**UNIVERSITY OF THE WESTERN CAPE**
**Faculty of Community and Health Sciences**
**Doctoral Thesis**

Title: What drives obstetric violence amongst nurses and midwives throughout the continuum of maternal health care in governmental hospitals and antenatal clinics in urban Western Cape.


Student Name: Jessica Dutton

Student Number: 3750532


Degree: PhD


Department/School: School of Public Health

Supervisor: Dr. Lucia Knight

Co-supervisor: Michelle De Jong


Date: September 20th, 2022

10 Keywords: obstetric violence, respectful maternity care, South African maternal health care, midwifery/nursing, reproductive justice, quality of care, mistreatment of women during childbirth, gender-based violence, reproductive labour, caring labour





http://etd.uwc.ac.za/

Acknowledgements

Firstly, I would like to express my gratitude to my supervisor, Prof. Lucia Knight. Thank you for your incredible patience, insight and intellectual guidance. Your high quality engagement remained consistent and your encouragement at some of the most difficult times is greatly appreciated. I would also like to thank my second supervisor Dr. Michelle De Jong for her keen interest in my work and bringing in the expertise I needed.

Thank you to everyone at the UWC School of Public Health and especially Carnita Ernest, Corinne Carolissen, and Asha George. From day one, your kindness and support has carried me through my PhD journey. To everyone at CHESAI, I thank you for providing community, time and space to work, intellectual engagement and friendship. To everyone at BRIDGES, thank you and I look forward to the future. Thank you Jennifer Githaiga for the keen writing retreat invites. Thank you to the MRC for your support.

A big thank you to my parents for your constant support and being there when I needed them the most. To Julia and Michelle, our weekly meet ups throughout lockdown always filled me with much laughter and gratitude. To my favourite people in New York City, Shahrina and Jeanne, thank you for the long phone chats and compassion.

Mayine, thank you for the balance you give to my life.

To all the nurses and midwives who gave their time to participate and share their stories, I am grateful.

With gratitude,

Jessica

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

## Table of Contents


**Declaration** ..... 5

**Dedication** ..... 6

**Acronyms/Abbreviations** ..... 7

**Abstract** ..... 8

**Chapter 1: Introduction** ..... 10

- 1.1 Introduction statement ..... 10
- 1.2 Motivation and rationale ..... 16
- 1.3 Literature Review ..... 18
- 1.4 Theoretical framework: Reproductive Justice ..... 28
- 1.5 Aim ..... 33
- 1.6 Outline of thesis ..... 34

**Chapter 2: Methodology** ..... 48

- 2.1 Study Design ..... 48
- 2.2 Study population and sampling ..... 49
- 2.3 Data collection ..... 51
- 2.4 Data analysis ..... 54
- 2.5 Rigor ..... 57
- 2.6 Statement of positionality ..... 59
- 2.7 Statement of reflexivity ..... 60
- 2.8 Ethical considerations ..... 61

**Chapter 3: Reproducing Neglect in the Place of Care: normalized violence within Cape Town Midwifery Obstetric Units** ..... 64

**Chapter 4: The Possibilities and Limitations of Midwives Practicing Compassionate Care in South Africa's Maternity Care** ..... 86

**Chapter 5: Barriers to Respectful Maternity Care in Cape Town Midwifery Obstetric Units: Midwives on delays in emergency transportation** ..... 113

**Chapter 6: Isolation during childbirth and the continuous devaluation of caring labour: COVID-19 before and after the pandemic lockdown** ..... 138

**Chapter 7: Reinforcing and Reproducing Perceptions of Women Seeking Care: "bad' attitudes and obstetric violence in Cape Town Midwifery Obstetric Units** ..... 150

**Chapter 8: Inter-personal level factors influencing disrespectful treatment towards women seeking care in South African midwifery obstetric units** ..... 182


UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

**Chapter 9: Discussion** ..... 217
**9.1 Recommendations** ..... 225
**9.2 Limitations of this study** ..... 230
**9.3 Conclusion** ..... 231
**Appendices** ..... 237
**Appendix I: interview guide** ..... 237
**Appendix II: Ethical approvals** ..... 239
**Appendix III Publications and Conference Presentations** ..... 244

http://etd.uwc.ac.za/

# Declaration

I declare that this work 'What drives obstetric violence amongst nurses and midwives throughout the continuum of maternal health care in governmental hospitals and antenatal clinics in urban Western Cape' is my own work. I declared that this work has not been submitted for any degree or examination in any other university, and that all sources I have used or quoted have been indicated and acknowledged by complete references.

Student: Jessica Dutton

Date: 09/09/2022



http://etd.uwc.ac.za/

# Dedication

I dedicate this thesis to my mother and father. Thank you for always supporting me even when a much easier path seemed the way to go.

http://etd.uwc.ac.za/

## Acronyms/Abbreviations

ANC – Antenatal care

CHC – Community Health Centre

CHW- Community health worker

HIV – Human Immunodeficiency Virus

LMIC – Low and middle-income countries

MMR – Maternal Mortality Ratio

MOU – Midwifery Obstetric Unit

OV – Obstetric violence

RMC – Respectful maternity care

SA – South Africa

VE – vaginal examination

QoC – Quality of care

WHO – World Health Organization

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

# Abstract

Obstetric violence is a particular form of gender-based violence that harms women physically, emotionally and psychologically. Obstetric violence has been reported throughout South Africa in both the public and private health sectors across the continuum of maternal health care. In the efforts to eradicate obstetric violence within South African maternal healthcare, we require a better understanding of what drives this phenomenon in this context. The perspective of nurses and midwives is indispensable in developing this understanding. As the ones who deliver care directly to patients, it is nurses and midwives who are at the interface of South Africa's health care system and women seeking maternity care.

The aim of this study is to use empirical evidence to better understand drivers of obstetric violence from the perspective of nurses and midwives providing services across the continuum of care in urban Western Cape.

A total of 24 in-depth interviews were conducted with nurses and midwives at three Midwifery Obstetric Units (MOUs) in urban Western Cape. Additionally, 24 hours of observation were conducted at each MOU. Observation took place in the ANC waiting area and at times in the nursing station. Interviews were recorded and transcribed. Data was coded and grounded theory was applied to analyze the findings. Reproductive justice was applied as a theoretical framework and provided an over-arching theoretical approach to this study.

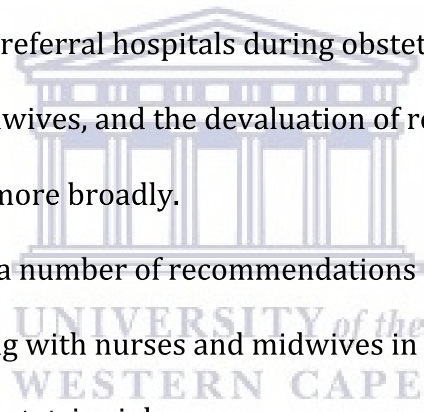
It has been argued that the South African health system is failing the people it sets out to serve- a lack of quality care, discriminatory practices and under-resourced

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

facilities have become normalised within the public sector. Such barriers to delivering quality and respectful care act to systemically perpetuate obstetric violence and carry harmful consequences that impact the patient-provider relationship in complicated ways. The key findings of this study show that obstetric violence is driven by a range of interconnected factors ranging from interpersonal relations, lack of resources and socio-economic issues. Within these over-arching factors that drive obstetric violence, a number of barriers to quality maternal health care were identified. These include: the absence of informed consent and communication, issues of patient neglect, negative patient-provider relationships delays in transportation to referral hospitals during obstetric emergencies, a lack of support for nurses and midwives, and the devaluation of reproductive labour in the health system and society more broadly.


UNIVERSITY of the
WESTERN CAPE

This thesis concludes with a number of recommendations for further research and action that involves working with nurses and midwives in moving towards maternity care free from obstetric violence.



http://etd.uwc.ac.za/

# Chapter 1: Introduction

## 1.1 Introduction statement

The central aim of this thesis is to better understand what drives disrespectful treatment and obstetric violence within public maternal health facilities in South Africa from the perspective of nurses and midwives. Going into this project, it was known that there is no single explanation for obstetric violence and understanding what drives the phenomenon would involve thinking beyond exploring individual behaviour and a deep consideration of how reproductive health and violence intersect (1–3). Obstetric violence is not unique to South Africa, disrespectful treatment towards women happens, across the continuum of maternity care, globally (4). This project makes use of local knowledge on what it is to be a midwife in South Africa to engage with existing research produced globally on disrespectful care and gender-based violence. This project is based on empirical data, and seeks to translate the narratives of nurses and midwives, along with observations of the clinic, into knowledge that contributes to the conversation globally.

The COVID-19 pandemic highlighted many existing problems, which were always there but previously ignored; Inequality in the health system was laid (even more) bare (5). When COVID-19 hit, this project was already deeply invested in an exploration of understanding how nurses and midwives work without adequate resources and that there is a devaluation of reproductive labour in the health care system and throughout society more broadly. Reproductive labour refers to the work done to reproduce society and the caring labour, often invisibilised, that goes



http://etd.uwc.ac.za/

into maintaining life (5). COVID-19 illuminated how societies across the world are reliant on 'essential workers' (health care practitioners, women working at grocery stores, garbage collectors etc.). However, this acknowledgement did not improve the conditions for people doing such work, nor did it transform the perceived status of reproductive labour within institutions of power, such as the state. The refusal of the state to give proper recognition to those who shoulder the responsibilities of reproductive labour, made it all the more necessary to highlight this negation in the work of nurses and midwives (6). Lockdowns across the world illuminated a crisis in care and highlighted how caring labour continues to be exploited. Even though data collection was complete before the pandemic, the response to COVID-19 by those in power, especially in relation to maternal health care, has greatly shaped this thesis and placed an emphasis on the need for a feminist critique of the ways in which care and care work are continually devalued.

UNIVERSITY of the
WESTERN CAPE

During this research, nurses and midwives spoke of feeling as if they shoulder much of what is broken in the public health system. The results revealed that the state turns its back on reproductive labour, and the people who perform it, this shaped much of how I understand nurses and midwives behaviour, at it's best and worst. What nurses and midwives shared with regard to having to operate, meet targets, improve quality, and deliver respectful care to a large population without adequate state support speaks to the paradox that caring labour is trapped within.

This thesis explores this paradox – the complete devaluation (both materially and with regards to status) of reproductive labour alongside the expectation that nurses and midwives will provide quality care regardless of such devaluation. Multiple



http://etd.uwc.ac.za/

layers of violence are entwined within this, one that this thesis is particularly interested in is the ways in which particular women, mostly poor and Black, are constructed as 'socially undesirable reproducers' (7) and the effect this has on midwifery practise and their treatment. Through the narratives of nurses and midwives, and the emotions they share within the stories, this thesis grapples with these conflicts. The remaining part of this introduction provides some context about maternity care in South Africa and offers a brief description of some of the key terms used throughout.

*Maternal health care in South Africa*

The vast majority of women in South Africa, over 95%, give birth in a health facility with a skilled birth attendant (8). This, on the surface, appears commendable; women in South Africa are receiving clinical care during childbirth. However, maternal health indicators and experiences women have shared of maternity care in the public health sector tells a more complicated story (9). A lack of quality care across the continuum of maternity care in the public sector is common (1,10,11). Inequality plays a significant role in this as South Africa has an extremely bifurcated public/private health care system. The amount of South Africa's GDP spent on the two systems is fairly equal despite approximately 83% of the population accessing public health services in South Africa (2). Such discrepancies can be seen in the services, equipment, and supplies available at public versus private maternity wards and maternal health care facilities (9). With such inequality, socio-economic status can sometimes determine the quality of care women will receive during childbirth

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

and women in poverty have no choice but to seek care at clinics offering a much lower standard of care than their middle-class counterparts.

In South Africa, prior to COVID-19 the maternal mortality ratio (MMR) was approximately 139 per 100,000 live births (12). This number is high for a middle-income country with few barriers to access to a health facility for childbirth (12). Maternal mortality increased drastically during COVID-19, with an estimated 40% rise (13). As the waves of COVID-19 hit South Africa, maternal mortality increased, with the most severe increase over December 2020 (13). It has been reported that the effects of COVID-19 on maternal health have been underestimated and the research to understand the sharp increase in death is incomplete (13).

Research shows that 60% of maternal deaths in South Africa are preventable through improved care. Currently 14.8% of maternal deaths are related to hypertension and 15.8% are due to obstetric haemorrhage (14). These complications suggest failures in health system responsiveness and an absence of person-centred care (14). Due to a successful antiretroviral treatment programme the number of maternal deaths due to HIV has reduced significantly. Non-pregnancy related infections are no longer the leading cause of maternal death, as was the case during the height of the HIV pandemic (14).

South Africa offers different levels of care to serve low-risk and high-risk pregnancies. Clinics and community health centres (CHCs) serve women with low-risk pregnancies (14). Clinics tend to only offer antenatal care, where CHC's are open 24-hours a day, seven days a week and consist of an antenatal clinic, labour

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

ward, and postnatal services. MOUs are located within CHCs (14). According to the South African clinical guidelines safe and effective emergency transportation from CHC's to hospitals is to be offered in the case of an emergency for all women and their newborns. Such services are vital to safe childbirth as CHC's do not offer services such as caesarean deliveries. Hospitals fall under the categories district level, regional and tertiary. Hospitals care for all pregnant women, however tertiary hospitals only offer services to women with high-risk pregnancies. It is recommended that all pregnant women attend a minimum of eight antenatal care appointments and attend postnatal appointments after childbirth (14)

*Definitions and terminology*

This thesis makes use of the terms obstetric violence, quality of care, and respectful maternity care. Depending on the focus of the section, different terms are used to best suit the content. The term obstetric violence is useful because of the ways in which the term already includes structural violence in its conception. The discussion of barriers to quality of care was useful in the clinic setting and often the preferred terminology of nurses and midwives as it allows for the impact of resources on how care was performed to be considered. Respectful maternity care is commonly used in studies on disrespectful care during childbirth in low and middle-income countries (LMICs) and there is a growing body of literature within public health research applying this term (15–18).

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*Obstetric Violence*

The term obstetric violence is applied in this study to encompass all acts of abuse towards pregnant people[1] across the continuum of maternal care by health care providers or the healthcare system. Obstetric violence includes verbal, physical, physiological, and emotional abuse as well as forms of mistreatment such as neglect, denying informed consent, and discriminatory attitudes and actions and can be driven by an individual or system (19). Obstetric violence has been understood within feminist studies as a form of gender-based violence and happens to women because they are women (20).

*Quality of Care*

The definition of quality of care varies according to the source of care, however it tends to encompass both provisions and experiences of care within its definition. According to the World Health Organization quality of care is achieved through evidence-based practise as well as effective communication, respect and preservation of dignity and emotional support (21). Good quality maternity care, is safe, effective, timely, efficient, equitable and people-centred (21).

UNIVERSITY of the
WESTERN CAPE

[1] Some of the more recent work on obstetric violence and reproductive justice uses the term pregnant people in the efforts to be more inclusive and to recognise that it is not just women who experience pregnancy. Throughout this thesis, with the exception of chapter 4, I predominantly use the term pregnant women. This is in no way to deny the lived experience of those who do not identify as women. All of the people who participated in my research identified themselves as women and spoke of their patients as women. The vast majority of the literature I engaged with also used the term women to describe their research subjects.



http://etd.uwc.ac.za/

*Respectful Maternity Care*

Respectful maternity care (RMC), which has been made a priority of the international organization White Ribbon Alliance, is based on the universal rights of childbearing women and offers a human rights perspective on improving the quality of maternal health care globally (22). The charter for respectful maternity care is composed of ten human rights, which include the right to freedom from harm and ill-treatment, the right to information, informed consent, and respect for their choices and preferences, including companion of choice during maternity care and refusal of medical treatment, the right to privacy and confidentiality, the right to equality, freedom from discrimination and equitable care, the right to liberty, autonomy, self-determination and freedom from arbitrary detention as well as particular rights dedicated to newborns (22).

## 1.2 Motivation and rationale

UNIVERSITY of the
WESTERN CAPE

This study was motivated by the need to engage with and develop knowledge about and understandings of obstetric violence in South Africa, with a particular focus on what drives this phenomenon. The research to date on drivers of obstetric violence in South Africa has focused on gender-based violence, the normalization of deviance, the colonial legacy, the normalised lack of communication in the maternity ward, and resource shortages (3,10). This study continues the investigation into these categories but also explores drivers that have not yet been explained in depth, most notably the multiple effects of the devaluation of reproductive labour and what it means to work within the uncertainties of a clinic under duress. This study focused



http://etd.uwc.ac.za/

on the perspectives of nurses and midwives; a perspective that had not yet been fully explored.

A particular approach has been taken in existing research into obstetric violence and disrespectful care in the global South that largely seeks to measure the prevalence of obstetric violence and explain mistreatment of women through creating a typology, using statistics, and conceptually informed frameworks (23–26). This approach achieves what it sets out to do - measure and provide visuals and lists to explain mistreatment promptly (27–29). The articles that make up this thesis explore aspects of obstetric violence and respectful maternal care that are difficult to capture in a typology or framework such as the emotions of care providers working in difficult conditions, how the lack of resources shape patient-provider relations, and how nurses and midwives perceive their environment and responsibilities.

My interest in understanding these less well understood and explored aspects of obstetric violence has guided much of the analysis and the focus of this research on resource shortages, infrastructure failures, inter-personal relations, policies around privacy and birth companions, neglectful care, and the absence of consensual care. To begin to build clinic environments that promote respectful maternity care, we require knowledge on how we can *work with* nurses and midwives to change the conditions that allow for abusive care. In order to do this, detailed and nuanced understandings of the experiences of nurses and midwives within their social, political and economic contexts are necessary. This research attempts to take on this challenge.



