra-uterine death, two went to deliver elsewhere and two were untraceable after the initial interview. Of the others, three delivered at Mowbray, one at home and eight at the MOU (two of these were unbooked). Half of the women in the in-depth interviews had broadly positive experiences delivering at the Northern suburb MOU, as did two of the nine from the group discussion. The others reported a range of distressing experiences including verbal abuse, being hit by staff and neglected.

The women were clear that it was not all the Northern suburb MOU staff who were 'bad'. Some sisters were "nice" and some were not. "Nice" sisters were said to explain or show women things; be caring towards the mother and baby, bathing them and cuddling the baby or expressing excitement about the birth; praised women for delivering well; and did not shout at or speak rudely to women. In order to be satisfied, women did not even expect nurses to be nice all the time, so long as their motivation was clear. In one delivery which "went well", a woman described how the midwife was "pleading with me, because she didn't want me to be difficult, so...she helped me deliver, but after that she became friendly". She said that the sister had explained afterwards "no I'm shouting at this person because I want her to do things the right way", and she indicated that she had not liked this but ultimately it was acceptable as at least she explained. One of the Southern suburb midwives discussed in her interview how important she regarded this explanation.

The male midwife at the Northern suburb was very highly praised by the patients, "they say he is the nicest one of them all" one asserted. He was said to be "so gentle" at examinations, "the most caring person", to "deliver... nicely" and be "the best in abdominal palpation". Several mentioned that they were not shy to be examined by the "male doctor" [sic]. He was also commended for not sleeping at night. One woman explained "the male nurses are empathetic, they don't sleep at all. They are the ones who are usually left to attend to these people who are always kept on hold [i.e. women told they are not ready to deliver and not to push]... [the nurses] just go to sleep and leave the male nurses on duty". The male nurse at the Southern suburb MOU was also particularly highly spoken of.

Most of the patients indicated that they expected problems delivering at the Northern suburb

MOU based on previous experiences, or on stories from other women who had delivered there. Given the expectations, it is perhaps not surprising that the twin problems of abuse and neglect, were dominant features of the narrative accounts of labour and delivery of many, although not all, of the women. Patients described being shouted at and scolded by staff, being beaten or threatened with beatings, and being ordered to do unreasonable things such as cleaning the floor. They also complained about not being checked when in labour, midwives not listening when they said they were in pain or about to deliver and several reported delivering on their own. The patients variously described the midwifery staff as “silly”, “rude”, “ridiculous”, “in-human”, “not caring” and “not kind”. They were said to speak to patients as if “talking to a child” and patients reported that “nobody showed any kindness”. This was particularly important to patients as they described labour and delivery as times of great “anxiety” and “worry” and times which were very “difficult” (an expression of pain). The women perceived that the care that they received substantially ‘depended on the midwife’ and many of the narrative accounts of abuse and neglect also included mention of rescue by the intervention of a ‘nice’ midwife at some stage.

All but one of the women who delivered in Northern suburb MOU reported experiencing shouting, scolding, rudeness or sarcasm of some form which they found unpleasant or “hurtful” during their time at the MOU in labour or during delivery. Some of the women were spoken to harshly as they had broken the ‘rules’ about delivery at the MOU in some way, either by not booking, pushing before the midwife told them to, not bringing baby clothes and wash things with them, being about to deliver in the wrong place or delivering without a midwife. Other women were scolded because they tried to argue with the staff about whether they were actually in labour or generally irritated the staff by asking for attention or getting onto a bed (or not doing so) at the ‘wrong’ times. The staff apparently also became irritated with, shouted at and scolded patients who repeatedly reported that they had pain or who asserted that they were ready to deliver. One reported being told ‘*Oh no, you are so irritating!, you are irritating*’ and the midwife left just before she gave birth on her own. Several patients also complained of harsh and accusatory things which midwives told them in an attempt to frighten them into compliance, particularly assertions that they were “*killing their babies*”. Many of the midwives interviewed gave examples of when they scolded women which closely supported with the women’s stories.

In some of the cases women perceived that they were scolded as the midwives had been caught off guard, for example not being ready for or present at a delivery because they ignored women when they told them that they were about to deliver. One of the women at rural hospital was scolded when she gave birth on her own after the midwife refused to believe her when she had said she was ready to deliver. Two of the Southern suburb women were probably scolded because the staff panicked because they suddenly discovered that a woman was almost ready to deliver.

Another patient who complained of being scolded said it were the cleaners who did this as she did not eat her breakfast.

Two of the women reported being hit by staff at the Northern suburb MOU and one said her sister (who had delivered shortly before she did) told her she had been beaten. One woman was “slapped” on her face by a midwife who found her squatting by her delivery bed when she had been to the toilet and found herself unable to climb on again. Another said she was repeatedly “beaten” on the thighs during delivery. At that time she was “dying with pains” and the midwife kept shouting at her and beating her.

Several women from the Northern suburb MOU also complained of other acts of unkindness by midwives which they found distressing. One teenager complained of being made to walk to labour ward immediately after delivery in the waiting room, she said at the time she “couldn't even walk” and the midwife delayed considerably in giving her a clean night dress. She also reported having her baby's bottle confiscated by a midwife when she returned for cord cleaning. Another example was in the account a woman gave of her sisters' treatment during delivery which was shortly before her own. She related this as follows:

“ [The midwife] ordered my sister to go into bed and as she was climbing she commented: "You are so untidy, can't you see that there's no plastic cover on your bed?, go and get one from that cupboard!" My sister told her that it is difficult for her to walk. The nurse scolded her still saying: " Yhey! I'll slap you if you deliver on that sheet without a plastic cover" She finally walked slowly to the cupboard but before she even opened the cupboard the baby came out. The nurse scolded her even more, calling her names, she said: 'I won't mess my hands with this, pick the baby on your own' She picked up her baby everything now was hanging out from her because she hadn't finished delivering. She said the nurse was shouting and beating her up and slapping her on her face. My sister then picked up the baby and put her on the bed. The nurse then called other nurses to come and see and she said to them: "look at this mother she is going to make us nauseous" and she said to her: "clean up your mess!"

Another Northern suburb patient who spilt a bowl of vomit just before delivery was also told to clean up her mess. She explained “*[the midwife] said: 'Now you must stand up and clean, I won't clean this and mess up myself' I was told to take papers and clean up the mess, so I struggled to walk but the nurse didn't feel guilty instead she continued saying: 'Yho, she should clean up I can't do it at all!' Just at that time another nurse appeared and she was surprised with what she*

saw, she said: 'Oh no! stop Sisi, stop'. She went to get a mop and she cleaned up then''

All but one of the Northern suburb women perceived that they were neglected by the midwives during pregnancy and, relatedly, five of the seventeen delivered on their own at the MOU. In most cases patients complained of staff ignoring them when they complained of pains or when they said they felt they were about to deliver. Although some women described having been examined several times by staff before delivery, several complained that after being sent to the waiting ward “*nobody comes to check you*”. Patients complained of acts by staff which made them perceive that they were not their main concern. These included staff dismissing them whilst talking to each other; a midwife remarking that a woman was delivering and telling her to wait whilst she goes to pass urine; staff sleeping; a midwife taking a (she thought private) phone call in the middle of a delivery; and, (in a previous pregnancy) staff watching TV. The women perceived much of this as unprofessional behaviour.

Many of the women described strategies which they used in order to try to get attention or to manage what they perceived as inevitably deliveries. Some described asking advice from older women who had delivered or cleaners, whilst others just went to labour ward and climbed on to a bed. Five of the women delivered on their own. One was booked to deliver at Mowbray and had not been able to get attention because the midwife was busy arguing that she should not be in the MOU. One teenager reported that she asked the other women in her room to call the staff but was told they were “sleeping”, so another woman helped her she explained: “*She then instructed me how I should do it because she had already delivered. She told me to open my legs then I delivered*”. Another teenager had a similar experience, she had asked a *Sisi* for advice about ‘*something that wants to get out*’ and had been told to go to the nurses as she was ready to give birth. The fourth woman delivered alone because her midwife took a phone call in the middle of the delivery. The fifth woman who delivered alone was the woman who had been squatting by the side of the bed and was shouted at and hit. She said that after she was finally helped onto the bed the midwife left her, she explained: “*I could feel the urge to push and the nurses were chatting all this time. I called out loud and said: 'the baby is dying!!!' at that time I hadn't stopped pushing until my baby came out and that's when they started coming... My only prayer was that they should not kill my baby because I knew that it was my last baby*”.

These narratives of perceived neglect contrasted quite markedly with the accounts of care at Southern suburb MOU and of care of two of the women at rural hospital. They all reported being examined regularly and two were transferred to the labour ward to deliver. All the women delivering at the Southern suburb MOU reported being examined on arrival and periodically thereafter until delivery. Most described the first part of their labour when they managed varying

degrees of pain and then reaching a point where they felt the urge to push, felt they wanted to defaecate or felt cold and shook. Many described informing the midwives when these feelings developed and being found to be full dilated or to have the head visible, at which point they proceeded to push the baby out (usually described as taking three or four pushes). At the Southern suburb MOU and Groote Schuur the midwives in each case responded to the women when they mentioned these feelings and took steps to prepare for the birth. Some women described having the urge to push at an earlier stage and being told not to do so. Many of the women reported being asked by sisters not to give birth until the night shift came on or they came back from lunch, but the women did not mind this as they did not perceive these to be serious requests or instructions. The responses of the Southern suburb midwives contrasted markedly with those reported at Northern suburb and this may account of the fact that none of the Southern suburb deliveries were unattended.