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

## 1.3 Literature Review

The bulk of this literature review looks at the research that has been published in public or global health journals on the mistreatment of women during childbirth. This review starts by looking at two seminal studies that have informed how research into the mistreatment of women during childbirth has been conducted. This is followed by an overview of the research that has been carried out in sub-Saharan Africa on this subject. A section is dedicated to research that has focused on the perspective of providers on disrespectful treatment of women during maternity care and that presents a theoretically informed conceptual framework on the drivers of disrespectful care from the perspective of African midwives. This conceptual framework has greatly contributed to the knowledge on disrespectful care and offers a tool for analysing future research. This review concludes with a section on research that has come out of South Africa on obstetric violence. This section is intended to demonstrate how a different approach to understanding the phenomenon of mistreatment of women in maternity care has come from South African feminist scholars and is rooted in exploring obstetric violence as a form of gender-based violence. An area of important work that I did not include within my literature review but I would like to highlight is the research on the history of the nursing profession in South Africa and how colonialism and apartheid has shaped this profession. Shula marks seminal book, *Divided Sisterhood* is an excellent resource for understanding this important history.

*Disrespect and abuse and mistreatment of women during childbirth – A global health approach to research on obstetric violence*



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

In recent times, research on disrespectful care during childbirth in sub-Saharan Africa has received a fair amount of attention in global public health. Within LMICs much of the research on obstetric violence has been carried out under the terms 'disrespect and abuse during childbirth' and 'mistreatment of women during childbirth'. These terms come from two seminal studies that brought together all the relevant literature at the time they were published and have identified key aspects of disrespect and abuse during childbirth worldwide. Bowser and Hill (2010) offer an exploration into the contributing factors and causes of disrespect and abuse, grouping the findings into five categories: individual and community, national laws and policies (including human rights and ethics), governance and leadership, service delivery, and providers (23). This landscape analysis also records interventions that have taken place and lays the groundwork for an operational definition of disrespect and abuse that includes physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities. Bohren et al. (2015) created a standardized and comprehensive typology of mistreatment of women during childbirth informed through a systematic review they had conducted. This typology thematically divides acts of mistreatment into the categories: physical abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health systems conditions and constraints (26). Within public health, these studies have shaped the discourse of disrespectful care towards birthing women.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Over the past five years a number of studies have been carried out on the prevalence of disrespect and abuse in maternal care across sub-Saharan Africa. The most common forms of disrespect, abuse, and mistreatment reported by patients have been lack of confidentiality between care providers and the women they care for. This has been reported in studies from Mozambique(30), Ethiopia (31,32) and Tanzania (33). Women have also reported the denial of pain relief in South Africa (1), Nigeria (34), Tanzania (18), and The Gambia (35) and the denial of birthing companions of their choice in Mozambique (30) South Africa (36), Ethiopia (37). Verbal Abuse was reported in Mozambique (30), Ghana (38), Guinea (38,39), Nigeria (38,40), Kenya (41–43), Tanzania (18,41), Sudan (41), Ghana (42) and South Africa (44). Other communication barriers such as poor provider-patient rapport were said to have occurred in Tanzania (18,33,45), Ethiopia (37), Kenya (42) and Ghana (42).

UNIVERSITY of the
WESTERN CAPE

Findings of non-consensual care have been reported in Mozambique (30), Tanzania (18,33), Ethiopia (31,37), Ghana (38,42), Guinea (38), Nigeria (38) , Kenya (42,46), and The Gambia (35). Women reported being detained in the health facility for non-payment in Nigeria (38,47) and Ethiopia (32). Neglect was commonly reported and occurred in Nigeria (34,47), Mozambique (30), Tanzania (18,45), Ethiopia (31,32,37), and Guinea (39). Physical abuse such as slapping and pinching was reported in Guinea (38,39), Sudan (41), Tanzania (33), Ethiopia (31,32), Ghana (38), South Africa (48), Kenya (42), and Nigeria (38).

Lack of privacy was said to have been a problem in Kenya (41,46), Tanzania (33) Sudan (41), and South Africa (41). Discrimination, often broadly defined, was



http://etd.uwc.ac.za/

reported in Ghana (38), Guinea (38), Nigeria (38,47) and Ethiopia (31). Studies within the above countries also reported non-dignified care (40,41,47), women denied birthing position of choice (18,35), unhygienic conditions and practices (37,49), women denied traditional practices (18), women feeling infantilised (37), unavailability of basic supplies (18,37), and psychological abuse (33). Weak health systems and poor policy support were named in other studies (49,50).

Three studies from Kenya highlight that improving the environment in which nurses work could potentially lower the chances of women experiencing mistreatment (43,49,50). This recommendation was echoed in a study from Guinea (39). Another common recommendation of studies carried out on disrespectful care in LMIC is that health care providers be trained specifically in respectful maternity care practices (40,42,51,52). Studies exploring the impact of respectful maternity care policy are few, which may be partly because the study of prevalence is recent, and so there has not yet been the time to measure policy impact (41).

UNIVERSITY of the
WESTERN CAPE

*Disrespect and abuse from the perspective of health care providers*

The perspective of health care providers has begun to inform studies on disrespect and abuse during childbirth. While some health care providers admit to committing acts of disrespect and abuse, they are more likely to report having seen another staff member do so (42,53,54). When asked about the barriers to respectful maternity care, existing research shows that many nurses and midwives report that resource shortages, including staff shortages are driving disrespectful care (55,56). A systematic review on provider perspectives about barriers to quality midwifery care



http://etd.uwc.ac.za/

in LMICs, suggests that burnout and moral distress is the outcome of economic, social, and professional barriers (56). Economic barriers that affect midwives come in the form of inadequate and irregular salaries. Feeling left out of policy dialogue, lack of recognition of skills, and missing supplies and equipment were described as the professional barriers midwives experienced. Social barriers were experienced as gender inequality and lack of safety including experiences of gendered and sexual violence (56). Such findings point to the systemic problems that prevent nurses and midwives from offering good quality care. These I argue cannot just be overcome through respectful maternity care training but and require a more transformative approach to health systems and societal norms around gender.

Nurses and midwives reported, in a study from Ethiopia, that disrespect was so common to the maternity ward that they too were on the receiving end of being abused while at work (57). Not only does this carry harmful consequences for the wellbeing of nurses and midwives, normalised disrespectful treatment impacts women's attendance at and willingness to go to the clinic for antenatal care (57). This has been found in a number of studies and disrespectful treatment has been listed as one of the reasons women do not attend maternal health care in low-resourced settings (31,40,53,58). When women do not attend antenatal care throughout their pregnancy, this can create further tensions between patients and providers. Nurses and midwives have shared their frustrations with having to care for women during childbirth who have not received any antenatal care (61). These situations are often described as precarious and very stressful for midwives as the chances of a negative outcome increases (60,61). A recent study conducted in

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Ethiopia that examined provider perspectives on disrespect and abuse found that the lack of training on RMC in midwifery curricula and weaknesses in the health system were perceived to be barriers to RMC (62). Other research on the topic has found that resource shortages, inadequate policy, lack of leadership, discrimination towards women with HIV, and gender based violence all contribute to obstetric violence (3,23,63,64).

Midwifery students have also been included in studies on what drives disrespect and abuse during childbirth. Students are understood as offering a unique perspective on the norms of a labour ward as they are fresh to the environment, medically trained, and witness what takes place in ways that researchers cannot (65,66). A study from Ghana that interviewed medical students found that disrespectful care was rationalized within the labour ward and that research participants felt that at times midwives have no alternative other than to mistreat their patients (67). Mistreatment was understood as a way to get women to cooperate and do as the midwives asked and avoid being blamed for a bad outcome (67). Students in South Africa also witnessed disrespectful treatment in the labour ward, often in the form of verbal abuse. However, they did not see this as beneficial to the patient and described the behaviour as harmful labour ward practices (66).

UNIVERSITY of the
WESTERN CAPE

Mutual distrust between patients and providers, as well as a lack of interest in patient-centred care was reported in a study from South Africa (28). Healthcare workers showed a deep understanding of what good quality care meant but a lack of motivation plus structural and organization problems stood in the way of practicing



http://etd.uwc.ac.za/

quality care. The hierarchical nature of health care, paired with poor leadership, was also stated to be a barrier to delivering good quality care in the facility ((28).

Provider perspectives offers insight into how mutual distrust festers and grows within maternal health care. Nurses and midwives in LMICs experience burnout and moral distress as an outcome of professional, economic and social barriers that exist within their profession (56). A lack of leadership and support also contribute to feeling overwhelmed. They worry about being blamed for negative outcomes during childbirth even though they work in conditions where supplies are missing and there are not enough staff on duty. Disrespectful treatment, such as verbal abuse, is an outcome of releasing frustrations, and as medical students have reported, a norm within the labour ward (68). When mistreatment occurs, women are deterred to attend the clinic for care and this fuels the stressful environment of the clinic. Including the perspective of providers in understanding disrespectful treatment of women during maternity care illuminates the systemic problems of the health system that effect both patients and providers and points out the complexities in addressing this phenomenon.

UNIVERSITY of the
WESTERN CAPE

*Theoretically informed conceptual framework on drivers of disrespectful care*

Within global health studies on mistreatment of women during maternity care the theoretically informed conceptual framework on drivers of disrespectful care from the perspective of midwives by Bradley et al. (2019) has contributed to more complex thinking about the problem. This conceptual framework moved beyond analysing only micro-level drivers to include those at the meso and macro level too.



http://etd.uwc.ac.za/

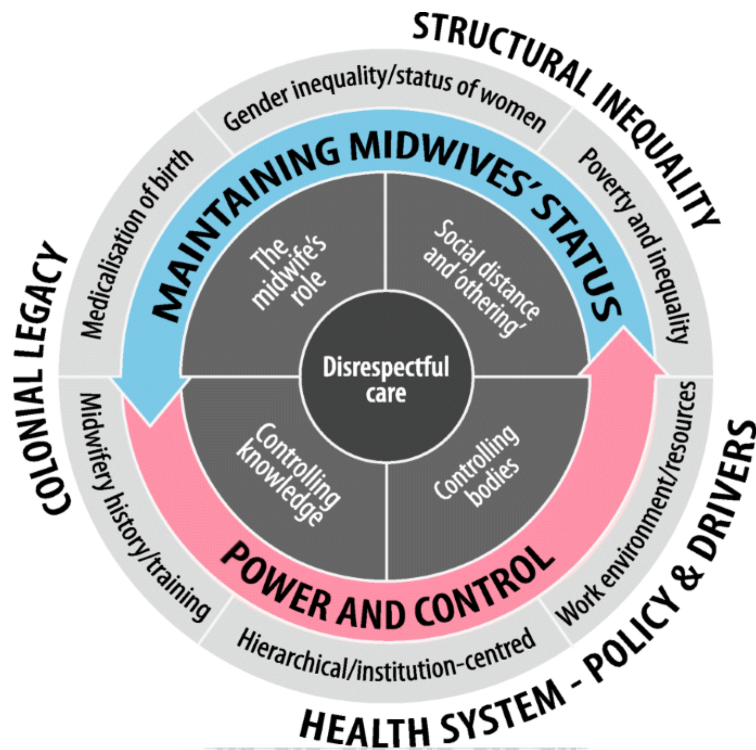



**Figure 1: Conceptual framework of the drivers of (dis)respectful care in the sub-Saharan Africa context. Bradley et al. (2019).**

This review and framework find that, the midwife's role, social distancing and 'othering', controlling bodies and controlling knowledge were micro-level drivers of disrespectful care. These factors were influenced by midwives needing to maintain their status and power and control. Meso-level factors that impact on the status and power and control were found to be gender inequality or the status of women, poverty and inequality, work environment, hierarchical or institution centred factors, midwifery history and training, and the medicalisation of birth. Macro-level factors that structure and impact on all drivers of disrespectful maternal care in the framework are structural inequality, health system and policy drivers and colonial legacy. This framework is a useful tool to understand what the different drivers are



http://etd.uwc.ac.za/

and where they are situated and how they relate to one another at the micro, meso and macro levels.

This framework encourages those working to eradicate disrespectful care to think holistically . For example, looking at how colonial legacies impact the labour wards of today requires expanding how we analyse mistreatment of women and move away from seeing this as the result of any individual behaviour only. A shortcoming of the global health approach to research on disrespectful care during childbirth is that it often overlooks historical contextualisation and, although more studies have pointed to structural violence as a driver of mistreatment, the analysis often lacks a deep analysis of this. The complexities of the labour ward are often lost in the global health approach to understanding mistreatment during maternity care and this framework has helped address this gap in knowledge.

*Obstetric Violence – research from South Africa*

UNIVERSITY of the
WESTERN CAPE

Within South Africa, a different approach to researching mistreatment of women during maternity care has been taken. Scholars aligning their work with that taking place in South America and the US, have used the term obstetric violence. The term obstetric violence serves as an epistemic rupture in that it calls out behaviours that have become normalised in maternal health as acts of violence (69). The work coming out of South Africa has also been critical of the global health approach, raising concerns that methods of analysis such as typologies are not getting at the crux of the problem (69). Fighting obstetric violence is rooted in feminist activism and understands obstetric violence as a particular form of gender-based violence



http://etd.uwc.ac.za/

carried out against women because they are women (20). The term obstetric violence has also been challenged in South Africa, stating that it is exclusionary and will deter health care providers from wanting to get involved in discussions about the problem (36). Such critique has been met with a strong response from feminist scholars whose work is dedicated to making explicit that acts to harm pregnant and birthing women need to be called what it is – violence (1,69).

Feminist writers have undertaken work to better understand what drives obstetric violence through a focus on South Africa's history of violence and the many ways in which Apartheid and its legacies have shaped the country's relationship with gender and heath care (1). Apartheid has played a major role in the creation of a culture of nursing, which is not necessarily invested in caregiving (70,71). Work in South Africa on obstetric violence has addressed racial, class, and gendered inequalities that have left public maternal health services that serve impoverished communities severely compromised. Understood as a continuation of apartheid injustices, inequality in South Africa's health care services plays a key role in understanding obstetric violence (1). Gender-based violence is severe in South Africa with the vast majority of the victims being Black women (1). Researchers have highlighted the connection between high rates of gender-based violence against poor Black women and the ways in which obstetric violence is carried out onto this same population, often with impunity (1). Failure to enforce basic human rights has left poor Black women vulnerable to violence and the rates at which women report experiences of obstetric violence within maternal health facilities is an example of this (1,3).

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Some of the writing on obstetric violence has taken the conversation in a different direction than the conversation within global health has allowed for. By focusing on obstetric violence as a specific form of gender-based violence, that is an outcome of a racist violent history, problems such as resource shortages become explicitly political. Under the analysis of obstetric violence, forcing women to give birth in a clinic that cannot meet standards of quality or safety set out in South African policy is an act of violence (41,72). This language may not be the most palatable for health care providers, and had triggered some defensiveness in response to its use, but it does allow for a consideration of the systemic problems that continue to plague the South African health system (69).

## 1.4 Theoretical framework: Reproductive Justice

Understanding drivers of obstetric violence goes beyond seeing any particular phenomena as independent or self-contained. A reproductive justice framework mandates this through a multi-layered analysis that in itself accounts for and interconnects the many aspects of maternal health (73). A reproductive justice framework allows for an understanding of obstetric violence as bio-political and a symptom of how the state, and in this study, South African maternal health services, value particular lives over others. As Luna and Luker (2013: p.329) explain, "reproductive justice centres unequal power relations, particularly as they are continually reproduced by the state. What marks reproductive justice as a useful analysis is the insistence on analysing a range of policy and practice as part of an interconnected system. In practice, this system regulates people's reproductive

UNIVERSITY of the WESTERN CAPE



http://etd.uwc.ac.za/

futures through assessments of worthiness originating in assumptions about race, class, and disability (among other dimensions)."

Traditionally, a reproductive justice framework has been used to analyse the people whose reproductive freedoms are being infringed upon by the state and not, as this study is proposing, those who work within health facilities and offer maternal health services (74). However, a reproductive justice framework always includes the health system within the context it is analysing, therefore service providers are already considered within it (74). Reproductive justice also includes an analysis of maternal health and reproductive policy (international, national, and local) and health systems. A reproductive justice framework, given its robust nature is able to understand the micro and macro aspects of obstetric violence and offers a tool that can analyse personal stories and narratives within a complicated context (74).

Operationalizing reproductive justice as a framework has allowed me to maintain a focus on the context of the research subject. Previous research on obstetric violence in South Africa has warned future researchers against a 'few bad apples' approach to understanding why nurses commit acts of obstetric violence (10). Such a viewpoint singles out individual nurses as the problem, rather than a holistic understanding of the systemic and structural layers within the South African maternal health context (10). A reproductive justice framework understands individual agency and acknowledges that nurses and midwives enact societal norms and uneven relations of power and they are, themselves, working and living within a system of uneven relations of power.



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

Originating in the 1990's amongst a collective of Black women in the United States (US): SisterSong, reproductive justice broadened the notion of choice and considered the wider aspects of women's social status and intersectional forms of oppression which together threatened Black women's bodily integrity (74). It soon became a larger movement towards reproductive dignity by incorporating women of colour from across the world (75). Reproductive justice has grown since its original conception due to continually changing politics in the US as well as growing interest in the theory internationally. Foundationally, reproductive justice was premised on three interconnecting notions: the right to have a child under circumstances of one's own choosing, the right not to have a child and freedom to use the legitimate means available to prevent this and the right to parent a child in a safe and healthy environment which is free from individual and state violence (74). Extending from reproductive justice theory and activism, the notion of birth justice has focused on women's experiences of pregnancy, labour, childbirth, and the post-partum period. Upholding the same principals as reproductive justice, birth justice calls for women's right to a safe and autonomous pregnancy and child birthing experience (76). Birth justice highlights the need to support those most vulnerable to reproductive oppression, namely Black women and women living in poverty. Birth justice has been applied to cases in the US of policing pregnant women by the state and unconsented medical interventions during pregnancy, labour and childbirth, such as coerced caesarean sections (76).