Many of the women were very upset about their experiences delivering at the Northern suburb MOU. Three women said they would never return as a result of their care nor even take their babies to the Day Hospital. One asserted that she understood “*that ‘they’ [women] do make mistakes but it would be better if the nurses were a bit polite in the manner of approach*”. Another woman suggested that the “*nurses need to be encouraged to help people when they need help*”. Only one of the women said that she would respond to the midwives, but she added that she would not during delivery, more commonly women said they “*never responded*”, as they were “*in pain*” and feared even worse treatment if they had. Some of the Northern suburb patients clearly perceived the midwives’ attitudes and behaviour as abuse of power.

3.2.4.1 *Conflicting perceptions of labour and delivery*

The Northern suburb women interviewed described labour [*ukulunywa*] and delivery as essentially “*natural*” processes (“*from God*”), one which “*nothing can stop*” (except supernaturally) i.e. they did not have control over, and one which no woman would want to delay. A couple of women mentioned that their waters had broken before coming to the clinic and one said she was bleeding, otherwise women’s indication that they were in labour was based on the start of pains [*ulunywa yinimba* - ‘*aching of the cord*’ - or *ulunywa yimbeleko* - aching due to birth]. Several described these becoming progressively worse as labour proceeded, becoming “*very severe*”, “*extreme*” or “*constant*”. Pains were often cryptically described as “*that thing*” which “*arrived*”. Most of the women described reaching a stage at which they perceived they were about to deliver, which was often described as “*I realized then that there is something*” or in terms of feeling “*pressed*”. One primigravida said she felt “*there was this heavy thing coming out*”, another woman told her that was the baby. They often then described sensations of being ‘told’ to push by their bodies, as one described it “*that thing arrived, the one that says push*” and

several women, particularly the experienced ones, said that from then on they responded by pushing until the baby was born.

In contrast, patients suggested that the Northern suburb midwives attempted to control the timings of their deliveries and patient care activities. They perceived this to be in order to create space for personal activities such as chatting, sleeping and (in one case) urinating. The accounts suggest that the midwives used prediction of time of delivery, based on vaginal examinations, as a strategy for managing the rationing of their attentions and in particular for determining their responses to patients' complaints of pains. Thus a recurring response in the narratives to patients' requests for attention was *'I'm the one who admitted you, I don't think you are about to deliver yet,. You are not going to deliver now go away you like bothering us'*. Several women reported being told to stop pushing or being scolded if they delivered 'early' because it was interpreted as a sign that they had pushed before the midwife told them to.

These competing constructions of birthing were a source of considerable conflict between patients and midwives. At a simple level the conflict arose because patients perceived that midwives were trying to delay a process which was either unstoppable or which it would not be in a patients' interest to stop, as one asserted *"I am the only person who is suffering the pain"*. In these circumstances midwives' interventions were perceived as at best an irritation and at worst as prolonging suffering. Conflict with multigravidas also arose because patients perceived that midwives were ignoring or denying their knowledge, which they interpreted as either indications of midwives' ignorance, callousness or rudeness. For example, one who was told not to push said *"I just ignored her and pushed because she should know that if the water breaks, the baby must be on the way. But she didn't even think of checking. She was only instructing me not to push whereas I was in deep pain"*. Another complained of that she particularly did not like being thought of by staff as *'stupid'*, asserting that she would tell them if they were rude *"I'm not having a baby for the first time I do have some knowledge"*, she continued *"I can deliver without their assistance, I just need to make sure I'm in the right place, the beginners have to call the nurses all the time they feel something"*.

Conflict was also reported over the diagnosis of labour. Several of the patients indicated that they had a general idea of pains indicating labour and several reported experiences attending the clinic or the hospitals and being turned away and told they were *"not in labour"*. The more experienced women spoke of the nature of the pain as coming and going, and one said she went to the clinic because *"it came and went and came back again very quickly"*. None of the less experienced women mentioned looking at the frequency of contractions before attending the clinic or indicated that they had been told to do so. As a result being turned away caused considerable

dissatisfaction, particularly as four of the women reported that the pains increased (or “returned”) when they went home and they had to return to the clinic again the same day.

None of these sources of conflict were visible in the narratives of women delivering at the Southern suburb MOU. It appeared that the midwives models of labour more closely approximated those of the women and conflict was averted because the midwives listened to the women. Instead of undermining their authority and control of ‘medical knowledge’ their actions enhanced their positions in their patients estimations with the obvious consequence that despite the fact that women were still scolded at Southern suburb MOU overall care during labour and delivery was perceived as satisfactory.

3.2.5 *Miscellaneous aspects of quality of care*

Birth companions

The Northern suburb women were asked in the interviews whether they would have liked to have been able to have their husband or another person present with them during the birth. The MOU policy was not to allow this. Several women expressed strong views against having their boyfriend or husband present. The concerns primarily related to modesty (being “shy”) about exposing themselves and not feeling free to “*act the way you feel like*”. One young woman in the group discussion had given birth in Karl Bremmer Hospital said that her boyfriend had been with her when she was in labour, she said “*when they were telling me to push, he was pleading with me to do as told, so I found that very useful*”. Another woman in the group agreed that “*it would be better if someone could accompany you at delivery but it should your sister... or your husband's brother's wife... I still think it is a good idea to have company at delivery because they [midwives] would be scared to scold you in the presence of the second person. The second person would even be energetic and thus able to respond to their rebukes even if she doesn't go as far as beating them up or fighting with them.*”

The midwives defended their policy by recourse to the ‘*tradition*’ that men should not be present during labour, but did not mention that female relatives were also not allowed, which was contrary to tradition. One mentioned that sometimes with a “**primip**”, when it was “difficult for her and she does not listen”, they would call the mother and “*explain to her so that she can explain to the daughter what is happening, how she is supposed to behave*” i.e. the mother would be called in to facilitate compliance with the midwife.

At Groote Schuur and the Southern suburb MOU staff said they encouraged husbands or mothers to accompany pregnant women to the clinic and labour ward. In the labour ward, companions were perceived as being able to provide aspects of care for the woman which the midwives were

too busy to provide, for example to “*support her*”, “*rub her back*”, “*pacify her*” or “*give her a bit of encouragement*”.

Pain relief

Although several of the Northern suburb women attended relatively early in labour and reportedly complained of pain repeatedly, none of the women were given pain relief in labour or mentioned it having been discussed with them or offered to them. Pain during labour was a central feature of narratives of the women delivering at the Southern suburb MOU and the Southern suburb MOU, with the recurring complaint that nothing was given to them for it. One woman who was induced for hypertension at Groote Schuur was given pain relief and two at the Southern suburb MOU were given an injection. A few women reported asking staff at the Southern suburb MOU and the rural hospital for pain tablets and were encouraged rather to walk around. None of the other women were given anything.

The Southern suburb women also perceived that there was a general lack of sympathy with vocal expressions of distress due to labour pains, as evident in the characterisation (by women as well as staff) of such behaviour as “*performance*” and the frequent complaints that “*lots of women perform because of the pain*” or warnings of women not to “*perform*”. One woman said she heard a midwife shouting at a girl of 18 or 19 who was delivering “*you [didn't] go on like this when the man was on top of you*”. Several of the women indicated that they found this aspect of delivery hard and unfair, as one commented that “*they are there to comfort us but they don't give it*”, none the less the women all participated in criticising women who were noisy in labour.

Enemas

A couple of the Northern suburbs women mentioned having had enemas (“*a spade*”) and described these as unpleasant and difficult, as one explained “*[I] was told to go to the toilet and all the time I was trying to stop the baby from getting out, I couldn't even relieve myself in the toilet, I just squatted and nothing came out*”. One of the women delivering at the Southern suburb MOU also complained about the enema.

Food

One woman who spent about 24 hours in the Northern suburbs MOU, mentioned lack of food as a problem. She had come in at about 8 am and delivered at 2.30pm but was only given soup in the evening to eat and then porridge, coffee and bread in the morning. She said people with money bought food but she was very poor and did not have any money.

Contraception

Several of the women reported being given Depo after the birth and complained of having little

choice. One described this as being “forced” to have it. Most of the Southern suburb women were given a contraceptive injection after delivery in labour ward. The lack of informed consent around contraceptive injections was particularly evident at the rural hospital when one young woman said she was given an injection but she was unsure why she had it: “*I do not know - I think it is not to get pregnant...I asked my mother when I got home. She said to me you do get it when you finish with the birth - not to get pregnant*”. She also remarked that they had not told her when to return for another injection.

3.3 Staff perceptions of their working environments

3.3.1 Managing the workload

The midwives perceived that in their work they had considerable responsibilities particularly as labour was inherently unpredictable, they were dependant on compliance of pregnant women for good outcomes and because they had quite a heavy workload. Stress was caused by having to manage uncertain situations, particularly with unbooked women who were not “*known*” or where complications arose without certainty of timely back up or sufficient staff to cope. In particular a still birth, neonatal death, or even maternal death were feared and the ambulance and flying squad back up, especially to the Northern suburb MOU, were regarded as inadequate. Midwives’ perceptions of their working environment and problems which they could or did encounter were largely shaped by concerns to increase their ability to control their work and, implicit in this, the actions of pregnant women and to manage their workload.