This research has been framed through building a theoretical relationship between the right to parent a child in a safe and healthy environment, free from violence,

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

which includes the right to birth that child free from violence. Focusing on this component of reproductive justice, has meant that throughout this research I have had to dedicate careful attention to the conditions that are required for women to give birth free from violence. This positions places such as maternal health facilities at the centre of achieving reproductive justice and highlights the ways in which everyone plays a role in offering safe care. The hard work of giving birth is done by the woman in labour, however childbirth is a relational experience and health care providers play a crucial role in determining women's experiences of childbirth (20). Structural inequalities are also a part of the relational experience of childbirth as women's safety during labour depends very much on the conditions of the clinic. Nurses and midwives also have a relational experience with structural inequality, which impacts them personally and professionally. A reproductive justice framework acknowledges the multiple relationships that are happening simultaneously within a labour ward and seeks ways to support everyone who comes up against the hardships of inequality and the structures that maintain injustice

*The politics of care*

Creating possibilities for safe maternity care requires a transformation of how society values care and caring labour. For maternal health facilities to become places that achieve the goals of reproductive justice, the right to birth free from violence, involves building clinics that emphasize a model of care that resists harm. This begins with moving what is currently invisible to the forefront: the value of

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

care. Care work itself is difficult to 'see' and is experienced mostly through affect, as Caitlin Henry points out in her article, *The Abstraction of Care, What work Counts?*, "care is the qualitative, emotional work, while clinical skills are tasks easily quantified and listed on a patient's chart. One is hard to count, while the other is regularly formally accounted for. These different tasks are intertwined, and yet the care work of health care can be subtle and even invisible, "[existing] in a kind of paradoxical simultaneity" (Boyer 2015) with clinical tasks" (77). Our approach to this research is underpinned by an understanding that overlooking the value of care contributes to the structural violence that prevents maternal health clinics from becoming safe places. This project works to disrupt any notion that care work is not a learnt and critically important skill, regardless of how difficult it may be to calculate its monetary value.

Although care work can be tiresome, wearing and undervalued, Honor Ford-Smith makes the point that "caring labour also gives back to those who do it because, where it is recognized as essential to existence, it enables a resonant community that counters the all too familiar alienation in the midst of profound inequality. Absence of care is death and so the work of care calls into being a recognition that life means something because of the meaning we create together" (78). Here lies the crux of how, within this project, I approach a politics of care - the possibilities of what care can counter and resist while simultaneously enabling community. To state that the absence of care is death highlights the need to investigate and understand what stands in the way of care within maternal health facilities and, to

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

understand, from the healthcare provider, why violence reproduces itself at the cost of the possibilities of care, and therefore life.

The theoretical framing of this project highlights the necessity of caring labour in the work towards achieving reproductive justice. This research argues that to continue with a system that devalues caring labour reproductive justice will remain out of reach.  Our exploration of what drives obstetric violence highlights this and pays particular attention to the ways in which caring labour is entangled into the work of achieving reproductive justice. This project highlights how the devaluation of care work is present in nurses and midwives' narratives of their daily lives in the clinic. The absence of value given to care work can be seen in the production and reproduction of harmful norms in the clinic and are woven into the contextual factors that shape nursing and midwifery practise.

## 1.5 Aim

UNIVERSITY of the WESTERN CAPE

The aim of this study is to use empirical and review evidence to explore and theorize about the drivers of obstetric violence from the perspective of nurses and midwives providing services across the continuum of care in urban Western Cape.

*Objectives*

*Objective 1*: To explore the personal and professional narratives of nurses and midwives working within public midwifery obstetric units (MOU) in Cape Town and to understand the impact daily experience has on nursing and midwifery practice.



http://etd.uwc.ac.za/

*Objective 2*:  To understand the contextual factors and social, systematic, and professional norms that influence midwifery practice within South African maternal health care.

*Objective 3*: To contribute to theories of reproductive justice and reproductive labour that can be used for further research and collaborative work those working in the field.

*Objective 4*. To offer recommendations based on the study's findings that contribute to convivial learning and working with nurses, midwives, and others in the health system.

## 1.6 Outline of thesis

This section presents the outline of the thesis and demonstrates how the subsequent chapters are interlinked. Due to the format this thesis takes, there is some overlap between the chapters that report the findings of the study. This is often due to the interconnectedness of what drives obstetric violence. These chapters offer explorations of neglect, the emotional and material effects of resource shortages, isolation, labour and childbirth without a companion of choice, negative perceptions of patients, and the lack of informed consent in the clinic. We explore these drivers of obstetric violence also as the refusal to recognize the value of reproductive and caring labour. We apply a theoretically informed framework of drivers of disrespectful care to discuss inter-personal level factors influencing disrespectful treatment as part of the contribution to the ongoing conversation on disrespect and abuse during maternity care.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Chapter 2, Methodology. This chapter describes the methods undertaken within this study. Beginning with a description of the study design, this chapter explains how I went about sampling and determining the study population, how data was collected and analysed as well as a section on rigor and ethical considerations. Grounded theory informed the methodology of this study at every stage and therefore a discussion of how I have understood and applied grounded theory is also included in this section.

Chapter 3, *Reproducing neglect in the place of care: normalised violence in Cape Town Midwifery Obstetric Units*, explores one of the fundamental findings of this research, the normalization of neglect as a barrier to quality maternal health care (79). Published in *Agenda: Empowering women for gender equity*, a South African based journal dedicated to feminism from the global South, special issue on gender inequality. For this paper, the ways in which neglect acts as a form of reproductive governance resulting from resource shortages within the clinic are stressed. From the stories told by nurses and midwives we understand resource shortages, including staff shortages as a form violence that devalues women's reproductive labour. The possibility that kindness can act as a form of resistance to the system is explored, however this resistance is always within the limitations of a health system that is predicated on inequality.

Chapter 4, *The Possibilities and Limitations of Midwives Practicing Compassionate Care in Maternity Care* was published as a Chapter in Tracy Morison and Jabulile Mary-Jane Jase Mavuso's book *Reproductive Justice: From margins to the centre* (80). This chapter explores how neglect is normalized through the constant uncertainties

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

of the clinic and builds on chapter 2. In the paper it is argued that that the role of the public healthcare worker, as state employee, provides healthcare while it is also to simultaneously police the population they serve. In the South African public health system, as in other countries, policing is achieved through acts of shaming, scolding, neglecting, and refusing to recognise the autonomy of their patients (36). Policing reproduction is also carried out through systemic violence, as particularly evident in many of the country's severely under-resourced clinics (2). The possibilities of compassionate care and the ways it is practiced piecemeal due to the conditions in the clinic are then explored. This chapter looks at how compassionate care is contently disrupted due the limitations that exist in the clinic.

Chapter 5, *Barriers to Respectful Maternity Care in Cape Town Midwifery Obstetric Units: Midwives speak on delays in emergency transportation*, submitted to *BMC Reproductive Health* on August 5, 2021. Returning to the theme of resource shortages this paper focuses on one of the most heavily reported barrier to respectful maternity care nurses and midwives reported, delays in emergency transportation during an obstetric emergency. This paper describes how without access to emergency transportation, negative outcomes are inevitable and achieving respectful maternity care is unattainable. The effects of this are far-reaching and extremely burdensome for care workers who will have to step in for health system shortcomings. It is argued that delays in emergency transportation within Cape Town public health care facilities deserve urgent attention and the chapter conclude with some recommendations of interventions to improve emergency transportation already operational in other South Africa contexts.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Chapter 6, *Isolation during childbirth and the continuous devaluation of caring labour: COVID-19 before and after the pandemic*, which has been submitted to the journal *Sexual and Reproductive Health Matters* as a commentary. This paper explores lack of privacy, companionship and labour support in midwifery obstetric units (MOUS) in South Africa. Although these are ongoing issues affecting the quality of care women receive in South Africa, for a short window of time women's experiences of childbirth was receiving attention globally, through media and research during the height of the COVID-19 pandemic. In this period issues such as denying women labour and birthing companions were raised as possible human rights violations. Restrictions due to COVID-19 were often understood as exceptions as a result of a public health crisis. However, experiences of isolation and labouring without a companion did not begin with the pandemic in South Africa and have been documented as an ongoing issue. This piece considers these issues within the context in which reproductive labour is devalued and care work is overlooked as nonessential. This commentary argues that in fact the opposite is true and reproductive labour is the work that maintains life.

UNIVERSITY of the
WESTERN CAPE

Chapter 7, *Referencing and Reproducing Perceptions of Women Seeking Care: 'bad' attitudes and obstetric violence in Cape Town Midwifery Obstetric Units*, an article submitted to *Feminism and Psychology*. This article looks at the ways in which obstetric violence manifests through reproducing and reinforcing harmful stereotypes about women who are poor seeking maternity care. The ways in which these constructions are not created by nurses and midwives, but exist in society more broadly, but are applied within the clinic to *other* some women as 'bad'



http://etd.uwc.ac.za/

patients are discussed. The construction of the 'difficult patient' obscures the realities of the clinic and places the blame on pregnant and birthing women, relying on stereotypical notions of women seeking maternity care. This article also explores how nurses and midwives can experience a sense of helplessness with regards to the conditions in which their patients live and how this is intertwined with their perceptions, Nurses and midwives cannot help their patients get out of the socio-economic conditions in which they live but they can internalise a hierarchical positioning with their patients, that at minimum provides a barrier and protection from getting too emotionally involved. Perpetuating and acting on harmful constructions that patients from economically disadvantaged communities are 'bad' helps us understand how the conditions that normalise obstetric violence are maintained in the efforts to move towards dismantling such violence.

Chapter 8, *Inter-personal level factors influencing disrespectful treatment towards women seeking care in South African midwifery obstetric units*, submitted to *PLOS Global Public Health* explores interpersonal level factors that contribute to disrespectful treatment of women. This paper revisits the findings from previous papers while considers an additional finding, which is the absence of informed consent in the clinic. This paper applies Bradley et al.'s (2019) theoretical framework on drivers of disrespectful care to organize the disrespectful care emerging from these findings. In addition, there is an exploration of instances where clinic staff demonstrate empathetic care, where clinic staff recognise patients are part of their community and show compassion. Returning to this work on

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

kindness as resistance the possibilities of disrupting uneven relations of power that drive disrespectful care emerge through compassion.

Chapter 9 - *Discussion and recommendations*. Having considered individual drivers of obstetric violence from the perspective of nurses and midwives in the chapters above, the drivers of obstetric violence more broadly will be discussed, along with the ways that they contribute to reproductive justice as a theoretical framework. This section will also consider the politics of care and resource shortages at the interface of violence. Finally, the thesis concludes with recommendations that focus on collaborative efforts in which this thesis can contribute to building.

http://etd.uwc.ac.za/

References for chapter 1


1. Rucell JZ. Obstetric violence & colonial conditioning in South Africa's reproductive health system. PhD Dessertation. University of Leeds; 2017.
2. Chadwick R. Ambiguous Subjects: Obstetric violence, assemblage and South African birth narratives. Fem Psychol. 2017 Nov;27(4):489–509.
3. Jewkes R, Penn-Kekana L. Mistreatment of Women in Childbirth: Time for Action on This Important Dimension of Violence against Women. PLoS Med. 2015 Jun 1;12(6).
4. Shakibazadeh E, Namadian M, Bohren M, Vogel J, Rashidian A, Nogueira Pileggi V, et al. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. BJOG An Int J Obstet Gynaecol. 2017. 125;8.
5. Frederici S. COVID-19, capitalism, and social reproduction in crisis. Lecture presented at The Centre for Alternatives to Social and Economic Inequalities. Department of Sociology, Lancaster Univeristy; 2021.
6. Mackett O. Journal of International Women's Studies Quality of work and unpaid reproductive labour in the South African labour market. 2022;22(7).
7. Gomez AM, Mann ES, Torres V. 'It would have control over me instead of me having control': intrauterine devices and the meaning of reproductive freedom. Crit Public Health. 2018;28(2).
8. Wabiri N, Chersich M, Zuma K, Blaauw D, Goudge J, Dwane N. Equity in maternal health in South Africa: analysis of health service access and health status in a national household survey. PLoS One. 2013;8(9).
9. Chadwick R. Bodies that birth: Vitalizing birth politics. Bodies that Birth: Vitalizing Birth Politics. London: Routledge 2018.
10. Jewkes R, Abrahams N, Mvo Z. Why do nurses abuse patients? Reflections from South African obstetric services. Soc Sci Med. 1998;47(11)
11. Chadwick R. Raising concerns : Quality of care in maternal health services in South Africa. African J of Midwifery and women's health. 2014;8(4).
12. Bomela NJ. Maternal mortality by socio- demographic characteristics and cause of death in South Africa: 2007-2015 BMC Public Health 2020 20;157.
13. Pattinson R, Fawcus S, Gebhardt S, Soma-Pilay P, Niit R, Moodley J. The impact


UNIVERSITY of the WESTERN CAPE



http://etd.uwc.ac.za/

of COVID-19 on use of maternal and reproductive health services and maternal and perinatal mortality. South African Medical Research Councel 2021.

14. South Africa Department of Health. Saving Mothers 2017: annual report on confidential inquiries into maternal death in South Africa. 2017.
15. Afulani PA, Kelly AM, Buback L, Asunka J, Kirumbi L, Lyndon A. Providers' perceptions of disrespect and abuse during childbirth: a mixed-methods study in Kenya. Health Policy Plan. 2020;35(5).
16. Mihret MS. Obstetric violence and its associated factors among postnatal women in a Specialized Comprehensive Hospital, Amhara Region, Northwest Ethiopia. BMC Res Notes. 2019;12(1).
17. Jungari S, Sharma B, Wagh D. Beyond Maternal Mortality: A Systematic Review of Evidences on Mistreatment and Disrespect During Childbirth in Health Facilities in India. Trauma, Violence, Abus. 2019.22;4.
18. Mselle LT, Kohi TW, Dol J. Humanizing birth in Tanzania: A qualitative study on the (mis) treatment of women during childbirth from the perspective of mothers and fathers.BMC Pregnancy and Childbirth. 2019.19;231
19. Kassa Z, Tsegaye B, . Disrespect and abuse of women during the process of childbirth at health facilities in sub-Saharan Africa: a systematic review and meta-analysis. BMC International Health and Human Rights. 2020.20;23
20. Cohen Shabot S. We birth with others: Towards a Beauvoirian understanding of obstetric violence. European J of Women studies. 2020
21. World Health Organization. Standards for improving quality of maternal and newborn care in health facilities. 2016;73
22. Respectful Maternity Care: the universal rights of childbearing women . The White Ribbon Alliance; 2011
23. Bowser D, Hill K. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis USAID-TRAction Project. 2010
24. Bohren MA, Vogel JP, Fawole B, Maya ET, Maung TM, Baldé MD, et al. Methodological development of tools to measure how women are treated



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

during facility-based childbirth in four countries: Labor observation and community survey. BMC Med Res Methodol. 2018 Nov 15;18(1).

25. Bradley S, McCourt C, Rayment J, Parmar D. Midwives' perspectives on (dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and meta-synthesis. Reproductive Health; 2019;16.

26. Bohren M, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. PLOS Med. 2015;12(6)

27. Burrowes S, Holcombe SJ, Jara D, Carter D, Smith K. Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: A qualitative study. BMC Pregnancy Childbirth. 2017 Aug 22;17(1).

28. Lambert J, Etsane E, Bergh A-M, Pattinson R, van den Broek N. 'I thought they were going to handle me like a queen but they didn't': A qualitative study exploring the quality of care provided to women at the time of birth. Midwifery. 2018;62:256–63.

29. Madeira A, Avery M, Buesseler H. Perspectives from Providers and Mothers on the Benefits of and Barriers to Respectful Maternity Care in a Refugee Camp Setting in Thailand. J Midwifery Womens Health. 2018 Sep;63(5):625–625.

30. Galle A, Manaharlal H, Cumbane E, Picardo J, Griffin S, Osman N, et al. Disrespect and abuse during facility-based childbirth in southern Mozambique: a cross-sectional study. BMC Pregnancy Childbirth. 2019;19(1).

31. Bobo FT, Kasaye HK, Etana B, Woldie M, Feyissa TR. Disrespect and abuse during childbirth in Western Ethiopia: Should women continue to tolerate? PLoS One. 2019 Jun 1;14(6).

32. Kassa ZY, Husen S. Disrespectful and abusive behavior during childbirth and maternity care in Ethiopia: A systematic review and meta-analysis, BMC Research Notes. 2019;12

33. Shimoda K, Horiuchi S, Leshabari S, Shimpuku Y. Midwives' respect and disrespect of women during facility-based childbirth in urban Tanzania: A qualitative study. Reprod Health. 2018;15(1).