At a global level the staff tried to impose order on the obstetric service through a system of MOU and hospital catchment areas and strict referral criteria which allowed for movement of patients between different levels of care. None the less, many women were perceived to try to book and/or deliver somewhere other than where they were ‘supposed’ to. Staff at Groote Schuur complained about women coming in large numbers with letters from GPs suggesting that they had complications of pregnancy which proved fictitious. Other patients were said to “*fake*” addresses in Mowbray, or to drive up in labour, sometimes giving birth in the car on the way. Midwives suggested patients sometimes wanted to “*by-pass the system*” to get a second opinion on a minor ailment, particularly if they felt they were not taken seriously by the MOU e.g. a patient being told they “*weren't getting pains*” or “*weren't in labour or there wasn't a problem at home*”, some wanted to see a doctor; others feared staff “*rudeness*”, or might fear a service because of knowledge of a problem e.g. a friend’s baby dying during delivery at a MOU. Patients did not only travel to the hospitals, but also to the other MOUs. Sometimes delivering in MOUs when they were booked in hospital because they had been sent home from the hospital earlier ‘*not in labour*’ and did not have the taxi fare (R10) for a second visit.

In keeping with a desire for order, the midwives interviewed at the two MOUs perceived their relationship with their patients to be governed by an implicit contract, with clear responsibilities on both sides. For midwives, these involved provision of care necessary for the delivery of a healthy baby, whereas for pregnant women, were expected to follow the “*ground rules*”. Tensions arose when staff feared they would not be able to fulfil their obligations, when women did not meet their side of the contract or when fulfilment of obligations appeared to necessitate conflict with another part of the system. Some staff suggested that the nature of the contract was such that their obligations diminished changed if women did not follow the “*ground rules*” or heed their health education messages. Compliance with the ‘*contract*’ was central to discussion of blame (or ‘cover’) if problems arose. At the Southern suburb MOU, staff explained that the terms of the contract were set out during the booking educational talks. A midwife explained that the purpose of the talk was to “*lay down the ground rules...what to expect, what is expected of them*”; she added “*we provide the service, they must bring the accessories*”. She explained that she would tell patients *I'll deliver your baby but the rest you should be able to see to.. this is not a hotel*. None of the patients indicated any perception of a contract relationship with staff of this nature.

Control in the antenatal clinics, particularly at Northern suburb MOU, was exercised through the booking system, which was perceived as a means of stopping the clinic being ‘*swamped*’. A puzzling aspect of this, however, was that the activity reports for 1996 (the year of most of the data collection), which are presented in Table 5, indicate that a figure well below the quota of 30 women per day were actually booked. During the group discussion the midwives indicated that the clinic did not book women attending after 9.00 a.m., irrespective of how busy they were, and did not take as many as 30 if they were short staffed. Each day the blood specimens were collected at 8.30 a.m. and taken to Groote Schuur Hospital, the results would be available by late morning of the same day and women were expected to wait for them. The staff asserted that this substantially dictated the booking times. The antenatal clinic was only run in mornings and staff said it usually finished by 12.00 noon. In the afternoon, a staff nurse explained, the staff “*check our records*” and “*document*” the day. They also tidied up the clinic and prepared specimen bottles and the linen for the next day. The success of their strategies to control is attested to by the assertion of one midwife that working in the antenatal clinic was “*retirement*”, compared with labour ward.

The Southern suburb antenatal clinic was run rather differently from that at the Northern suburb. It opened at 7 a.m. and staff said that women could attend for booking and repeat visits throughout the day although most of the clinic work was completed in the mornings, there were no restrictions on numbers. Women attending after 4 p.m. could be booked by labour ward staff. The number of women attending for booking was said to vary between about 5 and 30 and about 35-50 women attended for repeat visits. Blood specimens were not tested the same day at the

Southern suburb MOU and women received their results at their second visit. This system was made possible partly because of the lower prevalence of syphilis in this population. One Southern suburb MOU sister explained that she perceived herself to be obliged to book any woman who attended and regarded booking as a task which inevitably would have to be done at some stage. These two factors, coupled with a reminder from their matron that it was their job and they were actually employed to work until 4p.m., resulted in the policy of open booking. One result of the Southern suburb MOU policy was that staff perceived that there were few unbooked deliveries. The activity data for the Southern suburb MOU antenatal clinic and number of unbooked deliveries is presented in Table 5.

The need for control in part arose from concerns about workload. This was identified as a particular problem in the Northern suburb MOU and the Groote Schuur labour ward, whereas the subject at the Southern suburb MOU was scarcely mentioned. As one midwife at the Northern suburb MOU graphically put it “*we are dying of workload here*”. Staff perceived that increasing amounts of work were being pushed down to primary levels without any increases in staff, in attempts to reduce workload at secondary and tertiary facilities. One Northern suburb MOU sister asserted that staffing problems were compounded on the MOU by staff resigning and not being replaced as posts were frozen. At Groote Schuur, staff complained that their problems were compounded by the need to deliver ‘normal’ women who came in labour.

There was a perception among all midwives interviewed that the Northern suburb MOU was very much busier than some of the other MOUs. The activity data for the two MOUs and a crude analysis of available staffing data are presented in Table 5. This data supports this assertion.

3.3.2 *Staff perceptions of patients*

Some of the strategies which staff used to impose control on their environment were shaped by their perceptions of their patients and influenced by a range of other factors. This was visible in the instances of dispute between staff in different parts of the service over the interpretation of and need for particular approaches. For example, although staff at the Northern suburb MOU represented the booking system as primarily concerned with numbers and blood tests, staff in Groote Schuur and the Southern suburb MOU often mentioned it in their interviews and indicated that they found it embarrassing and unacceptable. This contrasted with the attitude of the Northern suburb staff interviewed who, with one exception, vigorously supported it and were not sympathetic towards women who found coming early difficult. This could be seen in the scolding of unbooked mothers, which staff said was justified on the grounds that they were “*lazy*”, “*didn't want to get up very early*” or “*did not want to book*”. The suggestion being that staff perceived the effort required to book at the Northern suburb staff as in some way indicative of the value of their work.

The staff interviewed at the two MOUs perceived that many patients were largely ignorant of pregnancy and childbirth and regarded education of their patients as a central part of their work. At the same time they regarded this as rather unsuccessful and staff perceived that women were not very interested to know more about pregnancy. One Northern suburb midwife described the educational task of midwives invoking notions of moral upliftment and even ‘civilisation’, explaining that it was “making patients from Ciskei and Transkei to be CapeTownian” and “making them to be responsible”. Another captured her frustrations by saying *"Frankly what we do here is a lot in the capacity of an educationalist, you do a lot of teaching, educating, especially with first time mothers...I'm not saying they don't listen, but you pick up when they go into labour that whatever they have been taught in the antenatal clinic has been disregarded"*.

Some Northern suburb staff acknowledged that one problem was that whilst they taught, some women slept because of the early hour that they had to rise in order to get to the MOU for booking. They tried to get round this problem by “revising” and testing women on the danger signs every time they attend, but often found them “forgetful”. Another problem in this MOU which was expressed by a family planning advisor was that many patients found the presentations “boring” as there were only three were not “too complicated” to use. So patients might keep hearing the same one. A combination of illiteracy and posters and pamphlets not being in Xhosa, meant that these were often also ineffective tools.

Table 5: Comparison of average activity and staffing data at Southern and Northern suburbs MOUs

	Northern suburbs MOU	Southern suburb MOU
Bookings		
No. of new patients per booking day	23 * (26 Jan - June) (20 July-Nov)	13.3
No. of patients making repeat visits per day	46 (55 Jan - June) (36 July - Nov)	50
Labour ward activity		
No. of admissions per day	14	11
No. discharged 'not in labour' per day	3	4
No. transferred per day	3.4	2.2
No. deliveries per day	7.6	4.4
No. of unbooked deliveries per month	21 (25.4 March - June) (17.6 July - Nov)	7.5
Ratio of booked to unbooked deliveries	10 : 1	18: 1
Staffing		
<i>Average monthly no.:</i>		
Professional nurses	21	15.6
Enrolled nurses	3.6	1.7
Nursing assistants	8.4	8.8
Professional nurse to admission ratio	1.5 : 1	1.4 : 1
Professional nurse to delivery ratio	2.8 : 1	3.5 : 1
Professional nurse and enrolled nurse to booking ratio	1.1 : 1	1.3 : 1
Nursing assistants to delivery ratio	1.1 : 1	2 : 1

* booking days in Northern suburb MOU excluding Thursdays and public holidays

At the Southern suburb MOU, a midwife similarly suggested that concentration and patient involvement in the education process were limited. For this reason she said they only did 10 minute talks, and that some women asked specific questions but others didn't "bother very much".

At the same MOU the staff said that only one to one communication was really effective and they tried to do as much of this as possible, however, most of them perceived the problem of patients not learning was a fault of the patients not 'theirs'.

Just as patients complained of problems which they encountered with staff, in the midwife interviews many complained of problems in their relationships with patients, and also problems between pregnant women and their colleagues. At times, staff perceived that they had unreasonable expectations of the other or behaved in an unacceptable manner. Thus, patients were perceived occasionally to be "*very difficult*", "*unfair*", "*hostile*" or "*abusive*" and staff reported that they and their colleagues were sometimes "*abrupt*", "*rude*" or "*not nice*", and would "*shout*" at or "*slap*" patients.

During the interviews at the MOUs many of the midwives complained of difficulties with the attitudes and behaviours of patients who used their services. At times this manifested itself through patients becoming "*very obstreperous*", "*rude*" or "*passing rude remarks*", whilst at others it generated conflict of a nature which was not explicitly specified or which caused difficulties for midwives.