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

34. Amole T, Tukur M, Farouk S. Disrespect and abuse during facility based childbirth: The experience of mothers in Kano, Northern Nigeria.Tropical Journal of Obs and Gynae. 2019 36;1.
35. Colley S, Kao C-H, Gau M, Cheng S-F. Women's perception of support and control during childbirth in The Gambia, a quantitative study on dignified facility-based intrapartum care. BMC Pregnancy Childbirth. 2018;18(1):413.
36. Lappeman M, Swartz L. Rethinking obstetric violence and the "neglect of neglect": the silence of a labour ward milieu in a South African district hospital. BMC Int Health Hum Rights. 2019 Oct 30;19(1):30.
37. Gebremichael MW, Worku A, Medhanyie AA, Edin K, Berhane Y. Women suffer more from disrespectful and abusive care than from the labour pain itself: a qualitative study from Women's perspective. BMC Pregnancy Childbirth. 2018;18(1):392.
38. Bohren MA, Mehrtash H, Fawole B, Maung TM, Balde MD, Maya E, et al. How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. Lancet. 2019;394.
39. Balde MD, Diallo BA, Bangoura A, Sall O, Soumah AM, Vogel JP, et al. Perceptions and experiences of the mistreatment of women during childbirth in health facilities in Guinea: a qualitative study with women and service providers. Reprod Health. 2017;14(1).
40. Orpin J, Puthussery S, Davidson R, Burden B. Women's experiences of disrespect and abuse in maternity care facilities in BenueState, Nigeria. BMC Pregnancy Childbirth. 2018 Jun 7;18(1).
41. Downe S, Lawrie TA, Finlayson K, Oladapo OT. Effectiveness of respectful care policies for women using routine intrapartum services: A systematic review. Vol. 15, Reproductive Health. 2018;15.
42. Afulani PA, Phillips B, Aborigo RA, Moyer CA. Person-centred maternity care in low-income and middle-income countries: analysis of data from Kenya, Ghana, and India. Lancet Glob Heal. 2019;7(1)



http://etd.uwc.ac.za/

43. Afulani PA, Feeser K, Sudhinaraset M, Aborigo R, Montagu D, Chakraborty N. Toward the development of a short multi-country person-centered maternity care scale. Int J Gynecol Obstet. 2019 ;146(1).
44. Chadwick RJ. Obstetric violence in South Africa, South African Medical Journal. South African Medical Association; 2016;106
45. Solnes Miltenburg A, van Pelt S, Meguid T, Sundby J. Disrespect and abuse in maternity care: individual consequences of structural violence. Reprod Health Matters. 2018.
46. Abuya T, Sripad P, Ritter J, Ndwiga C, Warren CE. Measuring mistreatment of women throughout the birthing process: implications for quality of care assessments. Reprod Health Matters. 2018 ;26(53)
47. Ijadunola MY, Olotu EA, Oyedun OO, Eferakeya SO, Ilesanmi FI, Fagbemi AT, et al. Lifting the veil on disrespect and abuse in facility-based child birth care: Findings from South West Nigeria. BMC Pregnancy Childbirth. 2019; 22;19(1).
48. Odhiambo A, Mthathi S. Stop Making Excuses: Accountability for Maternal Health Care in South Africa. Human Rights Watch; 2011.
49. Abuya T, Sripad P, Ritter J, Ndwiga C, Warren CE. Measuring mistreatment of women throughout the birthing process: implications for quality of care assessments. Reprod Health Matters. 2018;26(53).
50. Oluoch-Aridi J, Smith-Oka V, Milan E, Dowd R. Exploring mistreatment of women during childbirth in a peri-urban setting in Kenya: Experiences and perceptions of women and healthcare providers. Reprod Health. 2018 Dec 17;15(1).
51. Asefa A, Morgan A, Bohren M, Lessons learned through respectful maternity care training and its implementation in Ethiopia: an interventional mixed methods study; Reproductive Health 2020; 17 (103).
52. Afulani PA, Aborigo RA, Walker D, Moyer CA, Cohen S, Williams J. Can an integrated obstetric emergency simulation training improve respectful maternity care? Results from a pilot study in Ghana. Birth. 2019;46(3)
53. Asefa A, Bekele D, Morgan A, Kermode M. Service providers' experiences of disrespectful and abusive behavior towards women during facility based



http://etd.uwc.ac.za/

childbirth in Addis Ababa, Ethiopia. Reprod Health. 2018 Jan 5;15(1):4.

54. Wesson J, Hamunime N, Viadro C, Carlough M, Katjiuanjo P, McQuide P, et al. Provider and client perspectives on maternity care in Namibia: Results from two cross-sectional studies. BMC Pregnancy Childbirth. 2018;18(1).

55. Ndwiga C, Warren CE, Ritter J, Sripad P, Abuya T. Exploring provider perspectives on respectful maternity care in Kenya: "work with what you have." Reprod Health. 2017;14(1).

56. Filby A, McConville F, Portela A. What Prevents Quality Midwifery Care? A Systematic Mapping of Barriers in Low and Middle Income Countries from the Provider Perspective. PLoS One 2016;11(5)

57. Asefa A, Bekele D, Morgan A, Kermode M. Service providers' experiences of disrespectful and abusive behavior towards women during facility based childbirth in Addis Ababa, Ethiopia. Reprod Health. 2018 Jan 5;15(1)

58. Austad K, Chary A, Martinez B, Juarez M, Obstetric care navigation: a new approach to promote respectful maternity care and overcome barriers to safe motherhood. BMC Reproductive Health. 2017; 14(148)

59. Ishola F, Owolabi O. Disrespect and abuse of women during childbirth in Nigeria: a systematic review. PLoS One. 2017; 12(3).

60. Gebremichael MW, Worku A, Medhanyie AA, Berhane Y. Mothers' experience of disrespect and abuse during maternity care in northern Ethiopia. Glob Health Action. 2018;11.

61. Ishola F, Owolabi O, Filippi V. Disrespect and abuse of women during childbirth in Nigeria: A systematic review. PLoS One. 2017;12(3).

62. Burrowes S, Holcombe SJ, Jara D, Carter D, Smith K. Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: a qualitative study. BMC Pregnancy Childbirth. 2017;17(1):263.

63. Warren CE, Njue R, Ndwiga C, Abuya T. Manifestations and drivers of mistreatment of women during childbirth in Kenya: implications for measurement and developing interventions. BMC Pregnancy Childbirth. 2017;17(1):102

64. Sando D, Kendall T, Lyatuu G, Ratcliffe H, McDonald K, Mwanyika-Sando M, et



http://etd.uwc.ac.za/

al. Disrespect and Abuse During Childbirth in Tanzania. J Acquir Immune Defic Syndr. 2014;67.

65. Moyer CA, Rominski S, Nakua EK, Dzomeku VM, Agyei-Baffour P, Lori JR. Exposure to disrespectful patient care during training: Data from midwifery students at 15 midwifery schools in Ghana. Midwifery . 2016;41:39–44.

66. Farrell E, Pattinson RC. Out of the mouths of babes - Innocent reporting of harmful labour ward practices. South African Med J. 2004;94(11).

67. Rominski SD, Lori J, Nakua E, Dzomeku V, Moyer CA. When the baby remains there for a long time, it is going to die so you have to hit her small for the baby to come out: Justification of disrespectful and abusive care during childbirth among midwifery students in Ghana. Health Policy Plan. 2017;32(2)

68. Burrowes S, Holcombe SJ, Jara D, Carter D, Smith K. Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: A qualitative study. BMC Pregnancy Childbirth. 2017;17(1)

69. Chadwick R. Breaking the frame : Obstetric violence and epistemic rupture. Agenda Empowering women for gender equity 2021; 35-3.

70. Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. Lancet . 2009;817–34.

71. Kim J, Motsei M. "Women enjoy punishment": attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. Soc Sci Med. 2002 ;54(8)

72. Pattinson RC, Hlongwane TMAG, Vannevel V. Challenges to improve antenatal and intrapartum care in South Africa. South African Med J. 2019;109(11b).

73. Luna Z, Luker K. Reproductive Justice. Annu Rev Law Soc Sci. 2013;9:327–52.

74. Ross LJ. Reproductive justice as intersectional feminist activism. Souls. 2017;19(3)

75. Bhakuni H. Reproductive justice: Non-interference or non-domination? Dev World Bioeth. 2021;1–6.

76. Chinyere Oparah J. Birthing Justice: Black women, pregnancy and childbirth. London: Routledge Press.; 2015.

UNIVERSITY of the WESTERN CAPE



http://etd.uwc.ac.za/

77. Henry C. The Abstraction of Care: What Work Counts? Antipode. 2018;50(2)
78. Andaiye. The point is to Change the World. Trotz A, editor. London: Pluto Press; 2020.
79. Dutton J, Knight L. Reproducing neglect in the place of care: Normalised violence within Cape Town Midwifery Obstetric Units. Agenda. 2020 ,1–9.
80. Dutton J, Knight L. Sexual and Reproductive Justice: From the Margins to the Centre. Morison, T. & Mavuso J., editor. Lexington Books.; 2022.

http://etd.uwc.ac.za/

# Chapter 2: Methodology

## 2.1 Study Design

This study has used reproductive justice as theoretical framework to analyses the project overall, from conceptualising a standpoint to what literature is used to discuss the findings. When engaging with the finding, (coding, creating categories, constant comparison) this study is designed using grounded theory and follows the steps of a constructivist grounded theory protocol. Grounded theory is an inductive approach to research that seeks to generate middle-range theory that is specific to the context and 'grounded' in the data (1). Being 'grounded' ensures that theory is developed in the social world rather than in the abstract (2). Originally conceptualized by Barney Glaser and Anselm Strauss (1967) through their observation that research studies have a firm presupposed and inferred theoretical orientation that limits the possibilities of new theory, which can be informed through data (3). Glaser and Strauss argued that when applying grounded theory, the researcher's role was to discover theory within the data, which implies that the theory is already there, ready to be discovered by the researcher. A constructivist version of grounded theory challenges this and offers a more nuanced approach through viewing knowledge as located in time, space and situation, taking into consideration how the researcher constructs theory through interacting with the data (1). The discovery process is then about the researcher, who creates an explanation, organization, and presentation of the data and through this constructs theory (2).



http://etd.uwc.ac.za/

Constructivist grounded theory is both the approach to research design and the method used to analyse data within this study. Each step within the research process is guided by a particular set of procedures and techniques (3). The fundamental principles of grounded theory are: categories, coding, constant comparative analysis, negative case analysis, theoretical sensitivity, theoretical saturation, and memo writing (2). The aim of this study is to develop theory from qualitative data, constructivist grounded theory offers the appropriate tools of analysis, methods, and process to achieve this.

## 2.2 Study population and sampling

Participants were sampled to ensure heterogeneous representation and to reflect diversity with regards to professional cadre, age, language, and religious background. They were selected through referral and discussion with the facility manager or head of the MOU (sister in charge). Following the procedures of grounded theory, this study sampled until saturation. The study population included all nurses and midwives who worked within the selected MOUs. Other members of staff such as management, security, custodial staff and those working in administration reception were excluded from this study. From auxiliary nurses to advanced midwives, nurses from all levels of qualifications were included in this study. South Africa does not have a direct-entry midwifery programme and therefore all midwives study as nurses, with midwifery as one component of the four-year nursing degree. There is also an option to become an auxiliary nurse, which involves a two-year diploma. An additional one-year advanced midwifery programme is offered after completing the four-year degree. The South African



http://etd.uwc.ac.za/

Nursing Council (SANC) regulates nursing and midwifery education and all those employed as nurses or midwives in government facilities must be registered with SANC.

## Participant Characteristics

| *Role* | *N (24 total)* |
|---|---|
| Advanced midwife | 6 |
| Auxiliary nurse | 6 |
| Professional nurse | 12 |
| *First/home language* | |
| Afrikaans | 3 |
| English | 2 |
| Xhosa | 18 |
| Zulu | 1 |
| *Religion* | 22 |
| None | 2 |
| *Reproductive status* | |
| No children | 2 |
| Has children | 22 |
| *Relationship status* | |
| Single | 10 |
| Partnered (Married) | 14 |

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

## 2.3 Data collection

This exploratory qualitative study consisted of 24 in-depth interviews with purposively selected nurses and midwives at midwifery obstetric units (MOUs) in Cape Town in the Western Cape province of South Africa. Three MOUs were included in this study and were selected after consulting with a senior member of staff at the University of Cape Town Department of Obstetrics and Gynaecology. The selections were made to include clinics in both the metro east and metro west regions of Cape Town. This allowed for the inclusion of MOUs with different referral hospitals to be part of the study.

MOUs are midwifery led maternal health facilities located in Community Health Centres and offer services for free. Services include care across the continuum of maternity care including antenatal, intrapartum, and postnatal care. MOUs are usually staffed with two midwives and two to three nurses in the delivery ward and a doctor is on call at all times. Women with complications during pregnancy are referred to tertiary hospitals. When complications arise during childbirth, women are transferred to the referral hospital for emergency care. All MOUs have an antenatal clinic which provides care five days a week and it is recommended that pregnant women start attending antenatal care at twelve weeks.

*Interviews*

The interviews took place within the clinic in as quiet and private a space as was possible within a busy MOU, during times when either the MOU was quiet or the nurse was able to take a break. The interviews were conducted using a semi-



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

structured interview guide (see Appendix I), however, because the aim was to collect personal narratives, the participants were encouraged to speak on topics of their choice with the limitation that the story was relevant to the study. Relevance was judged with the consideration and understanding that narratives are not always linear and experiences are shared in complex ways. All interviews were conducted in English, which is the language of nursing and midwifery education in South Africa, by the primary researcher, who herself has midwifery training and practical experience.

Following the methods of grounded theory this study applied theoretical sampling and collected data in light of the categories that emerge and were constructed, which ensured saturation. While the initial interviews took a very open approach with regards to the content within a narrative, at times I selected particular stories for further investigation in the following interviews. 21 of the 24 interviews were recorded using a voice-recorder with permission of the participants, while the remaining three chose not to be recorded so the interviews were written down verbatim. Additionally, I took field notes to describe the context (private office, nursing station, ANC clinic) as well as to note body language and facial expressions.

*Observations*

Including observations of practice environments was one way to better understand not only how the clinic functions but how the environment perpetually shapes norms within the MOUs. Nurses and midwives are affected by and participate in the construction of midwifery norms and this was observed through

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

closely watching the interactions between all people in the clinic. How people spoke to each other in the clinic was as informative as the content being communicated. Observing how, at times, abrupt communication was used to speak to patients and at other times, more compassionate ways of speaking told of what the norm within the space was. The absence of communication was another insight into how the clinic functioned. At times the clinics were full of patients chatting to each other and at other times the room was quiet and the pregnant women awaiting their appointments appeared to be exhausted from the long period of time they had been sitting.

The majority of observations took place in the antenatal care waiting room and at times, from the nursing station in the labour ward. The antenatal waiting areas were comprised of an open space, a room and often the hallway, and plastic chairs or wooden benches. The antenatal clinic was often at full capacity as women would come early in the morning for care and wait for most of the day. The same space was used for women who were returning for postpartum check-ups, therefore a number of patients were holding newborns. If a chair were available, I would sit and take notes or stand when a chair was not free. I conducted a minimum of 24 hours of observation at each facility. At one clinic, I conducted observations in the evening from the nursing station, this was an opportunity to see how the labour ward ran and without the presence of management, as they had gone home for the day.

UNIVERSITY of the
WESTERN CAPE

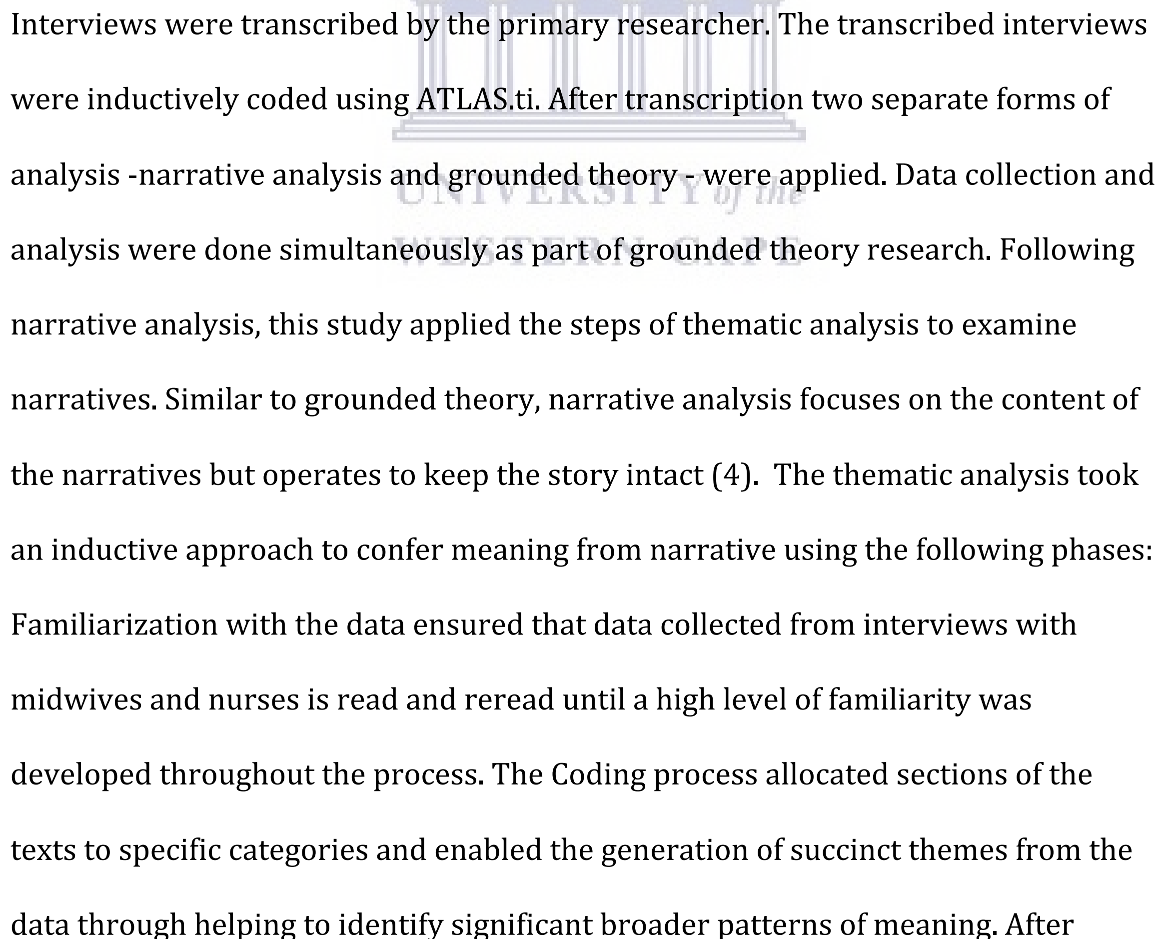
Detailed descriptive notes were taken using active observation, attending to details, and paying close attention to the environment. I paid attention to the



http://etd.uwc.ac.za/

interactions that occur in the setting such as who talks to whom, who seems to receive attention and respect, how decisions are made, and who occupies the space (i.e., where pregnant people sit and for how long). I counted the number of staff and pregnant people in the antenatal clinic and described how the setting accommodated the people in the space. I recorded body language and due to the limitation of only understanding English, I could not always understand what was being said. As recommended within observational data collection, at the time of observations, I focused on describing activities as they occurred and not infer meaning.

## 2.4 Data analysis



Interviews were transcribed by the primary researcher. The transcribed interviews were inductively coded using ATLAS.ti. After transcription two separate forms of analysis -narrative analysis and grounded theory - were applied. Data collection and analysis were done simultaneously as part of grounded theory research. Following narrative analysis, this study applied the steps of thematic analysis to examine narratives. Similar to grounded theory, narrative analysis focuses on the content of the narratives but operates to keep the story intact (4). The thematic analysis took an inductive approach to confer meaning from narrative using the following phases: Familiarization with the data ensured that data collected from interviews with midwives and nurses is read and reread until a high level of familiarity was developed throughout the process. The Coding process allocated sections of the texts to specific categories and enabled the generation of succinct themes from the data through helping to identify significant broader patterns of meaning. After



http://etd.uwc.ac.za/

particular themes were generated from nurses and midwives' narratives, the data was collated according to each potential theme. This offers validation to the themes through working closely with the data. The themes were then reviewed, refined, and checked against the dataset in order to examine if they accurately represent the narratives within the interviews. Throughout this process, each theme was analysed in depth to determine its scope and focus. Each theme tells a 'story' within the narratives collected through the interview process. The analytic narrative and data extracts were then, enmeshed and contextualized in relation to the existing literature on nurses and midwives' experiences and drivers of obstetric violence. The above steps have been explained in a sequential order, however, analysis is a recursive process and a back and forth often took place between the stages, which is not unusual within a narrative analysis (4).

*Grounded Theory*: The fundamental principles of grounded theory were also applied to this study in order to create a categorical understanding of drivers of obstetric violence based on the interview process with nurses and midwives, which informed a conceptual understanding. Grounded theory addresses a number of methodological stages within the process. The first of these makes use of categories. Categories are constructed through the grouping together of instances within the data that share characteristics. The process of categorization begins with low-level abstraction that creates descriptive labels. Descriptive labels are designed to organize data by similarities in events, occurrences, and processes within the data. As the analysis process progresses the researcher identifies categories at a high-level of abstraction and these are analytical categories as their

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

role is to interpret. Grounded theory is a cyclical process, therefore I continued to analyse the data to strengthen categories and understand how the categories also interrelate. Therefore the categories that emerged are not mutually exclusive and were constructed through process (2). Categories were conceptualized through three stages of coding.

- Open coding – creates the descriptive categories
- Axial coding – interconnects the different categories
- Selective coding – establishes the core or analytical categories (3).

The categories created through coding use words from within the data to ensure that the theories being developed represent social world, the worlds of the MOU, and not the abstract (2).

The second stage of this process is constant comparison. This part of the grounded theory process involved the moving back and forth between the identification of similarities and differences within the constructed categories. Once commonalities were identified and phenomena united within a category, constant comparison was applied to look for differences that formulate sub-categories. Grounded theory is a constant process of making categories and dismantling them into meaning. This allows for the creation of diversity and full complexity within the analysis. Because grounded theory grapples with the social world and therefore not all phenomena captured in data will fit neatly into the constructed categories, negative case analysis was used to find the instances that do not fit. This also allowed me to represent the full complexity and density of the phenomena (2).

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Theoretical sensitivity was applied when interacting with the data, to asks questions of the data, and makes modifications based on the answers. Theoretical sensitivity shifted categories from descriptive to analytical (2).

Theoretical saturation was reached in the process of data analysis when coding was complete and no new categories were conceived and no new variations of the existing categories were identified (2). A written record of the process was kept as part of theory development within grounded theory. Alongside providing a record of progress regarding defining categories, justifying labels, and tracing relationships between categories, memo-writing offered evidence of reflexivity and notes changes within the analytical process.

Observation notes were also analysed. The notebooks were read over a number of times and connections were made between the categories that emerged from the analysis of the interviews. The notes from observations did not create new categories but supported and enriched the categories from the interviews.

UNIVERSITY of the
WESTERN CAPE

## 2.5 Rigor

The components that make for a rigorous research project involve a continuous and comprehensive process that were applied at every stage. This study focused on credibility, dependability, transferability, and reflexivity to ensure rigor was achieved throughout data collection and analysis.

To address credibility within the study, peer debriefing was performed. Peer debriefing is a validation technique that enhances the trustworthiness of a study (5). During all stages of this study, I had regular meeting with my supervisor. This



http://etd.uwc.ac.za/

provided the opportunity to share the data and analysis process and received detailed feedback. Another way in which I engaged with peers was through presenting my research as it was being conducted at local conferences such as at the annual Society of Midwives in South Africa congress. Feedback provided after presenting allowed for midwives to comment and critique my work. If descriptions were vague or needed more emphasis this was an opportunity to address this with South African midwives.

Credibility and dependability were also achieved through applying different methods of analysis to allow for different ways of seeing the data. Narrative and thematic analysis were conducted and while the ladder created connecting and related patterns from the data, the former allowed me to analyse the interviews individually and get a sense of temporality and plot. Achieving dependability was also ensured through an audit trail, which detailed the decisions made throughout the research. Grounded theory requires detailed memo-writing that records the analytic process of theory development and notes any changes to the study. Before data collection began, the interview guide was piloted to ensure that it functioned as needed and that I was familiar with the content. This was conducted with trained midwives from Canada and these interviews were not included within the study.

UNIVERSITY of the
WESTERN CAPE

Transferability has been addressed within this study by providing thick description of the research design, context, and conditions in order to assess generalizability. Using purposive sampling method assisted transferability by selecting participants that are knowledgeable regarding the clinic and its daily operations. Including



http://etd.uwc.ac.za/

advanced midwives, professional nurses and auxiliary nurses, the sample population could also offer insight into what differs with respect to knowledge on how care is performed in the clinic.

In efforts to maintain transparency, reflexivity helped make explicit my philosophical position by not merely reflecting on positionality but taking into consideration how one arrives at a particular positionality and generates awareness about potential bias within the research project.

## 2.6 Statement of positionality

Being a white woman, who underwent midwifery education in Canada, has impacted both data collection and analysis. How I 'see' the MOU cannot be separated from how my education has shaped my understanding of maternal health care. The model of care and resources available in Canadian hospitals differs greatly from the realities of South Africa's public health system. My experience of working with pregnant woman and assisting women give birth prepared me for conversations on clinical care but I have no idea what it feels like to work in an under-resourced environment where supplies such as sheets and gloves are not abundant.

UNIVERSITY of the
WESTERN CAPE

Not being from South Africa came with its advantages and disadvantages. A central barrier to this study is that I do not speak isiXhosa or Afrikaans and my observations of the clinic were severely impacted by this. I could make notes based on body language and the ways in which people spoke to each other (volume, displayed anger, laughing) but I did not know what was being said at all times. The



http://etd.uwc.ac.za/

benefit on being an ‘outsider’ was that, at times, nurses and midwives expressed that they could tell me particular things because I am not from here and there was no worry that I would share information with members of their community. My ‘outsider’ position was also influenced by my race and nationality. I was, at times, introduced to the research participants by clinic management as a researcher from Canada and this appeared to come with a particular status attached to whiteness and being from the global North.

## 2.7 Statement of reflexivity

Research on violence demands reflexivity, which is more than a reflection on the events witnessed and stories told. It asks the researcher to seriously ask what are the ethics around conducting researcher in places where harm is done onto others and what are the responsibilities of the researcher in that hierarchical context. I witnessed acts of neglect and care that lacked compassion and as a silent observer this translated into feelings complacently – as silence often does. The majority of violence I encountered was systemic and it carried harmful consequences even for nurses and midwives who hold positions of power in the maternity ward. My responsibility to the nurses and midwives was more definitive. I could practice respectful research through valuing their time, listening to their perspective, and taking serious their grievances. How a researcher ethically engages with the ways in which this systemic and structural violence affects many of the women seeking maternity care in public health facilities in South Africa, raises unanswered questions and work yet to be done

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

## 2.8 Ethical considerations

Clearance was obtained for the study to be conducted from the UWC Bio-medical Research Ethics Committee and the Western Cape Department of Health ethics approval. Each community health centre where the MOU is located approved the study before it began. Contact and permission with management at each facility was made and a conversation was had before the start of this study.

Participants within this study will have their full rights respected. An information sheet detailing the study and the role of the participant was provided to all participants and informed consent was sought from each respondent using a consent form. In the form and information sheet participants were informed of their rights within this study including the right to withdraw from the study at any time. This study was conducted without any coercion or manipulation.

UNIVERSITY of the
WESTERN CAPE

Confidentiality of participant's information was insured throughout the entirety of the study. All field notes, tape-recorded interviews, and transcriptions were locked in a safe drawer in which the only I have access to. Anonymity was ensured throughout this study and within all publications. When quoting the research participants, the clinic in which they work at was not disclosed to further insure anonymity.

Throughout the data collection, I acknowledged the risks and sensitivity of the topic and treated the interviews with caution and respect. Interviews took place in an environment of the participants choosing. Due to the sensitive nature of this topic and addressing experiences of violence there is a risk that interviews will trigger



http://etd.uwc.ac.za/

hurtful personal memories of trauma and abuse. I had ready the contact information for support, particularly with regards to mental health if necessary, however nurses and midwives did not express any distress due to the interviews. The societal benefits of this study are still unfolding but with publication on drivers of obstetric violence from the perspective of nurses and midwives and future plans for collective engagement on the topic, this research hopes to contribute knowledge to a field that is working to improve maternal health for patients and providers.

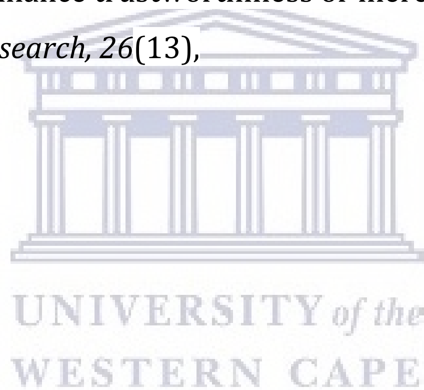
UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

References for chapter 2

1. Charmaz K. Grounded Theory Methods in Social Justice Research. In SAGE Handbook for Quality Research (2011) Edited by Denzin, N. & Lincoln Y. California: Sage Press.
2. Charmaz K. Constructionism and the Grounded Theory Method. (2008) New York: The Guilford Press.
3. Robson C, McCartan K. Real World Research. 4th ed (2016). Sussex, United Kingdom: Wiley & Sons Ltd.
4. Riessman CK. (2008) Narrative methods for the human sciences. Thousand Oaks, Califonia: Sage Publications.
5. Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(13),


UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

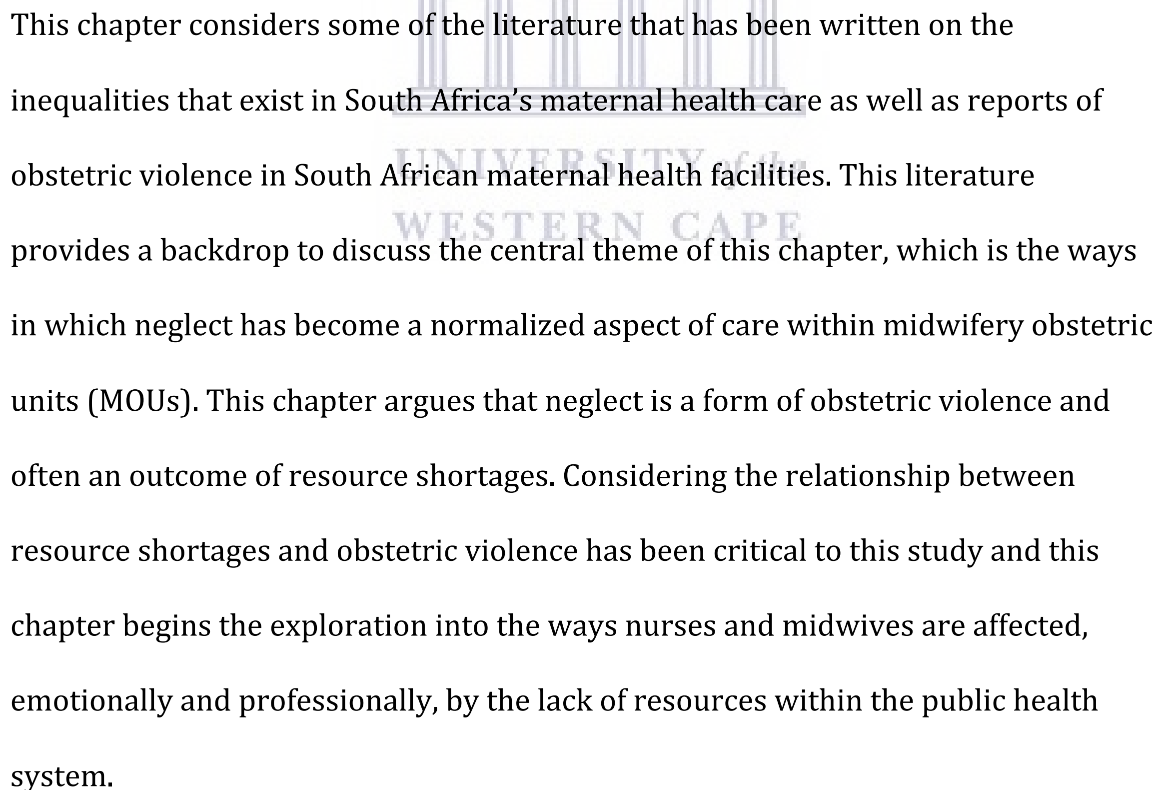
# Chapter 3: Reproducing Neglect in the Place of Care: normalized violence within Cape Town Midwifery Obstetric Units

Authors: Jessica Dutton & Lucia Knight

Published in Agenda Empowering women for gender equity

Volume 34, 2020 - Issue 1: Gendered and Feminist Inequalities

https://doi.org/10.1080/10130950.2019.1704481



This chapter considers some of the literature that has been written on the inequalities that exist in South Africa's maternal health care as well as reports of obstetric violence in South African maternal health facilities. This literature provides a backdrop to discuss the central theme of this chapter, which is the ways in which neglect has become a normalized aspect of care within midwifery obstetric units (MOUs). This chapter argues that neglect is a form of obstetric violence and often an outcome of resource shortages. Considering the relationship between resource shortages and obstetric violence has been critical to this study and this chapter begins the exploration into the ways nurses and midwives are affected, emotionally and professionally, by the lack of resources within the public health system.



http://etd.uwc.ac.za/

*Abstract*

Access to quality maternal health care within South Africa is strongly determined by where a woman lives and her socio-economic positioning. Through an analysis of experiences shared by nurses and midwives working within midwifery obstetric units (MOU) within Cape Town, this paper considers how the South African health system maintains and reproduces gendered inequalities. The ways in which such inequalities materialize within an MOU are vast, for this article we focus on the issue of patient neglect. We approach neglect as a form of reproductive governance and resource shortage as a form of violence, and the ways in which both devalue women's reproductive labour. Resistance takes the form of kindness and is always under duress within a system that is predicated on inequality.

Keywords: reproductive labour, obstetric violence, neglect during childbirth, midwifery, resource shortage

UNIVERSITY of the
WESTERN CAPE

*Introduction*

Public maternal health care in South Africa serves approximately 83 percent of the population and is failing the women it sets out to serve (Chadwick, 2018). South Africa's high maternal mortality ratio, currently estimated at 134 deaths per 100,000 births is considered a form of obstetric violence and rightfully so, considering 64 percent of deaths are avoidable (DOH, 2017). The vast majority of those who access public health services are Black women who cannot afford the costs of care in the private health sector (Rucell, 2017). Within the South African health system a woman's socioeconomic status greatly determines the quality of



http://etd.uwc.ac.za/

maternal health care she will receive (Chadwick, 2014, 2018). As Chadwick explains, “birth politics are inextricably shaped by these sociomaterial inequalities and historical legacies. The health system, in particular, continues to be plagued by the aftermath of apartheid and racial inequalities that materialize as sharp differences in health infrastructure and resources between the state-funded public sector and the private health care sector” (2018:4).

Obstetric violence as a specific form of gender-based violence has gained attention as both a public health concern and an impediment to realizing reproductive justice (Jewkes and Penn-Kekana, 2015). This article approaches obstetric violence as any form of mistreatment towards a person during their maternity care, with specific attention paid to a person’s autonomy during childbirth. Obstetric violence is driven by many factors and “should be analyzed as a consequence of structural violence” (Perera *et al.*, 2018:.3). This article reflects on neglect within maternal health care, as a common form of obstetric violence and situated within the politics of reproductive health care in South Africa. We contextualize neglect as a form of reproductive governance that reinscribes racial and gendered hierarchies (Castro and Savage, 2019) and approach the subject from the viewpoint of nurses and midwives. In doing this, we explore neglect as an attack on the labour women do to reproduce life more generally, including the crucial work of caring for others. By focusing on the midwifery experience of working within conditions of resource shortages that lead to constant uncertainties that make quality care unattainable we set out to politicize neglect, not as an outcome of individual behavior, but a form of systemic and structural violence. This paper concludes with a reflection on the ways

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

in which nurses and midwives attempt to resist systemic violations to their own social reproduction and the reproductive freedoms of the women they serve.