Many of the problems with patients were perceived to stem from patients' unrealistic expectations of the MOUs and a lack of understanding of their own contribution and the patho-physiology of pregnancy. One midwife exclaimed "*they don't want to book, they come here with babies between their legs and they expect good results*". Another asserted "*they see those ambulances and they think that they are going to get good health*". One midwife at the Northern suburb MOU related how she had recently seen a woman who had brought her daughter in repeatedly over a weekend with pre-labour contractions and when told for the third time that she was not in labour, she became angry and demanded transport to Mowbray hospital. The midwife explained that this conflict had arisen from unrealistic expectations of the MOU, "*when they come here, you must not say she is not in labour go home... if they come here they must come back with a baby when they are discharged*".

Some midwives at the Northern suburb MOU explained their problems in terms of patients not understanding "*how the hospital works*". One example of this was relatives not understanding about visiting times and trying to visit patients at other times. Another example of this was reports of patients misunderstanding the motives behind particular lines of inquiry followed by some of the midwives, for example one related how a woman who came in labour had become angry with her when she was asking routine questions as part of her "*admission*" and went to sit in the corridor, where she refused to allow the midwife or her colleague to touch her and sometime afterwards gave birth. The midwife attributed her reaction partly to her being made crazy by the

pain but also to a lack of understanding about why she should have to answer the routine questions when in labour. Another midwife commented that patients sometimes were deliberately “*hiding*” their history from the nursing staff, in order that the staff should not know “everything of hers” without knowing “*how dangerous*” it might be to hide information.

Another example of patients misunderstanding the service was attributed to “*culture*”. A Sister gave the example of a midwife asking a woman with bleeding per vagina when she last had sexual intercourse. She explained that pregnant clients would often not want to answer such a question, and might think the Sister to be “*silly*” or “*rude*” by asking as the subject was “*sensitive*” or “*confidential*”. She explained that this sort of information was “*confidential*” in “*our culture*”, she continued “*they, according to our cultures, are not supposed to say a spade is a spade, you must say a spade is a fork*”.

Some midwives reported that they perceived that, at times, patients would go beyond hiding information to actually lying to them. Midwives at both the MOUs complained bitterly of patients who they said lied about having just come from Transkei or Ciskei when they came in in labour unbooked and of others who said they had no transport to get to Mowbray or Groote Schuur when they had just come to the MOU in a form of transport. Sometimes the nurses perceived this to be a Northern suburb survival strategy and they did not condemn women for it even if they commented that it made their work more difficult one way or another. For example, a sister said that when asked, patients would always deny that they had money because they would be worried that the staff were going to rob them and before the advent of free care they would give false addresses in order to avoid having to pay.

Several of the midwives reported that their work was made more difficult by patients who were “*cheeky*” and this was another apparent source of conflict. A Southern suburb midwife gave the example of young women did not do as they are advised and made contrary assertions, for example 16 year old who told the midwife “*I’m not going to breast feed*”, “*I’m not going to take family planning*”, “*I’m not going to do this...*”. At the Northern suburb MOU, a midwife explained that a patient who did not want to talk to nurses and tell them about, perhaps, a social problem would be considered “*cheeky*” and contributed to making her job “*tough*”.

Some midwives at the Southern suburb MOU explained that patients who were “*dirty*”, and in particular those who did not care about this, were also a source of “*frustration*”. Another problem which one midwife from this MOU reported with patients was that she did not feel appreciated. She explained “*its very seldom that once a mother is delivered she will thank you*” and as an aside “*we always have to remind them*”.

As well as being found sometimes “*difficult*”, some of the staff interviewed also criticised patients for being too passive with respect to the health services and unwilling to question things. Thus midwives reported that many patients would not ask why they were given a Caesarian Section, whether they could bring their husbands in to see a doctor with them, or question what a doctor or nurse said to them. As one Southern suburb sister explained: “*our people has not been schooled in the art of asking questions and you know, standing up for themselves type of thing, they just accept all the time, you know you are the nurse, you know better, its your word*”.

At the same time as complaining about some patients, many of the midwives in the MOUs complained about the attitudes and behaviours of some of their colleagues towards patients who used the services. Others gave examples of situations in which they themselves became “*frustrated*” and slap a patient or gave the patient a “*mouthful*”. Sometimes midwives perceived harsh actions of colleagues to be unjustified and attributed this to people having “*different personalities*” or “*bringing problems from home*”.

On other occasions it was perceived to be justified. Staff confirmed that there were several groups of patients who were said to be routinely “*scolded*” or “*given a mouthful*”; these included women who came in labour to the MOU after they had been transferred to Groote Schuur or Mowbray Hospitals, unbooked patients, and those whose babies were born before arrival as they had been told when they booked not to have the baby at home. In these situations the midwives felt justified in their actions because the patients risked unsatisfactory clinical outcomes or made the job much harder for the midwives.

Another group of patients whom a Southern suburb MOU sister said she would sometimes shout at were those who “*performed*” in labour i.e. acted in a manner which was not “*controlled*”, was “*uncontrollable*” or did not “*co-operate*”. She said that “*patients always end up saying ‘but that Sister’s rude’*”, but she explained that she was not being rude, just “*very direct*” and “*telling them what is expected, how it is going to be and what is expected of them in return*”. She explained that this was necessary in order to ensure a “*complication-free labour*”.

In the Northern suburb MOU some midwives explained how similar problems with women in labour could result in a midwife “*slapping*” a patient’s thighs in labour. For example, one Sister explained that during such deliveries, the midwife would be “*panicking*”, she explained: “*when you are conducting a delivery and you tell your patient to do this she does the opposite and when you say the patient must push, she must push and when you say OK don’t push breathe in and out [she must breathe in and out]...[if]I say pant she will just push, if I say push, she just breathes in and out*”. She exclaimed “*those are the things that make one to be furious*” and as a result you

may “*incidentally slap your patient on the thigh*”.

The midwives reported and indicated that the rudeness of colleagues impacted on the obstetric service as a whole in a variety of ways. It was described as being bad for relationships between colleagues as staff often indicated that they found it embarrassing. Whilst some staff would challenge those they heard had been rude, others found themselves trying to “*talk away*” or cover up for others who had caused offence. Another effect was that pregnant women would avoid particular facilities which they had heard had rude staff. This inconvenienced them as well as the staff members at the “*receiving*” facility. At the Southern suburb MOU a sister reported that pregnant women would sometimes go to Groote Schuur or Mowbray to try to book because of this. She added, however, that they would usually be referred back to the MOU anyway. Another sister spoke of women from the Northern suburb MOU, by-passing and coming to the Southern suburb to deliver complaining that they “*beat me down there*”.

As a result of being scolded, one Northern suburb midwife explained that patients became frightened of the midwives, which in turn caused its own problems. She became aware of this when she was testing patient's urine. She found it necessary to tell patients not to “*share the urine*” with others who cannot pass urine. She explained that patients did this because they were “*scared*” to say to the nurse that they could not produce urine, but this practice could endanger a patient's health.

They perceived that staff rudeness was quite widely discussed both by patients attending the services and in the community at large. Patients were reluctant to complain through ‘official’ channels, include a Southern suburb MOU suggestions box, but staff reported that one response of patients, which was also seen in participant observation, were patients, within the protected space of ‘*their*’ waiting area, talking about the staff in a manner deliberately designed to be overheard.

One of the most important consequences was that, as a result of prolonged conflict of this nature, particularly at the Northern suburb MOU, midwives but also those of the Southern suburb, perceived that they had become estranged and alienated from the community - if indeed they had ever been otherwise - and this became ever perpetuating. In the Southern suburb a midwife described how patients' expectations of rudeness could become a self-fulfilling prophecy; if patients came in with an “*attitude*” of “*I'm not going to let the staff tell me this*”; they would provoke staff “*resistance*” which could lead to “*a big fight*”. Similarly a Northern suburb MOU Sister asserted that patients hear in the community that the nursing staff slap them and so come in with an attitude that they are not going to accept nonsense from the staff and so when they come in they start “*to pass remarks*” and demand to be attended to immediately, thus provoking

conflict with the staff.

The alienation between nurses and local people was most graphically illustrated by a midwife at the Northern suburb MOU who spoke of her experiences in public transport. She said that she was “*watched*” when in her nurses uniform, “*even if you are in a taxi, in a transport, public transport like taxis, bus, train or whatsoever*”, and whenever there was a nurse around people would change their conversation to talk about the hospital. She exclaimed: “*they don't care about us... the community is having a bad attitude towards nurses*”.

4. DISCUSSION

4.1 Health seeking practices

The women indicated that in most cases they recognised they were pregnant after their first or second missed period and many confirmed their pregnancy in the first or early in the second trimester. The women who were more experienced with pregnancy, did not want the pregnancy, were in rural areas at the time or who looked for other pregnancy signs such as kicking, tended to confirm their pregnancies and book later. The reasons for delaying booking were often complex, but the study showed that women were uncertain about when they should book. The Northern suburb Day Hospital appears to have played a role in delaying booking as several women were told they were not pregnant after tests there and so had to seek confirmation elsewhere; others were given very different messages about when they should attend the MOU. This suggests that the services need to develop a clear policy on the timing at which they want to encourage booking and to communicate it to all staff at clinics and Day Hospitals and that the midwives at the MOU should tell women in an effort to improve the level of information about this in the community. The pregnancy testing process at the Northern suburb Day Hospital should be reviewed to discover why women are being given incorrect results.

The main factors associated with late booking in this study were broadly similar to those which have been reported by other authors (Larsen & van Middelkoop 1982; Pattinson & Roussouw 1987; Hamilton et al 1987; Mphlanga 1985; Van Coeverden de Groot & Howland 1988). By following women over the period of their pregnancies it was possible to see that these influences were roughly weighed up by the women against their perceptions of benefit to be derived from visits in making decisions about whether and when to attend. Although some authors (Chalmers, 1990:35; Loening & Broughton 1985; Westaway 1994) have asserted that women lack knowledge of the benefits of antenatal care, this study suggests that the problem is more complex. Many of the women regarded as antenatal care beneficial, apart from its role in avoiding scolding and neglect when they arrived in labour unbooked, but they differed substantially in their perceptions of how much antenatal care is needed and at which stages. Here the perceptions of the women in fact mirror, although obviously are not informed by, debates which have been in progress in obstetric literature.

The study has shown that the women's own needs were not met by the service as they were given very little information and this undoubtedly contributed towards ambiguous views on the value of antenatal care. The importance of meeting women's perceived needs in gaining satisfaction with service provision is illustrated by the Southern suburb MOU and the rural hospital women's use of private practitioners who they knew would prescribe when they were sick and the Northern suburb women's use of Dr John of Belville who gave them liquid medications which they perceived to be *'protective'*. Attendance might be improved if women's own perceived needs for

information were met. The findings suggest that these include being told when they will deliver (with ultrasound confirmation where this is quite unclear), being reassured actively about the baby after each palpation, and being individually reassured about negative test results in order to highlight the importance of knowing that everything is fine as well as detecting problems.

The other factors associated with late booking and missed visits were the Northern suburbs booking system, difficulties with child care and staff patient relationships in the clinic, which often made attendance an unpleasant experience. Alternative ways of organising booking at the Northern suburb MOU must be investigated so that patients do not need to attend the clinic so early in the morning. Women need to be informed that they can bring their children to the antenatal clinic if it is impossible for them to find child care, although this would not be encouraged for everyone. Attention is needed to improving staff patient relationships so that the experience of attending the obstetric services at an interpersonal level is a pleasant one.

4.2 Use of indigenous healing practices

The discussion of Xhosa indigenous healing practices suggests that there is considerable overlap between these and ideas of bio-medicine. At a general level pregnancy in both systems is regarded as a time of vulnerability and unpredictability and both recognise the need for preventative measures to be taken by asymptomatic women. The findings suggest that use of indigenous medications for 'protection' of the pregnancy and treatment of infants is common. Indigenous healers and medications in most cases were used in a manner which was complementary to, but not a substitute for, use of biomedical services, although several women indicated that in rural areas where access was poor they would be used instead. The only possible exception was the young unbooked women who took medicine for protection whilst not attending antenatal care, however it was not clear in the interview that she consciously regarded it as a substitute. Some of the women consulted with traditional healers when they had symptoms which the clinic did not offer relief with. The women and healers indicated ingested substances, taken in small quantities, formed only a part of the repertoire of treatments and there was some evidence of success of clinic strategies to encourage women to use non-ingested treatments at least for their baby.

None of the Southern suburb MOU and rural hospital women indicated that they perceived the MOU or Hospital to be their first point of call when experiencing ailments in pregnancy, with the exception of the symptoms of vaginal bleeding. This partly stemmed from experience that most midwives were disinterested in women's minor ailments, but also because women were unimpressed by the reluctance of obstetric service providers to dispense medications. The accounts of self-medication by the women indicate that a considerable range of products are taken during pregnancy and after childbirth. Many of the women mentioned that pregnant women

should be careful about medication use and it is notable that Versterk Druppels was the only Dutch remedy used during pregnancy, although this was largely because their use, like that of herbs, was for treating indigenous problems, particularly the ‘10 day attack’ and womb dirtiness, which affect women after birth. In view of the evident commonness of their use, it is important that researchers investigating the pharmacological properties and side-effects of indigenous herbs also include Dutch remedies.

4.3 Sterilisation

Many women said early in the pregnancy that they planned to be sterilised after the birth but most changed their minds later on. The interviews suggest that they developed concerns about the procedure which were not addressed by the staff as after the initial ‘*motivation*’ the subject was not addressed. This highlights the need for staff to discuss sterilisation with women who agree to it on repeated occasions during the pregnancy so that new concerns which may have emerged can be addressed. Although only one of the Northern suburb women interviewed was sterilised, the fear of general anaesthetic emerged strongly. It is possible to speculate that this fear may be held more widely and may contribute to a reluctance to go for sterilisation. Family planning motivators need to be aware of this as a possible problem and Mowbray Anaesthetic Department might consider greater publicity of the use of epidurals, which all the women having operations at Mowbray in this study had, if this is common practice.

4.3 Perceptions of quality of care

The women’s accounts suggest that, with a couple of exceptions, most women delivering at the Southern suburb and rural hospital were generally happy with their experiences of childbirth and perceived that the most important staff they came across was “*nice*” to them and very helpful. Women’s perceptions of quality of care at the Northern suburb MOU were quite different and were shaped by experiences of poor staff patient relationships, although the women indicated that not all staff treated them badly, and that some staff did not do so all the time. The findings indicate, however, that in all the facilities studied patients experienced verbal abuse in the forms of shouting, scolding and general rudeness. Notably at the Northern suburb MOU they also encountered a lack of respect from staff, in general, and of their autonomy, in particular and arbitrary acts of unkindness perceived as bordering on cruelty, physical violence, and neglect. The patients resisted this treatment in a variety of ways, but most avoided direct confrontation and did not complain to staff at the time or afterwards as they feared even worse treatment. The study has shown that as well as being unpleasant these practices of the staff put patients at risk as they contribute towards late booking and difficulties during delivery.

International studies have also demonstrated the importance of poor staff-patient relationships as barriers to access to care (Lazarus 1994; Eades 1993). Such studies also indicate that many of

the problems described in the PMNS can be found in reproductive health services in many other countries and examples include services for poor women in the USA (Lazarus 1994); North India (Jeffery *et al* 1989), Morocco (Mernissi 1975), Jamaica (Sargent & Bascope 1996), Ghana (Eades 1993) and Tanzania (Gilson *et al* 1994). It also appears that these problems are found, not only in other parts of the Western Cape (as illustrated by rural hospital) but in many other parts of South Africa. Recently investigations in Gauteng (Fonn 1995) have highlighted very similar problems and, in late 1997, the local media in Durban highlighted a case of neglect of a labouring women by midwifery staff (Moloney 1997). Several recent studies (e.g. Wood 1997: Northern Province; Mathai 1997: Eastern Cape; Stadler 1997: Northern Province, and Abdool Karim 1992: Kwa-Zulu Natal) suggest that such problems are widespread in South African reproductive health services. The apparently extreme commonness of various forms of abuse in staff patient relationships should not be taken as an indication that such practices are accepted and acceptable. Improving staff patient relationships should be a high priority for managers of the local service and for those concerned with nursing in the country as a whole. The findings suggest that interventions on several fronts are needed to improve staff patient relationships and that action is needed locally from the service managers as well as from other Departments of Groote Schuur, the Departments of Health, Nursing Colleges, DENOSA and the Nursing Council.

In some cases women are abused because they constitute patient groups which the staff apparently perceive as '*morally deviant*', for example pregnant teenagers. This problem is related to constructions of the professional roles of nurses which may be influenced by historical factors. It is interesting to note that the South African nursing historian Shula Marks argues that from the "*earliest days*" African nurses were taught that they *were* "*to moralise and save the sick and not simply nurse them*" (1994, p.208). It also reflects a lack of respect for patient autonomy. The study findings suggest that nurses need reorientation through workshops to redefine their professional roles in ways which respect patients' autonomy and does not include a duty or right to judge or attempt to correct patients. The Departments of Health, Nursing Colleges, DENOSA and the Nursing Council need to reflect on their roles in shaping and changing professional attitudes, particularly as the reports of this from other parts of the country, suggest that the problem is widespread and thus is likely to be rooted in patterns of training and leadership given to the profession as a whole. Nursing educators should review the extent and manner in which emphasis is placed in nursing training on the need for staff to respect patients and their knowledge in their daily lives irrespective of their age, poverty, cleanliness, sexual practices, illiteracy, or level of bio-medical knowledge.

In some cases patients experience abuse in an attempt by nursing staff to correct '*deviant*' behaviour which they perceive as endangering the woman or baby or as placing unnecessary demands on staff. In these cases it is not necessarily what they try to do that is the problem but

the manner in which they do it. The study suggests that some staff may have poor communication skills and that communication is made more difficult by gaps in many patients' knowledge and failure of information provided by the clinic to fill these. Three pieces of evidence suggest that poor staff patient communication is more than a problem of lack of skill and in part derives from a perception that patients are not 'worth' the time and effort of proper explanations. These are the observations from the interviews and participant observation that better educated patients receive more information and are treated better; the anecdotal evidence that staff behave differently towards patients in public and private settings; and the characterisation of many patients by staff as "*stupid*" or like children.

These attitudes need to be changed through workshops. Training should be provided for staff in communication where there is evidence of difficulties and the Nursing Colleges should make arrangements for communication skills to be included in nursing curricula where this is not already the case. Staff should be shown strategies for dealing with difficult situations effectively and politely and helped to understand the potential for reducing the overall levels of conflict through good communication, for example by explaining why they tell women not to push early so that women do not just assume that they are uncaring and prolonging their suffering. The education given to patients in the clinic needs to be carefully revised and in particular more information is needed about pregnancy and delivery and how women should look after themselves and full explanations about procedures the clinic and labour wards. The long waits which women have in the clinic could be better used for educating patients, particularly if modern technologies, for example videos were used. The services should investigate whether special funding or sponsorship might be available to install videos in the antenatal clinic waiting area and whether information videos are available or could be dubbed into African languages. They should also consider introducing a 'tour' of the delivery areas with explanations of procedures for booking mothers. The Department of Health nationally should fund the development of information videos on pregnancy and delivery in all national languages which could be used in clinics.