As part of my PhD research, I have spent the last year visiting three Midwifery Obstetric Units (MOUs) in Cape Town to discuss things related to quality of care with the nurses and midwives who work there. MOUs are midwifery run health facilities that are comprised of an antenatal clinic, labour ward, and post partum care for women and newborns. They are accessible free of charge and care for low-risk pregnant and postpartum women. The MOUs I visited operate with two midwives and one auxiliary nurse within the labour ward. All three MOUs are located within townships of Cape Town.

I have spent long days sitting in the antenatal care clinic wait room or labour ward while waiting for an available nurse or midwife to find time for an interview. Many days this was not possible and I would leave the clinic without interviewing anyone. During this time, I witnessed a spectrum of interactions and engagements between nurses and the women coming for care. Whether it was getting through forty to sixty antenatal appointments, making do with insufficient equipment and supplies, nurses and health workers demonstrated patience and were often kind. There were incidences where kindness was sidelined and from where I sat, this usually took the form of a nurse ignoring a woman needing her time and attention. This was not met with surprise from anyone within the facility, including the patients. Other staff members did not condone such behavior and if this was anything outside of the norm, no one expressed concern. There seemed to be a general dissatisfaction within the clinic – wait times were too long and there never seemed to be an

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

adequate number of staff. Midwives spoke of conditions getting worse with time, but having to work under duress isn't a recent phenomenon within this context. Other than those who had experience in the private sector, it has been this way for the entirety of their careers and the idea of this ever changing was met with skepticism.

Apart from neglect being the most obvious form of mistreatment within the MOU, it is worth thinking more about it as a form of gendered inequality. Being ignored, or made invisible, during childbirth as Rachelle Chadwick points out is not, "an individual matter or experience" but rather "entwined with the broader body politics and social inequalities" (2018:6) Expanding the analytical lens on neglect from an individual act to a product of systemic social inequality allows for neglect to be understood as firstly evidence of ongoing devaluation of reproductive labour and secondly, a form of reproductive governance. Reproductive labour is understood as the labour, which disproportionally falls onto women (working class and poor women specifically), and makes social life possible. It encompasses the necessary work needed to keep our population alive and the labour of caring for others dominates much of this. Jobs that include caring for others such as childcare, nursing, midwifery, and domestic work, which are often poorly paid, are targeted within the continual attack on social reproduction in current neoliberal models of government (Frederici, 2013). Quality maternal health care is predicated on not only a high level of clinical skill but that the maternal health facility be a place where all women, staff and patients alike, will be cared for and their reproduction valued.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Reproductive governance is defined as "the mechanisms through which different historical configurations of actors—such as state institutions, churches, donor agencies, and non-governmental organizations (NGOs)—use legislative controls to produce, monitor and control reproductive behaviours and practices" (Morgan and Roberts, 2012:1) Within South Africa, one way in which the state regulates woman's reproductive practices and freedoms is through a bifurcated health system (Rucell, 2017). On one side, within the private health care system a culture of quality, time, sensitive and safe care is produced and available to those who can afford the high costs. On the other side, the public health system operates under constant resource shortages, a patient/health professional ratio that impedes the possibility of safe care and ensures long wait times (Morgan and Roberts, 2012; Rucell, 2017). Health outcomes differ greatly between the two systems, for example, "women in the public sector are approximately eight times more likely to die because of pregnancy-/birth-related complications than privileged women accessing private health care" (Chadwick, 2018:5) A value regime is reproduced through the normalization of access to quality care based on socioeconomic status. Acts such as neglect become routine within public health care as a mechanism of reproductive governance that devalues Black woman's reproduction. The state enacts legislative control through maintaining the current conditions of public maternal health care with the knowledge that the majority of South African women have no other choice but to access these facilities.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*Accounts of neglect in South African maternal health care*

When looking at the existing research on obstetric violence in South Africa, findings show that neglect is a common violation within maternal health facilities (Odhiambo and Mthathi, 2011; Solarin and Black, 2013; Honikman, Fawcus and Meintjes, 2015) In many accounts of obstetric violence, women describe neglect as an interpersonal experience - an intentional act by health care workers that reflects individual behavior and attitudes (Odhiambo and Mthathi, 2011). Jewkes, Abrahams & Mvo's (1998) seminal article on obstetric violence in South Africa, *Why Nurses Abuse Patients*, published in 1998, demonstrates that neglect is a recurring theme within women's narratives of mistreatment during childbirth and often the most distressing aspect of giving birth in a public maternal health facility. When women speak of experiences of neglect, they often draw attention to how customary and disciplinary it seemed, not the outcome of a heavy workload within the facility but rather a deliberate choice the nurses made (Solarin and Black, 2013).

UNIVERSITY of the
WESTERN CAPE

Jewkes et al. (1998) analytically approach neglect by contextualizing and historicizing obstetric violence and highlighting the ways in which apartheid-sanctioned racism, classism and patriarchy structured and shaped the nursing profession. They argue that acts of neglect, as well as other forms of obstetric violence, derive from a desire held by nurses and midwives to emphasize a status gap between them and the women in their care. During apartheid black women were allowed to enter the nursing profession under the assumption that they would assume a position of superiority over their community (Marks, 1994). At this time,



http://etd.uwc.ac.za/

nursing was considered a profession for white women, and for black women to be employed they were expected to adopt a particular gendered and class prejudice. As Rucell explains,

> Within the context of colonial and apartheid governance historic orders attendant to race and gender were entrenched. The formal practice of midwifery and obstetrics emerged through the normalisation of degrading notions of sexuality, and embodied exploitation…This history reveals a key origin of the trajectory of epistemological and practical gendered hierarchy within maternal health. During the apartheid era the inculcation of these ideologies within health services expanded, especially through the inclusion of training (albeit intentionally at a below-average standard) and employing Black women in the profession of nursing. (2017:309)

UNIVERSITY of the
WESTERN CAPE

The development and perpetuation of behavioral norms that contribute to obstetric violence within the nursing profession are rooted within this history. This alone does not explain why nurses mistreat their patients today but provides a historical context to a profession that has come under great criticism without receiving sufficient theoretical analysis in order to understand the ways in which violence and nursing intersect.

The experience of neglect, as obstetric violence, has featured as a critical issue in a number of other studies since Jewkes et al.'s (1998) Human Rights Watch (2011) published a damning report on the state of South African public maternal health care, offering a number of narratives of neglect often enmeshed with acts of



http://etd.uwc.ac.za/

discrimination towards foreign Africans and women of low socioeconomic status. A connection has been made between labeling women as 'bad mothers' due to their inability to afford the basic supplies for their newborn and feeling shamed and neglected while in the MOU. In her book on narratives of childbirth in South Africa, Chadwick states, "…giving birth in a South African MOU is thus no guarantee of receiving bio-medical assistance or even having a skilled birth attendant present during delivery. Such blatant neglect and disregard leaves women feeling abandoned, unworthy and unsafe… In MOU contexts, the birth stories of poor women were pervaded by a sense of institutional disregard for their welfare communicated to them by systemic practices of neglect, lack of care and invisibilization. They became 'invisible bodies' that did not matter." (2018:99).

The politics of 'invisabilization' has discursively shaped a feminist response within conversations on obstetric violence. As the quote above demonstrates the process of invisibilization, is a mechanism of ascribing value or the lack of value onto women. From turning women away from clinics, leaving women to birth alone, lack of informed consent, and neglecting to debrief women after a traumatic birth experience - women are made to feel devalued, unimportant and invisible at times when they most require quality maternal health care (Solarin and Black, 2013; Chadwick, 2018). Women may not birth alone within private maternal health facilities, however, they are not completely free from being made to feel invisible or neglected during childbirth (Chadwick, 2018). The common occurrence of neglect during childbirth speaks to the systemic devaluation of women and reproduction more generally. A woman of low socioeconomic status is at greater risk to being



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

made invisible and neglected during childbirth because her reproductive labour is devalued to the point of being portrayed as a burden on the system (Castro and Savage, 2019)

Carrying a heavy workload, resource shortages and low work morale have been cited as drivers of mistreatment of women during childbirth by providers (Bowser and Hill, 2010). This certainly does not explain the phenomenon in totality but, from the conversations I have had with midwives, this does need to be taken seriously in addressing violations such as neglect. The normalization of neglect within the MOU, even when the labour ward is not busy, is associated with the devaluation of reproductive labour and the work women do to reproduce society. Much of the labour nurses and midwives do falls under reproductive labour, especially the labour that goes into care. If the politics of invisibilization are to grasp the context of the MOU, the erasure of reproducing social life, in the greater sense of the term, needs to be sufficiently considered. This includes the ways in which nurses and midwives are also under attack when hierarchies of value are place on people and their labour.

*Working under duress: the narratives of nurses and midwives*

During the time I spent in the MOUs, nurses and midwives rarely spoke directly about neglect but did speak candidly about the ways in which women attending the antenatal care clinic, labour ward and postpartum care would have to wait for a considerable amount of time before being seen. Waiting would take place on a wooden bench along the hallways or plastic chairs in one of the designated wait



http://etd.uwc.ac.za/

areas.

From my observations, within the antenatal clinic tension would build as the day passed. Woman attending the clinic as well as the nurse and midwives seemed to be reasonably pleasant in the morning. The waiting room was lively and often full of women in conversation. As the day went by, restlessness and discomfort set in and the mood shifted, nurses and patients displayed impatience with each other, and attitudes ranging from mild frustration to anger. Depending on the appointment requirements, pregnant women could sit in the clinic from seven in the morning until four in the afternoon, with most of that time spent waiting. When returning to the clinic for postpartum visits, women would come with their newborns and often sit amongst those attending ANC. They too would have to arrive early in the morning and wait as appointments are allotted on a first come first serve basis, beginning at seven in the morning.

UNIVERSITY of the
WESTERN CAPE

All MOU labour wards are comprised of an antenatal room, for admission and care during the first and second stages of labour, a delivery room, and a post-partum area where women who have given birth are to be monitored for a minimum of six hours. Women arrive at the labour ward at various stages of childbirth and having attended a varied number of ANC appointments, ranging from eight to none at all. Depending on how busy the labour ward is at any given time, will determine how quickly a midwife will attend to a woman who presents in labour. Midwives spoke of women not having to wait long or only having to wait when the ward is busy. This speaks to the ways in which waiting for care within the labour ward is normalized.



http://etd.uwc.ac.za/

According to international standards of care, a woman who presents in a maternal health facility in labour should not have to wait at all (The White Ribbon Alliance, 2011). When patients outnumber midwives, an auxiliary nurse will tend to women who arrive in labour. The scope of an auxiliary nurse is limited to taking a patient's vitals and attending to the basic tasks to admit a patient. Currently the skill set of an axillary nurse does not include a physical examination. There are limitations to simply visually assessing a woman in labour, without proper examination by a midwife, a birth plan cannot be developed and complications that need immediate attention may go undetected.

When talking to a very experienced midwife about some of the difficulties she has experienced over the years working in the MOU, she shared a story of being short staffed during an emergency situation.

UNIVERSITY of the
WESTERN CAPE

> I had a cord prolapse (the descent of the umbilical cord through the cervix) when we were short staffed, two sisters and one nurse. I wanted to present to a doctor so I went to the phone. The patient was screaming and I looked over and there was meconium all over the floor. I had to keep my hand inside her vagina and call the doctors because the cord was prolapsed. The patient didn't want to get on hands and knees. It's not a dignified position I couldn't explain to her not with one hand in her vagina and calling the doctor. I had to get her into the ambulance with my hand in her vagina. Can you imagine? That is very difficult climbing into the ambulance like that. Yho, the patient was crying and screaming. When the doctor did the scan there was no fetal heart. I was, yho.



http://etd.uwc.ac.za/

> The doctor was supportive, said sister, I'm sorry. I had to write a statement and I couldn't answer a lot of questions. Was the cord pulsating? What was the BP? Now, how am I supposed to take a BP with my fingers like that? I can't. The mother was hysterical, how was I supposed to check if the cord was pulsating? How could I do a BP? I was like really? When you lose a baby it's depressing and the office has to ask questions and they are not supporting you, like you came here to kill babies. In some clinics there is debriefing but not for this case. For the first time I fought with the management, sho.

This story demonstrates the ways in which staff shortage puts life in crisis - a violence done onto both patient and midwife. When describing the events of that evening, the midwife explained that she had moved the patient to avoid evidence of long wait times within the labour ward, saying that:

> There is a camera on that bench where women sit and wait and we cannot let them wait there too long, because the camera and then people will see they are waiting too long. So I moved her into the admission room so she wouldn't be on the camera. So she was waiting in the admissions room and we were short staffed. It was only when she started screaming...

UNIVERSITY of the
WESTERN CAPE

The potential risk to women caused by a delay in care is acknowledged through the decision to place a camera over the wait area, however this does not address the root cause of why women are not getting the care they need. The presence of a camera without changes to the system that would address resource shortages and long wait times places nurses in a precarious position. It either assumes that the problem rests in the behavior of nurses, that they in fact do have the capacity to



http://etd.uwc.ac.za/

attend to patients quickly and are choosing not to do so and therefore surveillance would correct this. Or the presence of the camera, as this case demonstrates, is to give the impression that the clinic is meeting professional standards of care, regardless of whether this is true or not.

Nurses and midwives emphasised the ways in which resource shortages had a negative impact on their ability to offer quality care to their patients, and often created further delays. Midwives expressed, accompanied with a sense of powerlessness, the tension between the managerial expectations of standard of care and the reality in the clinic. Midwives spoke of policies such as 'Quality of Care' and 'Person-centred Care' as theoretical and just descriptions or terms used but not practically applied in the facility. One senior midwife responded with laughter when I asked her about the level of quality in the facility stating, "*quality of care, there is no quality of care here. We cannot say that, we must say oh yes we give quality of care but how?*" (Midwife, Cape Town). Continued resource shortages included; a lack of basic supplies such as linen and linen savers, constantly having to tinker with broken equipment, and too few midwives to handle the patient load. These left nurses feeling demoralized and unappreciated. During an interview in one MOU, a midwife described her working environment:

> We are always short of equipment. Staff, there is a shortage of staff… we are pressurized by stat[istic]s, follow the stat[istic]s, quantity more that quality. We don't take tea because we are rushing, the department is full, you must rush because you are dealing with the patients, they can't stay



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

long. They don't want the patient to stay long… even now the autoclave machine is not working, we are struggling even with speculums, the endo-hooks we were struggling, delivery packs, our delivery packs, they don't have scissors, so its things like scissors. And the suturing materials, you are using blades but I think they have got scissors, but the last time I was there, there was no scissors and we were using blades. (Midwife, Cape Town)

Similar descriptions were commonplace in a number of the midwives' stories. Equipment shortages featured in the narratives of midwives so frequently that it was often normalized as just the way in which the clinic functioned. The high midwife/patient ratio was another common theme in the interviews and again spoken about as normal to maternal health care in the public sector. A discussion with a nurse on duty the difficulties of only having two beds in the labour ward her words demonstrate both the problem with lacking the basic necessities and the ways in which this is normalized,

…we get a lot of three deliveries at the same time so sometimes they have to deliver on the antenatal beds on the other side, not in the labour ward.