Some of the practices reported in the Northern suburb MOU need to be dealt with very firmly by management as they are essentially unprofessional and indeed infringe patients' constitutional rights. The observation that staff were prepared to discuss in interviews their own practices of beating patients (Jewkes et al 1997) suggests that they perceive a culture of permission as regards assault of patients in the Unit. Staff need to be told that the use of physical violence on patients is unacceptable and staff who do so should be disciplined and reported to the Nursing Council. This needs to be coupled with specific training to manage the situation in which beatings are most common, which is when women panic during delivery and close their legs through communication and encouragement. The interviews with midwives (Jewkes et al 1997) confirmed patients reports of this in these circumstances. Disciplinary action should be taken by staff who

engage in arbitrary acts of cruelty such as telling patients to clean up their own mess. Identifying such acts will be difficult for management as the study findings indicate that patients are very reluctant to complain as they fear further bad treatment. These practices need to be identified through closer observation and monitoring of labour ward by senior staff and by creating a climate in which staff want to distance themselves from colleagues who abuse patients by reporting them. Such staff may need to be protected from possible victimisation. From discussions with colleagues from around the country, the use of physical violence by midwives is widespread. The Nursing Council should investigate this and send a clear message to the profession that they will take firm action against those who do so and the Nursing Colleges need to ensure that these are not incorporated into student midwives' repertoires of practices through seeing them as 'normal' during their socialisation in Units.

The reports of neglect of women in labour in the Northern suburb MOU are of great concern. Although the MOU system has made a major contribution to reducing peri-natal mortality in Cape Town, it seems likely that eventually avoidable deaths will occur if women continue to deliver in the facility unattended. Although some women indicated that the MOU was very busy on the night they had problems, the perceptions that staff were "*chatting*" or "*sleeping*" rather than caring for them need to be investigated. Managers should be investigating the circumstances of some of the women who deliver on their own or in corridors or toilets in order to identify what went wrong and how it can be prevented in future. If patients report of neglect whilst staff sleep are found to be true the staff involved should have action taken against them.

A notable difference between the narratives of delivery of women from the different units was that at the Southern suburb and the rural hospital, in most cases, women reported perceiving that they were ready to push, calling staff and the staff immediately made ready to deliver the baby. In the Northern suburb MOU, women reported often being ignored or told they weren't ready without being examined. Staff in the Northern suburb MOU need to undergo some form of reeducation process in which they are taught to listen to patients more carefully. The study findings suggest that the problem here may lie more in negative attitudes towards patients and perceptions of their "ignorance" than in a need for clinical retraining.

It is important also to say that there were indications in many of the narratives that the reported neglect was often perceived rather than outside the bounds of professional good practice. The perceptions often reflected the anxieties and lack of knowledge of first time mothers and the impatience of a woman suffering severe labour pains. These problems were aggravated by the midwives' impatient attitudes and (as women perceived it) rudeness towards them when they expressed concerns or asked for help. They may have been considerably alleviated if women had instead been given explanations, reassurance and (where possible) offered pain relief.

Another important difference between the MOUs was that at the Southern suburb MOU there was far greater communication between staff and patients, many of the staff were friendlier and so encouraged communication, there were more personal explanations and discussions, more one-to-one health information was provided, the staff used bio-medical language with patients in a way which empowered them, and staff listened to patients' reports of changes in their bodies, particularly in labour. The women from the Southern suburb MOU had far more bio-medical knowledge than those from the Northern suburb MOU and the interviews suggest that this was contributed to by the midwives giving full explanations of what was happening. One consequence of the improved communication was that women at the Southern suburb MOU had a much clearer idea of what was happening around them, a much greater level of acceptance that the procedures were necessary and a greater dependence on bio-medical care than the women of the Northern suburb MOU. In some respects these factors made the midwives' work easier, which also helped to reduce tensions and conflict. The Southern suburb MOU is an example of a service which is working reasonably well for women, although there is obviously scope for further improvement, and this clearly indicates that change is possible at the Northern suburb MOU .

4.5 Education of patients

The study suggests that education of patients was perceived by staff as one of the most important tasks at the Northern suburb MOU as safe pregnancies and delivery require patients to monitor their own bodies and to take appropriate action in response to changes they perceive. Midwives face two challenges in educating patients, which should be regarded as equally important. The first is to provide sufficient information to enable a safe pregnancy and delivery and the second is to meet patients perceived needs for information as in doing so antenatal care will be perceived by patients as more worthwhile.

The educational talks at the Northern suburb MOU antenatal clinic emerged as the single most important source of information for pregnant women, apart from personal experience (where available). Communication among lay networks about pregnancy was found to be very limited, as it has been found by other authors (for example Wood 1997) about sex and menstruation. Women's narratives suggest that, possibly because of their limited bio-medical knowledge, women were usually regarded by the staff as 'ignorant'. Many women, however, had considerable experiential knowledge from previous pregnancies and particularly disliked midwives' failure to acknowledge this and use patient knowledge as well as their own in decision-making. The findings also suggest that in many cases this results in poorer decision making by the midwife. As well as recognising the tremendous importance of their educational role, midwives also need to develop greater respect for patients' own knowledge and to use that to help them make better clinical decisions.

Although most of the Northern suburb MOU women interviewed could not remember the danger signs, many of them indicated that they interpreted the message generally in terms of reporting to the clinic should anything unusual happen and several said they had made extra visits later on in pregnancy. Dissatisfaction was often expressed with their reception at the MOU when they did so if the midwives did not agree that they were in labour or did have a problem. This was manifested in complaints about confusing messages. Women at the Southern suburb MOU also reported unhelpful attitudes from staff when they attended after hours with something which was perceived not to be serious. Staff need to be made aware of this and consider very carefully how they respond to women who come in these situations as it could seriously undermine their educational strategies and discourage women from attending again when they have important problems. The particular issue of attendance when “*not in labour*” could be alleviated by improving the information given to patients about how to recognise labour and how to recognise when labour becomes established to the point that women should attend. None of the women indicated that they had been given any information about observing the frequency of contractions.

Several specific gaps in the information provided were identified by women (discussed above) in addition the need to demonstrate breast feeding to new mothers and ensure suckling is established before they leave hospital was highlighted. Many of the gaps identified by some women were described as information which had been provided by others, for example about pains when the baby turns. This may suggest that women’s experiences of information depends considerably on which midwife they see or which talks are given that day. It equally may reflect differences in recall. None the less this suggests that certain key areas of information need to be identified and reinforced repeatedly to pregnant women. None of the women reported having been given information about labour and delivery and many of the anxieties and problems which occurred could have been minimised if they had been. The staff need to consider patient management strategies which enable them to provide as much information as possible to women during labour to reassure them and prepare them for delivery.

At the rural hospital the lack of privacy in the consulting area severely impeded patients from asking about sensitive subjects and the interrogational approach to history taking frequently resulted in this interaction becoming fraught with conflict which negated any educational possibilities. The women from farms usually spent the whole day at the antenatal clinic and there was no evidence of the opportunity of having them present being taken to provide them with general health information. The interviews suggested that many would have benefited from this.

4.6 Aspects of the service in labour and delivery

The northern suburb MOU, unlike Groote schuur and the Southern suburb, did not allow women

to have birthing companions. The women were specifically asked about having a companion with them during labour as having a companion in labour has also been demonstrated by the Cochrane Centre reviews to significantly improve birth outcomes. The women mostly indicated that they did not want their male partners to be there but there was support for being allowed to have a woman with them. In view of the proven effectiveness of this as an intervention and the perceptions of staff in other parts of the service that it makes their job easier (see Jewkes & Mvo 1997) this change should be introduced to the MOU.

Complaints of pain were, perhaps not surprisingly, dominant features of the women's narratives of delivery. Few of the women were given any pain relief, even when they attended early in labour, and those who were given injections were given a 'one off' which would not have been part of a concerted strategy to reduce pain in labour. This suggests that the MOUs should review their pain relief policies as some women could clearly be offered relief who are not being given anything at present. Providing effective pain relief might also make the staff's work much easier.

The study also highlighted the additional problems faced by the poorest women who use the service, for example in making small additional purchases of food after delivery and materials for cord care. Staff need to be sensitive to this and offer additional assistance to women who do not have the money for food and materials.

Information on contraception appeared to be unsatisfactory. Most of the women suggested that they had not been given much choice of method, did not always know when they were supposed to have their next injection and in rural hospital did not always appear to have given their consent. Contraceptive policy needs to be reviewed to ensure that women are not coerced into accepting a method which may be unsuitable for them. This is particularly important in view of the alarming proportion of unplanned/ (at least initially) unwanted pregnancies in the study.

4.7 Staffing and workload

The staffing levels information presented in this report did suggest that staff at the Northern suburb MOU had a heavier workload than those at the Southern suburb MOU. The comparisons were fairly crude, but need further investigation, particularly after changes to the Northern suburb MOU workload since the study finished with the opening of a new MOU in the area. Since important problems have been identified with the Northern suburb MOU service it is very important that management is also seen to be even handed in staffing allocations and to take seriously staff perceptions that their workload is heavier in that MOU. The study findings so also suggest that the job of the staff is harder there as the levels of bio-medical information are so low and staff perceive that their ambulance and flying squad support services are often very slow in responding.