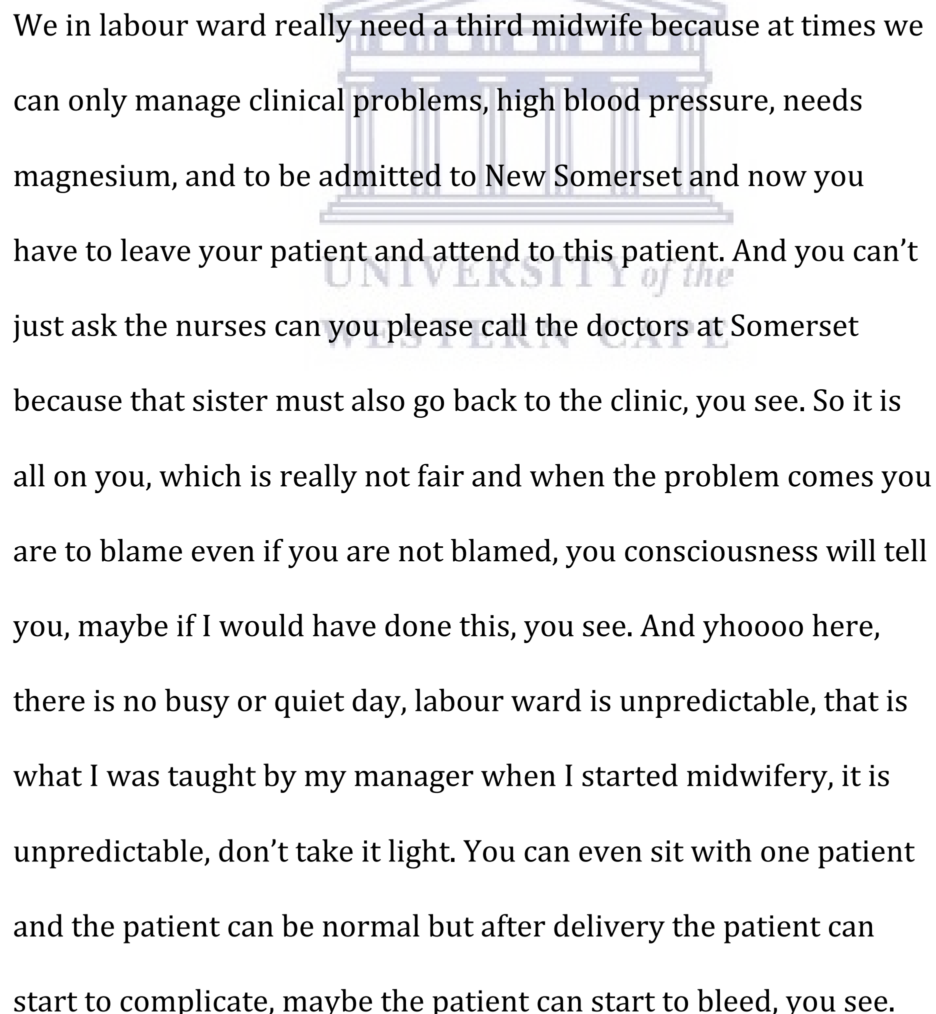
When asked whether this caused problems, she responded; No, only if we are short of staff, like if there are only two sisters and the two sisters are helping on the delivery on the other side. The nurses will just deliver the baby quickly and change the gloves and go to the next one. (Auxiliary nurse, Cape Town)

There are real risks of complications directly after a woman gives birth, such as



UNIVERSITY of the
WESTERN CAPE
http://etd.uwc.ac.za/

postpartum hemorrhage, which require constant monitoring. Therefore, in conducting two deliveries back to back as described above, attending to each patient's needs is compromised. Nurses and midwives are aware of these dangers all too well, however over time and with regular occurrence, practicing under such conditions stops raising alarm. However, this does not mean that clinic staff became oblivious to their working conditions, often midwives spoke with much compassion about the staff shortage, stressing their worries and fears. I interviewed a midwife, who had just finished her shift and spoke with much concern,



> We in labour ward really need a third midwife because at times we can only manage clinical problems, high blood pressure, needs magnesium, and to be admitted to New Somerset and now you have to leave your patient and attend to this patient. And you can't just ask the nurses can you please call the doctors at Somerset because that sister must also go back to the clinic, you see. So it is all on you, which is really not fair and when the problem comes you are to blame even if you are not blamed, you consciousness will tell you, maybe if I would have done this, you see. And yhoooo here, there is no busy or quiet day, labour ward is unpredictable, that is what I was taught by my manager when I started midwifery, it is unpredictable, don't take it light. You can even sit with one patient and the patient can be normal but after delivery the patient can start to complicate, maybe the patient can start to bleed, you see.



http://etd.uwc.ac.za/

> And you will sit with a dead mother or a dead child, that 's the saddest thing. (Midwife, Cape Town)

The midwife continued with a story of a stillbirth due to ambulance delay, she spoke with great sadness of the memory and experience of having to explain to the woman in labour that her baby had died. She spoke of carrying this memory with her and the trauma that has not resolved. Ambulance shortages, which is not usually characterized as a form of neglect, does however demonstrate a health system failure that denies women care. All MOUs in this study are located in areas of high crime and nurses and midwives felt that the MOU was often not prioritized by the EMS services or that there were too few ambulances to serve both victims of violence and the community clinic. Stories of having to wait for over four hours for an ambulance were commonplace in the narratives of midwives and brought about feelings of helplessness and frustration. One midwife shared her frustrations stating,

UNIVERSITY of the
WESTERN CAPE

> …the other big challenge that we have got at the moment is with referrals, the ambulance system, the EMS, ahhh, I thought it was only a problem in the Eastern Cape but ahhhh, because of the type of place and the distance but then you find that even in Cape Town where it is only 15 minutes away from the hospital but you get patient who are sitting here with big problems, sitting here for 4 hours (Midwife, Cape Town).

Another system barrier to quality care is the clinic building itself. Again, not usually thought of as contributing to neglect, midwives expressed the difficulties of respecting patients' privacy and making room for implementing new policy



http://etd.uwc.ac.za/

that allows all women to have a birth companion of their choice. When looking at literature on women's testaments of neglect during their childbirth, feeling alone and abandoned is often mentioned (Lambert *et al.*, 2018). Studies have also demonstrated the importance of a companion in a positive birth experience, especially in relation to pain management (WHO, 2018). Currently in two of the three MOU's I visited women can only bring a companion when they enter the labour room of the ward and are ready to deliver. While in the antenatal part of the labour ward, where women experience long hours of contractions, the space is communal and small. Unless there are no other women present, women are denied companions, especially if they are men. Utilizing public maternal health care means women are often denied a companion affecting their experience and increasing the feelings of abandonment and neglect.

*Kindness within crisis: health care workers resist*

UNIVERSITY of the
WESTERN CAPE

Equipment shortages, inadequate number of staff, inaccessible ambulance services, and a lack of physical space required for quality of care does not exhaust the list of nurses and midwives' concerns, however these do greatly affect the possibility of health care workers reaching their potential with regards to clinical care and care based on mutual respect.  Within the narratives above, two midwives shared stories of stillbirth as the outcome of having to work under conditions of profound constraints. In both cases the women in labour experienced neglect and in both cases the neglect was connected to the lack of resources within the clinic. Literature on obstetric violence as a form of reproductive governance provides a historical and contextual analysis for the way in which apartheid and current modes of racism and



http://etd.uwc.ac.za/

patriarchy are mechanisms which dehumanize and devalue women's reproduction, especially if the women are black and poor (Castro and Savage, 2019). The stories above are the lived experiences of this process and both the patient and midwife are entangled within an inherently violent system that treats women's labour and bodies as if they are disposable. When we understand that there is a violence to working under conditions of constant resource shortages and uncertainties then neglect becomes predictable and a constitutive aspect of public maternal health care. Without a radical deconstruction and transformation of a system that perpetually devalues or makes invisible social reproduction we can expect to produce the same outcome (Frederici, 2013), which in this case is substandard care despite a high degree of clinical skill.

One does not have to observe an MOU, especially the ANC waiting room, for very long, to see that the formation between health care workers and patients is predicated on the two being pitted against each other, where one guards their interests against the other. The interest, or demand, is often the health care worker's time. On one hand the nurses and midwifes scramble to manage increasing amounts of paperwork, high patient volume, tinkering with broken equipment, while compensating for staff shortages, while on the other hand patient's patience dwindles as they await care. In spite of this, acts of kindness were performed regularly. I witnessed nurses staying past their shift to attend to all patients and there was often an exchange of food and laughter. On one occasion, an auxiliary nurse, who described herself to me as poor, gave an undisclosed abount of money to a woman who had recently delivered and was back for postpartum care. These acts

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

of generosity are in no way solutions to a health system that must be reimagined and transformed. However, within a system that is predicated on inequality, acts of kindness go against the grain of the health care workers role in maintaining this system. Health care workers resist the devaluing of their own reproductive labour through realizing ways of sharing under conditions of duress.

One MOU has been working towards adopting a model of care that prioritizes women's autonomy. Midwives and nurses spoke about women having the freedom to birth in the position of their choice, allowing women more time to labour, the presence of a birthing ball, showers for pain relief, and informed consent on issues such as contraception – aspects of maternity care that are often perceived as too frivolous or outside of what is considered necessary in the public system (Castro and Savage, 2019). The midwives I spoke to felt the new sister in charge was responsible for these changes more so than the implementation of any specific policy. Again individual efforts are not the solution to what is a deep and complex systems issue and implementing care based on self-determination comes with its challenges. The shortcoming of individual generosity or attempts to adopt a new model of care were also expressed by the midwives as they often felt management was more concerned with litigation and financial risk than participating in alternative forms of governing maternal health care. Despite these limitations, it is something worth taking the time to explore - that health care workers demonstrate resistance from inside the very system that devalues the work they do and the women they care for.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

References for chapter 3

Bowser, D. and Hill, K. (2010) 'Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis USAID-TRAction Project'.

Castro, A. and Savage, V. (2019) 'Obstetric Violence as Reproductive Governance in the Dominican Republic', *Medical Anthropology: Cross Cultural Studies in Health and Illness*. Routledge, 38,2, 123–136.

Chadwick, R. (2014) 'Raising concerns : Quality of care in maternal health services in South Africa', *African Journal of Midwifery and Women's Health.* 8,4.

Chadwick, R. (2018) *Bodies that birth: Vitalizing birth politics.*, New York: Routledge.

Department of Health, South Africa. (2017) *Saving Mothers 2017: Annual Report on Confidential inquiries into maternal dealth in South Africa.*

Frederici, S (2013) 'Women, reproduction, and the construction of the commons. Presented at Reproducing Values Series, Museum of Art and Design, New York

Honikman, S., Fawcus, S. and Meintjes, I. (2015) 'Abuse in South African maternity settings is a disgrace: Potential solutions to the problem', *South African Medical Journal*, 105, 4, 284.

Jewkes, R. and Penn-Kekana, L. (2015) 'Mistreatment of Women in Childbirth: Time for Action on This Important Dimension of Violence against Women', *PLOS Medicine*, 12,6.

Lambert, J. *et al.* (2018) '"I thought they were going to handle me like a queen but they didn't": A qualitative study exploring the quality of care provided to women at the time of birth', *Midwifery*. Elsevier, 62, 256–263.

Marks, Shula. (1994) *Divided Sisterhood: Race, class and gender in the South African nursing profession,* Johannesburg: Witwatersrand University Press.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Morgan, L. M. and Roberts, E. F. S. (2012) 'Reproductive governance in Latin America', *Anthropology and Medicine*, 19, 2, 241–254.

Odhiambo, a and Mthathi, S. (2011) *Stop Making Excuses: Accountability for Maternal Health Care in South Africa*. Human Rights Watch.

Perera, D. *et al.* (2018) '"When helpers hurt": Women's and midwives' stories of obstetric violence in state health institutions, Colombo district, Sri Lanka', *BMC Pregnancy and Childbirth*. BMC Pregnancy and Childbirth, 18(1), pp. 1–12.

Rucell, J. Z. (2017) 'Obstetric violence & colonial conditioning in South Africa's reproductive health system', PhD Thesis, Department of Politics and International Studies, University of Leeds.

Solarin, I. and Black, V. (2013) '"They told me to come back": women's antenatal care booking experience in inner-city Johannesburg.', *Maternal and child health journal*, 17, 2, 359–67.

The White Ribbon Alliance (2011) *Respectful Maternity Care: the universal rights of childbearing women*. Available at: http://whiteribbonalliance.org/wp-content/uploads/2013/10/Final_RMC_Charter.pdf site accessed 2 October 2017

World Health Organization (2018) *Intrapartum care for a positive childbirth experience*. Available at: http://apps.who.int/iris/bitstream/10665/260178/1/9789241550215-eng.pdf?ua=1%0Ahttp://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/. site accessed August 5, 2019.

UNIVERSITY of the
WESTERN CAPE



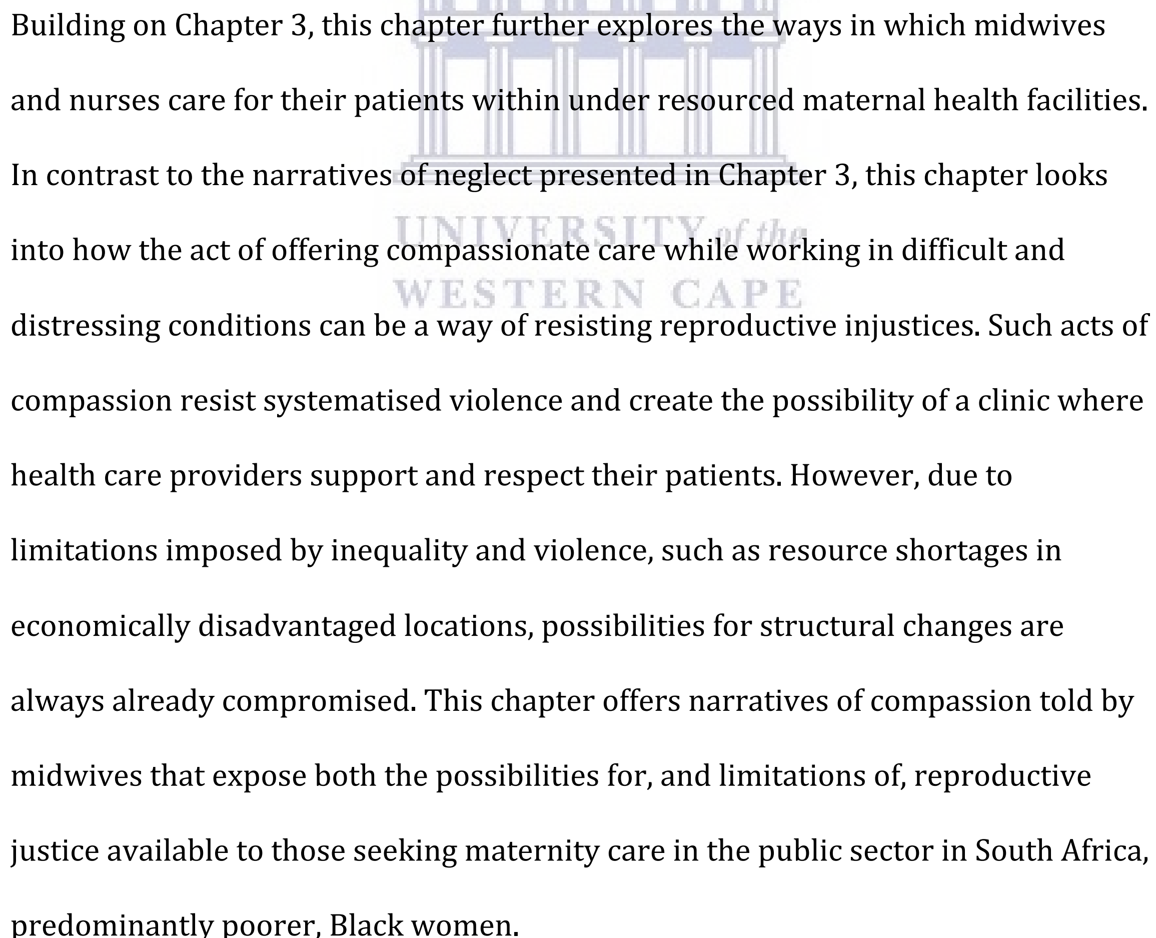
http://etd.uwc.ac.za/

# Chapter 4: The Possibilities and Limitations of Midwives Practicing Compassionate Care in South Africa's Maternity Care

Authors: Jessica Dutton & Lucia Knight

Published as a chapter in Tracy Morison and Jabulile Mary-Jane Jase Mavuso's book *Reproductive Justice: From margins to the centre* Lexington Books, 2022.

https://rowman.com/ISBN/9781793644206/Sexual-and-Reproductive-Justice-From-the-Margins-to-the-Centre




Building on Chapter 3, this chapter further explores the ways in which midwives and nurses care for their patients within under resourced maternal health facilities. In contrast to the narratives of neglect presented in Chapter 3, this chapter looks into how the act of offering compassionate care while working in difficult and distressing conditions can be a way of resisting reproductive injustices. Such acts of compassion resist systematised violence and create the possibility of a clinic where health care providers support and respect their patients. However, due to limitations imposed by inequality and violence, such as resource shortages in economically disadvantaged locations, possibilities for structural changes are always already compromised. This chapter offers narratives of compassion told by midwives that expose both the possibilities for, and limitations of, reproductive justice available to those seeking maternity care in the public sector in South Africa, predominantly poorer, Black women.



http://etd.uwc.ac.za/

Maternal health facilities play a fundamental role in shaping experiences of pregnancy and childbirth. Maternity clinics and wards are systemically and structurally regulated by the state, and their everyday practices therefore reflect the local and global bio-political landscape in which they are located. In South Africa, pronounced socio-economic inequalities and institutionalised racism structure access to quality health care (Fried et al. 2013). Everyday practices in the clinic are often governed by state order as much as they are by the implementation of clinical guidelines and formalised codes of behaviour. Reproductive injustice is undoubtedly produced and reproduced within the clinic as an institutional setting. Yet, it can also be a place of compassion and resistance as healthcare providers and patients go against the grain of systemic violence in everyday practices of being together.

In the context of a poorly resourced public health system, where are midwives and nurses situated within the politics of reproductive justice? What possibilities for reproductive justice can midwives and nurses assemble and what are the limitations? Much of the current writing on obstetric violence, a major barrier to achieving reproductive justice, positions midwives within the rigid language of either perpetrator or victim. In this chapter, we take the position that the role of the public healthcare worker, as state employee, is equivocal: to provide healthcare and, simultaneously, to police the population they serve. In the South African public health system, as in other countries, policing is achieved through acts of shaming, scolding, neglecting, and refusing to recognise the autonomy of their patients (Lappeman and Swartz 2019). Policing reproduction is also carried out through

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

systemic violence, as particularly evident in many of the country's severely under-resourced clinics (Chadwick 2017).

The position of midwives and nurses is therefore more complicated than the uncompromising language of victim or perpetrator allows for. The midwife's position to in/justice is always relational to the health system and never static. In this we follow Bhakuni's (2021) thinking on reproductive justice as requiring non-domination in our reproductive lives. Bhakuni (2021, 5) states:

> The notion of freedom as non-domination is therefore useful for reproductive justice because it places emphasis on the circumstances that make separate instances of oppression possible rather than on the individual and her choices. Non-domination focuses on the ways in which human beings are systematically situated in relation to the structures that limit (or empower) us. Similar to non-interference, non-domination comes in degrees, meaning that a person is not either free or unfree, but *relatively* free depending on the extent of non-domination the person enjoys.

UNIVERSITY of the
WESTERN CAPE

We think about the circumstances and conditions of the maternal health clinic and how forms of structural and gender-based violence shape midwifery care. What are nurses' and midwives' relationship to freedom and what does this mean for the possibilities of compassionate care?

In this chapter we explore the ways in which midwives and nurses care for their patients, drawing on empirical data generated at three government maternity facilities in low resource settings in Cape Town (South Africa) through site observations and qualitative interviews conducted with midwives working there.



http://etd.uwc.ac.za/

We demonstrate how the act of offering compassionate care while working under difficult and distressing conditions is a form of resistance to reproductive injustices as a form of mundane and systematised violence in under-resourced public maternity care settings. Through compassionate care, midwives and nurses imagine and create possibilities the health system does not currently provide for. However, due to limitations imposed by inequality and violence, such as resource shortages in economically disadvantaged locations, possibilities for structural changes are always already compromised. This chapter offers narratives of compassion told by midwives that expose both the possibilities for, and limitations of, reproductive justice available to those seeking maternity care in the public sector in South Africa, predominantly accessed by poorer, Black women.