5. CONCLUSION

The MOU system in Cape Town has been responsible for dramatic and sustained reductions in peri-natal and maternal mortality amongst women delivering in the services. Notwithstanding this, many patients still use the services in ways which would be considered medically sub-optimal. In trying to understand why this occurs, this study has highlighted the importance of investigating patients' perceptions of quality of care. It has identified serious problems with staff patient relationships, particularly at the Northern suburb MOU, which need to be addressed as a matter of urgency since they make many women's experiences at the MOU highly unpleasant, discourage women from attending early and create situations of risk during delivery. A multi-dimensional approach is needed to solve these problems, involving national institutions as well as local ones. Many of the problems which arise in the MOU stem from negative attitudes of staff towards patients and their social worth, a culture of permission of violence in the Unit, insufficient and inappropriate emphasis of patient education and poor communication between staff and patients. These findings contrast markedly with the reports of the Southern suburbs MOU which is a well established and well functioning service, although staff patient relationships here also demonstrated room for improvement. At both units, patient education emerged as an important area which needs to be revised.

6. RECOMMENDATIONS AND ACTION PLAN ARISING FROM THE STUDY OF HEALTH CARE SEEKING PRACTICES OF PREGNANT WOMEN IN CAPE TOWN : 14 AUGUST 1998

RECOMMENDATION :	AGREE / DISAGREE	RESPONSIBILITY	TIME FRAME
BOOKING AND ANTENATAL CLINICS			
1.1] Booking arrangements be revised so that women attempting to book are not turned away.	Agree	Nursing management	Already implemented.
1.2] Blood tests be undertaken in their respective day hospital laboratories	Not currently feasible, no facilities at present		Long term planning
2.1] Staff should be encouraged to provide more support when patients complain of minor ailments even if there is not much which can be done about them.	Agree	- support is given & more attention is being given for minor ailments. Staff perception is however that patients are dissatisfied & expect to get 'medicines' whenever they attend clinics.	
2.2] ***At booking visit all women should have a palpation as well as history and investigation.		Responsibility : Community obstetrician, nursing management. Already being implemented. It is necessary to improve access to ultrasound services for patients.	
2.3] The possibility of providing facilities at ANC's so that women can bring their children to the clinic if they cannot arrange childcare should be investigated.		Agree in principle but currently impractical due to lack of staff and space. Responsibility : Admin & possible NGO funding of project. Women already bring their children to the clinic, but no facilities are available. This system to continue.	
2.4] The organisation of the ANC should be reviewed so that staff can interview patients in private.	Agree	Nursing management.	Already implemented.
3.1] The services should develop a clear policy on the timing at which they want to encourage booking and communicate this to all staff at MOU's & CHC's. The level of information about this should be increased in the community.	Partially disagree.	Such a policy is in place, needs to be better disseminated in the community and positively encouraged by the MOU's. Responsibility: Nursing management & CME, community liaison and district health forums. Long term planning.	
3.2] *** The booking system at the MOU's should be changed so that women can book anytime during the morning at the MOU's.		Morning bookings allow for blood tests to be sent and results received on the same day. Already implemented.	
3.3] Explanations about blood tests and other invasive procedures be given before they are undertaken.	Agree	Community obstetrician, Nursing, guideline circular for patients and follow-up. Short term. Patient circular is currently being revised by obstetrics and nursing.	
3.4] *** The MOU's and ANC's should be made more welcoming to teenagers.		Community obstetrician and nursing need to investigate the possibility of training some midwives as teenage counsellors. Long term planning. NGO groups who assist with crisis intervention are already helping with counselling of patients at the MOU's.	
3.5] ***MOU services need to build greater understanding by staff of women's perception of 'strengthening' during pregnancy and to respond to this need.		Already occurring.	

HEALTH EDUCATION

1.1] Arrangements for health education need to be reviewed and more effective approaches explored. Materials used need to be commensurate with levels of patient literacy.	Agree	Nursing to liaise with Health education and Adult education experts. Long term - already partially implemented. Use is being made of NGO's to supplement nursing staff teaching / education.
2.1] Health promotion should be reviewed in the clinic so that information about what to expect in labour and childbirth can be provided for primigravidas. Smoking cessation advice should be reviewed and the incorporation of information on nicotine replacement should be investigated.	Agree	Needs improvement. Already implemented. Patient leaflets are being revised.
2.2] Ways of encouraging women to confirm their pregnancies earlier should	Disagree	Pregnancies frequently seem to be confirmed in the private sector. This facility needs to be investigated. be improved in the CHC's and MOU's. Responsibility : MS to liaise with CHC. Short term.
2.3] The provision of health education to women from the farms who wait considerable periods of time in the ANC should be investigated, particularly the use of videos.	Agree	Already implemented, need more video machines and access to shared resources such as video libraries. Responsibility : Nursing and MS.
3.1] The education given to patients in the clinic should be revised and women should be given more information about pregnancy and delivery and how to look after themselves with full explanations about procedures in the clinic and labourwards. A "tour" of the delivery areas with explanations of procedures for booking mothers should be introduced.	Agree	Nursing + health education. Long term. Patient education leaflets are being revised. 'Tours' of the MOU's prior to delivery are being implemented.
3.2] Services should investigate whether special funding or sponsorship is available to install video's in the ANC waiting area and whether information videos are available or could be dubbed into African lang's.	Agree	Nursing + health education. Already in place but video's and TV's are frequently broken. Long term.
3.3] Staff should identify key areas of information needed by women & reinforce these repeatedly to pregnant women. Practices such as breastfeeding should be demonstrated and women should not be sent home before the baby is suckling properly.	Agree	Nursing + health education. Breastfeeding is already promoted. Babies not suckling are not sent home but referred ie. already being done.
3.4] Education at the MOU should be revised to include full explanations about why ANC is important, to ensure that all women are told when they will deliver (with ultrasound confirmation where this is unclear), are reassured about the baby after each palpation and about neg. test results in order to highlight the importance of knowing that everything is fine as well as detecting problems and asking about other concerns.	Agree	Routine ultrasound is unaffordable at present at the MOU's. This service needs improvement and additional funding. Responsibility : MS and community obstetrician.

CARE IN LABOUR & LABOUR WARD

1.1] Encouraging women to be accompanied in labour.	Agree	Nursing. Already promoted, but dependant on patients wishes. Policy is to encourage birth companions. Patients are informed from booking.
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| 2.1] Policies on pain relief should be reviewed and many more women should be offered this. | Agree | Policies on analgesia in labour need research and review. Staff have been reminded to document patients choice. Responsibility : community obstetrician and nursing management. |
| 3.1] Staff should be trained in ways of managing deliveries of panicking patients using communication rather than beatings, when it appears that lack of training is a problem.
ASSAULT OF PATIENTS IS UNETHICAL, ILLEGAL AND CONTRARY TO THE NURSING AND MEDICAL CODE OF PRACTICE.
ASSAULT WILL BE SUBJECT TO DISCIPLINARY PROCEEDINGS BY NURSING AND HOSPITAL MANAGEMENT. | Agree | Nursing, group discussions. Short term. |
| 3.2] Specific cases of women who deliver on their own or in corridors or toilets must be investigated in order to identify what went wrong and how this can be prevented in future. | Agree | Nursing management. Already implemented. |

AMBULANCE SERVICE DELAYS AND DIFFICULTIES

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| 1.1] Complaints about ambulance services should be investigated. | Agree | Community obstetrician, head of 2' and 3' units. Already implemented.
Communication has improved. |
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SECONDARY AND TERTIARY LEVELS OF CARE

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| 1.1] Staff at 2' and 3' level be made aware of the problems which patients face in access to their services so that this is taken into consideration when suggesting patients make return visits. | Agree. | Already implemented. This is the reason why 2' and 3' doctors visit MOU's to see sick patients. |
| 1.2] Avoid frustrations caused by folders being mislaid on return of patients referred from MOU's to 2' or 3' level e.g by patient being given her own folder to return to the MOU or a patient-held record. | Agree | Already implemented and patients carry cards. |
| 1.3] MOU's keep copies of essential details of pregnant women after they have been transferred to 2' or 3' level so that MOU staff have some information should these women return later in advanced labour. | Disagree | Not necessary as patients already carry own cards. |
| 1.4] Communication within 3' level about the operations of the MOU ANC's be improved. | Disagree. | Unsubstantiated : communication problems are regularly addressed and staff are orientated to all levels of the obstetric services. |
| 1.5] Unhelpful responses of doctors to midwives from MOU's trying to refer patients to 3' level must be addressed. | Disagree : | Unsubstantiated. Addressed as above. |
| 3.1] Women should not be transferred to other hospitals without explanation unless they are unconscious. | Agree | Nursing - already implemented. Staff have been reminded to inform families of patient transfers. |
| 3.2] Staff at 2' and 3' level should be made aware of transportation problems and consider keeping patients longer for observation to minimise turning women away who go into established labour later in the day. | Disagree : | Staff are expected to take into account transport problems for patients. Strict protocols on the management of patients are in place at all levels of the service. Protocols for discharge of patients at primary level at the MOU's have been revised. Responsibility : Nursing manage. |
| 3.3] Staff at 2' and 3' level should be made aware of the patient who delivered at home because she was turned away. This could have been prevented if the staff had asked the women directly whether she thought she was in labour. Patients who think they are labour should not be | Disagree : | Already implemented as above. |

sent home without a full examination.

3.4] Women attending 2' and 3' level care should be given more information about investigations.

3.5] *** The anaesthetic departments should consider giving greater publicity to the use of spinal anaesthesia for sterilisation and c/s, as this is very reassuring for women who fear general anaesthesia.

Disagree - already implemented. Responsibility : medical and nursing staff. Patient information leaflets are currently being revised. Sharing of information needs constant reinforcement.

Agree. Medical staff and nursing management - to be included in health education. Short term.

COMMUNICATION WITH THE PRIVATE SECTOR

1.1] Communication with GP's about the operation of the obstetric services should be improved.

Agree

Obstetrics department, community obstetrician and nursing management. Written circular should go out regularly to local GP's (?via the 'Cape Doctor') and information should be included in GP refresher courses.

STEPS NEEDED TO BE TAKEN WITH OUTSIDE GROUPS

3.1] *** CHC's should promote better early pregnancy test services and review procedures to discover why women are being given incorrect results.

Agree. The method of pregnancy test used at CHC's needs to be investigated as some methods are apparently outdated and ineffective. Responsibility : MS and community obstetrician to liaise with CHC's.

CONTRACEPTION AND STERILIZATION

2.1] Contraceptive information and arrangements should be reviewed, particularly those for sterilisation, to ensure that women are given a genuine choice and that previous problems (which often led to pregnancy) are taken into account in the advice given. Sterilisation at an interval after birth an be arranged and women who seem keen to be sterilized are encouraged to take up this option..

Agree

Already implemented.

2.2] Managers should ensure that staff do not give contraceptive injections to women without informed consent.

Agree

This is a major problem in the obstetric services and requires much attention and improvement. Nursing management and community obstetrician to liaise with family planning advisors at the MOU's and CHC's. Staff should be reminded about alternative choices and methods. This issue should be raised at the PAWC maternal and womens health units.

STAFF TRAINING WITH RESPECT TO PATIENT CARE AND COMMUNICATION

1.1] Reorganize activities in the MOU's so that care is provided in a patient-centred manner

Agree, if more staff are available.

1.2] *** Need to improve staff training in order to build staff respect for patients & focus on patient care, respect and clinical outcomes rather than completion of tasks.

Agree. Responsibility : community obstetrician and nursing management.

1.3] Nursing management give priority to giving positive affirmation when it is due and effective communication over policy changes.

Agree, improved staff support is needed.

1.4] Communication between staff and patients across languages be addressed.

Agree. Funding for interpreters is needed and interpreter posts should be built into the

<p>Where possible staff and patients should share language and where not, proper interpreting arrangements should be made.</p>	<p>establishment of each unit.</p>
<p>1.5] A policy of encouraging training in African languages should be adopted.</p>	<p>Agree, National Language Project (NLP) is already implementing this, long term.</p>
<p>2.1] Management should reinforce to staff that they should not be scolding patients and should reward staff who do not do so. There should be immediate correction of staff who are heard to shout at or scold patients, backed up by disciplinary action for those who refuse to change their practice.</p>	<p>Agree, Nursing management and Head office. Positive reward and incentive systems should be explored.</p>
<p>2.2] Staff should be encouraged (if necessary through further training in communication skills) to increase the amount of information given to patients during exams especially reassurance of normality, and made aware that patients usually want more information than they ask for and may be shy to ask for this.</p>	<p>Agree, Nursing management and Health Education. Long term.</p>
<p>2.3] Staff should be encouraged to improve their listening skills.</p>	<p>Agree, Nursing management and Health Education. Long term</p>
<p>2.4]*** Biomedical ethics workshops should be held to redefine midwives' professional roles in ways which respect patients' autonomy, dignity and knowledge and does not include a duty or right to judge or attempt to correct patients.</p>	<p>Partly agree, workshops needed to assist midwives to cope with stress, patients demands, and nature of equity.</p>
<p>2.5] Staff should be informed of management's determination to eradicate verbal abuse of patients from the obstetric services and management should take appropriate action to indicate that they are serious.</p>	<p>Agree. Nursing management. Already implemented and ongoing attention needed.</p>
<p>2.6] Closer management of ANC's and labour ward should be instituted in order to identify bad practice and staff should be encouraged to report colleagues who they hear abuse patients. Such staff must be protected from possible victimisation.</p>	<p>Agree. Nursing management. Already implemented and ongoing attention needed.</p>
<p>3.1] Training should be provided for staff in communication skills and staff should be shown strategies for dealing with difficult situations effectively and politely and helped to understand the potential for reducing the overall level of conflict in the MOU through good communication.</p>	<p>Agree. Nursing management. Ongoing issue - communication skills workshops are needed.</p>
<p>3.2] Staff should be given additional training in the provision of explanations, reassurance and pain relief for women in labour in order to reduce anxiety. Training should include consideration of the extent to which women's own knowledge of their bodies should be incorporated into their clinical practice so that assessment of time of delivery is not so much based on midwives examinations.</p>	<p>Agree</p> <p>Disagree - strict protocols for clinical management of patients are in place.</p>
<p>3.3]*** Staff should be made aware that they are perceived to be giving confusing messages in ANC's about when women should present with "labour" or problems. They should consider carefully how they respond to women in this situation & women should be given more information about observing the frequency of contractions.</p>	<p>Partially agree - Patients are educated about the signs of labour but often arrive in very early or 'false' labour - already implemented. Need to provide longer waiting areas in MOU's for mothers in early labour.</p>
<p>3.4] Staff should be reminded of the particular difficulties of very poor women at the</p>	<p>Partially agree - Staff do understand these specific needs and food is provided.</p>

MOU and food should be given after delivery to patients who have no money to buy their own food.

- 3.5] Staff should be made aware of the importance of small gestures, particularly of appreciation of the baby and these should be encouraged.
- 3.6] Efforts should be made to offer explanations in the patients own language, even to women who appear to speak quite good English.

Limited to cereal/bread and soup. Long term patients eg. photo therapy mothers encouraged to bring their own supplies. Need to further investigate the availability of social work assistance and funds.

- Agree. Staff are encouraged to maintain a professional attitude at all times. Already implemented.
- Agree. Already implemented where feasible.

STAFF ALLOCATIONS

- 1.1] Staff allocations be reviewed to ensure equity between MOU's
- 1.2] Dissatisfaction over study leave and rotational arrangements in the services should be investigated further.

Agree. Nursing and medical administration. Note limitations due to budgetary constraints. Rotations are already under review by nursing management. The rotation of staff through different units should be investigated.

DISCIPLINARY ACTION AGAINST STAFF

- 3.1] Staff should be told that the use of physical violence on patients is unacceptable and staff who do so should be disciplined and reported to the Nursing Council. Disciplinary action should be taken against staff who engage in acts which degrade patients.
- 3.2]*** Reports of staff neglecting patients should be investigated and action taken against such staff.

Agree. Nursing management and Nursing council. Ongoing measures are already enforced.

Agree. Responsibility : nursing management. Ongoing measures already implemented. Staff are reminded to act in a professional manner at all times.

RECOMMENDATIONS TO THE DEPARTMENT OF HEALTH OF THE WESTERN CAPE PROVINCE

- 3.1] Liase closely with Groote Schuur Hospital and the management of the MOU services to ensure that action is taken on the recommendations of this report.
- 3.2]*** Staffing norms for midwife obstetric units need to be workshopped, agreed upon and implemented.

RECOMMENDATIONS TO THE NATIONAL DEPARTMENT OF HEALTH:

- 3.1] It should consider the provision of biomedical-ethics workshops more widely for staff in other parts of the services in the country.
- 3.2] It should fund the development of information videos on pregnancy and delivery in all national languages which could be used in clinics.
- 3.3] It should liase with the Nursing Council and Nursing Colleges to discuss their roles in improving staff patient relationships.
- 3.4] Establish a national working party of staff-patient relationships including representatives of the professional bodies, services, nurses, provinces and researchers to investigate strategies for improving relationships. Disagree, the existing maternal, child and womens health units at provincial and national level should be better utilized. .
- 3.5] *** Staffing norms for midwife obstetric units must be workshopped, agreed upon and implemented.

RECOMMENDATIONS TO THE NURSING COUNCIL AND NURSING COLLEGES:

- 3.1] That they review their roles in shaping and changing professional attitudes including the extent and manner in which emphasis is placed in nursing training and through professional discourse on the need for staff to respect patients and their knowledge at all times irrespective of their age, poverty, cleanliness, sexual practices, illiteracy, or level of bio- medical knowledge and the importance of not judging patients.
- 3.2] Communication skills should be introduced into the curriculum of all nursing colleges and in-service training in communication be introduced.
- 3.3] The Nursing Council establish a national inquiry into the abuse of patients by staff, verbally physically and through degrading and in-human practices.
- 3.4] The Nursing Colleges review training in patient education to ensure greater emphasis on one-to-one education in the course of patient management.
- 3.5] They work together with the Department of Health to improve staff patient relationships throughout the services.

Agree with the above recommendations which are already being implemented.

ADDITIONAL RECOMMENDATIONS FROM THE OBSTETRICS SERVICES

- 4.0] Improve community participation in the running of the obstetric services.
- 4.1] Promote the value and services of the MOU's within local communities.
- 4.2] Staffing norms for midwife obstetric units must be workshopped, agreed upon and implemented.

NOTE : *** indicates recommendations which have been substantially amended or changed by the obstetric services working group from the GSH region.

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