*Obstetric Violence in South Africa*

UNIVERSITY of the
WESTERN CAPE

Obstetric violence is an expression of violence during the provision of healthcare that ranges from neglect, absence of informed consent to physical harm. It most commonly involves dehumanising, disrespectful, aggressive, and humiliating treatment of labouring and birthing patients, most of whom are women, in social contexts that foster uneven power relationships between patients and healthcare providers (Lappeman and Swartz 2019). The body of work exploring obstetric violence in economically disadvantaged communities, where under-resourced health facilities are the norm, has grown over the past decade or so (Chadwick 2018; Rucell 2017). South African research has shown that acts of disrespect and abusive treatment by healthcare providers toward their patients are not a simple result of



http://etd.uwc.ac.za/

individual wrongdoings (Jewkes, Abrahams, and Mvo 1998), but forms of systemic violence (Chadwick 2017), a particular form of gender-based violence (Rucell 2017). Drawing on these findings, we regard obstetric violence as structural violence, acknowledging that the problems and hardships in South Africa's health system are shaped by historical and contemporary injustice (Rucell 2017).

We apply the term gender-based violence to capture "violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders" (Sabri 2016, 2). In South Africa, like the rest of the world, women are more likely to be victims of gender-based violence, however, South Africa's rates of violence against women are much higher than the global average (Chadwick 2018). Gender-based violence is pervasive and touches on all aspects of South African society, public and private spaces alike (Kim and Motsei 2002; Rucell 2017). Obstetric violence is the form gender-based violence takes in the maternity ward, across the continuum of maternity care.

UNIVERSITY of the
WESTERN CAPE

South Africa's health care is divided into a public and private sector, with 84 percent of the population using public health services (de Villiers 2021). The private sector, accessed by those who can afford the costs of medical aid, is still compensated by government expenditure and offers high-quality care to patients. In contrast, public health services are characterised by a lack of resources and high numbers of patients. To give an idea of the severe imbalance between the two sectors, only 30% of doctors in South Africa work in the public system, the sector that serves the majority of the public (de Villiers 2021). Severe economic and racial segregation in South Africa means that the vast majority of Black people cannot



http://etd.uwc.ac.za/

access private healthcare. Though obstetric violence may occur in private healthcare settings, it may take particular forms in these settings. Moreover, some patterns of obstetric violence may be more pervasive in government maternal health services where the majority of patients are poor, Black women. In this context, obstetric violence functions to shame and punish those who live in poverty for being pregnant and becoming mothers; a clear instantiation of reproductive injustice in which the rights to motherhood, and good healthcare is denied to poor, Black women. The normative (white, middle-class) role expectations attached to who *ought* to be a mother, or *will* be a 'good mother', are violent constructions that penalise those outside the narrow definition of 'good mother' (Chadwick 2017). When such normative role expectations are institutionalised in public healthcare, obstetric violence, as a form of gender-, race- and class-based violence, can be committed with impunity. Discipline in the clinic, accordingly, manifests in acts such as refusing care and neglect.

UNIVERSITY of the
WESTERN CAPE

Much of the research being conducted on obstetric violence in Africa—often referred to as disrespect and abuse towards women during pregnancy—has focused on defining, categorising, measuring, and developing interventions (Bohren et al. 2015; Bowser and Hill 2010).

Understanding the issue as something definite with concrete boundaries may be useful for developing interventions, such as workshops and human rights training, but this approach does not adequately address the complexity of obstetric violence as a systemic form of violence. Nor does it effectively consider the roots of the issue, especially the contemporary and historical context in which the maternity clinic is



http://etd.uwc.ac.za/

located. Such research often relies on maternal health standards of care developed in the West, far from low-resource settings, leading to impossible expectations being placed on healthcare providers (Arnold et al. 2019).

When discussing the role of nurses and midwives in situations where obstetric violence has been reported, the discourse often oscillates between two positions—nurses as perpetrators *or* as victims (Arnold et al. 2019). When nurses and midwives are seen simply as *perpetrators*, the problem is often individualised and reduced to an issue of human behaviour to be corrected through training or education. Yet, portraying staff only as victims of under-resourced health systems misses the ways in which they negotiate and make decisions in their work environment and profession. Neither extreme provides a complex understanding of the ways healthcare providers are implicated in, and act within, the healthcare system. The call to rethink obstetric violence requires tools of analysis that go beyond understanding obstetric violence as strictly an (interpersonal) incident between a caregiver and patient. We therefore work towards broadening the scope of our understanding about these relationships and what repair and justice can look like in maternal healthcare, especially in contexts where gender-based violence against women is extreme.

UNIVERSITY of the
WESTERN CAPE

*Materiality of Care*

The challenges of working in an under-resourced health facility have received attention in the literature on obstetric violence (Bohren et al. 2015). Recognizing that under-resourced clinics functioning without basic supplies and equipment is



http://etd.uwc.ac.za/

itself a form of undignified care and constitutes obstetric violence, much of the literature on obstetric violence acknowledges the impact materiality of care has on providers and patients (Bradley et al. 2019). There have been a number of studies highlighting the stress caused by having to offer midwifery care in a clinic without the basic equipment and supplies (Freedman and Kruk 2014; Freedman et al. 2018). However, a common perception is that this issue can be overcome, or is expected to be prevailed over, in order to prioritise the quality of care in the facility (Tantchou 2018). Similar treatment of the issue can be found in South African maternal health policy documents and guidelines (South Africa DOH 2016). These documents maintain that no matter how poor the working conditions are, respectful maternity care should be a guarantee.

Tantchou's (2018) notion of "materiality of care" provides a framework to think about this, particularly the extent to which the material aspects of the clinic impact relationships in it. Tantchou (2018) defines materiality of care as encompassing, "infrastructures, spatial organization, equipment and supplies, income, and the ways professional status is managed–all of which are determined by history, broad economic and political forces, a specific position in medicoscapes, and thus the 'visibility' and 'invisibility' of a specific place" (272). She explains that the requirements for constant tinkering with broken equipment, working with missing supplies, limited space for privacy, low salaries, and societal beliefs towards care work and midwifery play an undeniable role in the tensions that grow between clinic staff and their patients and patient's families. What enriches Tantchou's (2018) standpoint is that she not only understands material constraints as

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

frustrating and stressful, but also connects these to historical and contemporary politics that explain how such adverse conditions have come to exist.

In this view, structural violence plays out through visible means—such as the lack of supplies and broken equipment—as well as forms of invisible violence, such as diminishing respect for care work and reproductive injustices that affect the clinic daily. Considering both the visible and invisible forms of violence, "materiality of care" is greatly influential in nursing and midwifery professional practice and where the clear connection between the materiality of care and the quality of care are made. In the following section we document some of the findings of our study, demonstrating how the materiality of care in the clinic setting and the impact of uncertainty shape possibilities for compassionate care. We offer a perspective of neglect as an institutionalised form of violence that plays a role in structuring the patient provider relationship. Providing evidence of obstetric violence, our intention is to give some context to the clinic space we are discussing and further the conversation on possibilities for reproductive justice for those it has been often refused.

*Our study*

This study was conducted in three midwifery obstetric units (MOUs) situated in community health centres in Cape Town (South Africa). Community health centres serve the majority in South Africa and serve primary health care. MOUs are midwifery-run health facilities staffed by nurses and midwives and comprise an antenatal clinic, labour ward, and post-partum care. They are accessible and provide



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

free-of-charge care for low-risk pregnancies and the postpartum period. Midwives are trained to provide care across the continuum of maternity care, as well as detect pregnancy related complications and transfer the care to a doctor and local referral hospital when necessary.

The MOUs visited in this study operate with two midwives and one or two auxiliary nurses in the labour ward. From auxiliary nurses to advanced midwives[2], nurses from all levels of qualifications were included in this study.

Ethics approval was given from the University of Western Cape Bio-Medical Research Ethics Council and the Western Cape Department of Health and informed consent was sought from all participants prior to data collection. The first author undertook observations of at least 24 hours at each MOU and conducted 24 semi-structured, in-depth qualitative interviews with nurses and midwives working there. All participants were South African nurses or midwives aged between 24 to 60 years, residing in the cape flats area of Cape Town, and identifying as Black or Coloured women.

UNIVERSITY of the
WESTERN CAPE

The interviews aimed to generate personal narratives of experiences working in the MOU. The transcripts were coded and analysed using grounded theory followed by a combination of feminist theory, including Reproductive Justice theory, for interpretation. We discuss three themes that speak to the question of midwives' situation and role in the politics of reproductive justice, (i) neglect as the norm in

[2] South Africa has no direct-entry midwifery programme; midwifery is a component of the nursing degree, with the option for an additional one-year training in midwifery. Auxiliary nursing training involves a two-year diploma.



http://etd.uwc.ac.za/

the MOU; (ii) working with constant uncertainty; and (iii) the limitations and possibilities for realising compassionate care.

*Neglect as a Norm in the MOU*

After spending close to a year interviewing nurses and midwives as well as observing each MOU, our interpretation of the relationship between the midwives and those seeking maternity care was that it seemed to be largely structured by the confines of the healthcare facilities as under-resourced. For the most part healthcare providers were working with what they had available, which was never enough. The staff were repeatedly having to make do with lack, whether it be equipment, supplies, or time. Obstetric violence, we observed, did not commonly take the form of direct mistreatment (such as verbal or physical assault) but a more subtle and pervasive practice of neglect and an accompanying normalised lack of communication. This observation aligns with another study conducted in a nearby hospital maternity ward (Lappeman and Swartz 2019).

The observed neglect seemed to involve different levels of intent on the part of healthcare providers. Incidences of neglect ranged from pregnant women in a crowded and short-staffed antenatal clinic waiting excessively long times to be seen by a nurse, to what appeared to be a more intentional refusal to provide care during and immediately after childbirth. While these forms of neglect varied in terms of the severity of the implications, and also the perceived callous or uncaring nature of the treatment, they came across as fairly ritualised and normalised. Instances of neglect



UNIVERSITY of the
WESTERN CAPE
http://etd.uwc.ac.za/

did not seem to be regarded as poor treatment by staff and seemed to be commonplace.

Nurses and midwives rarely spoke directly about neglect but did speak candidly about the ways in which those attending the antenatal care clinic, labour ward, and postpartum care would have to wait for a considerable amount of time before being seen. Waiting would take place on a wooden bench alongside the hallways or a plastic chair in one of the designated wait areas. Tension would build throughout the day in the antenatal clinic waiting area. In the morning, the waiting and the nurses and midwives seemed reasonably pleasant and relaxed, the waiting room was lively and often full of conversation. As the day passed, restlessness and discomfort set in and the mood shifted, both staff and patients displayed impatience ranging from mild frustration to anger. Those arriving at the MOU and present in labour would not necessarily be attended to immediately and, depending on how busy the MOU was at that time, might spend the duration of the second stage of labour (when experiencing strong contractions) without the support of a birth companion. The maternity ward offered limited privacy and therefore the company of a family member or spouse is not always possible. The combination of waiting for care while in labour and labouring without a companion has been identified in similar studies and seems to be characteristic of government maternal health facilities in South Africa (Lambert et al. 2018; Rucell 2017).

Our efforts to rethink obstetric violence in the context of low and under-resourced maternal health facilities in South Africa requires a particular engagement with neglect, and how and why it is so commonplace. Although the

UNIVERSITY of the WESTERN CAPE



http://etd.uwc.ac.za/

concept of materiality of care does not explicitly include the temporal constraints on healthcare providers, it does allow for a reflection on the status of care work (Tantchou 2018). There are several ways in which neglect speaks to the status of the midwifery and nursing profession, and the lack of value placed on maternal healthcare more broadly in South Africa (and beyond). If quality of care is to exist in the MOU, then it is the midwife who must deliver it. When the patient/ provider ratio becomes unmanageable, and there is limited time to give during childbirth, at ante- or post-natal care, escalated tensions and neglect are a foreseeable outcome. Although there is evidence that patients' perceptions of nurses and midwives is changing, the belief that nurses are rude and gratuitously punitive still remains and for good reason; disrespect and abuse is still carried out by healthcare providers (Lappeman and Swartz 2019). Disrespectful behaviour, including but not limited to, neglect by midwives and nurses may be direct responses to their working conditions. Linking acts of neglect to the disregard for quality maternal healthcare by the state does not condone the act of neglecting a patient, but allows for the nurses and midwives actions to be understood as part of a broader pattern of systemic violence (Solnes Miltenburg et al. 2018).

During one clinic visit, shortly before the day-staff were handing over to the staff on night shift, the antenatal care clinic (ANC) was closed and the clinic relatively quiet. There were two patients and their new-borns in the post-natal section of the labour ward and one in labour in a room off the nurses' station referred to as the consultation room. The woman in labour was alone and, from the intensity of her moans, seemed to be experiencing strong contractions. In the nurses' station, which

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

separated the consultation room from the labour ward, two senior midwives sat at a table with two nurses and a student nurse. One midwife was reviewing patient charts while the other went briefly into the consultation room to examine the woman in labour. The midwife returned to the nurses' station and was followed shortly thereafter by the labouring woman, who entered the nurses' station alone, breathing intensely and holding onto the wall for balance. She slowly made her way through the room without assistance, stopping when a contraction came on, passing the table where the nurses sat, to the labour ward and got herself onto a bed. Approximately ten minutes later, the same midwife who had examined her, along with the student, entered the labour ward and assisted in the birth of the baby. The midwife and student remained in the labour room with the patient and her baby to, presumably, continue with new-born and postpartum care.

One may not consider the event discernibly violent but there seemed to be something cold and unfeeling in the treatment towards the woman who was labouring alone without support. That not one of the four members of staff assisted her from the consultation room to the labour ward shortly before giving birth, appeared to lack compassion. Observing, it seemed that the labouring woman was struggling to walk unassisted, and a wheelchair would have been helpful and safer for her. The unresponsiveness displayed by nursing staff can be understood as a collaborative effort to refuse care. Of course, one can make an individual choice to neglect a patient in labour, but that not one member of staff responded to a patient clearly needing assistance, is a demonstration of a shared attitude.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Overall, the ritualisation of neglect appears to sum up much of the mistreatment observed in the MOUs. Midwives speak of their inability to be as attentive as they would like to be when the antenatal care clinic and labour ward are busy and unmanageable, however, neglectful treatment continues, even when the clinic is quiet and few patients require care.

*Working with Constant Uncertainty*

Midwives at all three clinics spoke frequently about shortages of supplies, broken equipment, and the restrictions they feel due to the MOU's spatial limitations. Having to provide care without some of the most basic of midwifery supplies was considered to be part of the daily routine. Supplies including speculums, auto-hooks, catheters, urine bags, sterile gloves, bed linen, and bed-linen savers may be missing from the labour ward on any given day. Making do without these essentials or finding ways to minimise their use in the effort not to run out, such as limiting bed-linen savers, were discussed as part of working at the clinics.

Working at a maternal health facility that functions in a constant state of uncertainty is something midwives are tasked with daily. This uncertainty comes in many forms – from unreliable emergency transportation services and lack of basic supplies, such as linin and sterile gloves, to caring for people in labour who have received no antenatal care and managing a patient/staff ratio that is unsafe for those seeking care. Midwives and nurses spoke about this uncertainty with great familiarity and frustration. In the last year, one of the clinics had undergone a change in

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

management and a new midwife was brought in as sister in charge[3]. Nurses and midwives spoke positively of this and how much change the new sister in charge was bringing to the clinic. They felt that the clinic was more organised and better care was being offered to the patients due to the new sister. However, when the issue of supplies was discussed, old frustrations remained, as one nurse explained in a conversation about the supply chain:

> *Extract 1,* (Advanced Midwife, Age 50)
>
> Yeah, yeah that is the bad part of it. It is, I don't think they [people working in the supply chain] follow up and if one person says, "Ag[4] man", the next person just says, "Ag man, I am not going to do it now. I will just pass the blame onto the next person". It's terrible, even linen! There was a time when people [patients] had to sleep on thin papers because there were no sheets and it is uncomfortable, and they are bleeding. Even when you order, you must follow up on your order. You must phone and find out, and according to them [supply chain], they say there is no stock. It's terrible.

UNIVERSITY of the
WESTERN CAPE

Improvements in one area of the clinic may therefore not translate to improvements in other areas. Limitations imposed by the health system, such as an unreliable supply chain, hinder the clinic staff's professional potential to offer quality care. Staff at this specific clinic were not alone in stressing discontent with the lack of necessary supplies. In the following quote, a midwife from another of the MOUs stresses the difficulty of having to work without enough sterile gloves, a basic

[3] A sister in charge is a senior midwife who manages the MOU. Her office is within the MOU and their duties are expansive.
[4] A filler word used to express irritation or resignation.



http://etd.uwc.ac.za/

requirement for offering safe midwifery care.

*Extract 2,* (Professional Midwife, Age 38)

Even with the gloves we are using, like when you do a PV [per vagina examination] to a patient, you are supposed to use the very sterile glove, but because we are saving, you use only one of the gloves and you cannot use the other one. When you do a PV on another client, you need to twist that other side of the glove, so you see how difficult that is?

Similar descriptions were commonplace in several midwives' stories. Supply shortages and faulty equipment featured frequently in the narratives and were often normalised as just the way in which the clinic functioned. Another area of tension regarding supplies is that patients often arrive without the personal essentials (such as new-born nappies, maternity pads, or food) required for childbirth and are not provided these by the facility. Familiar with their communities, midwives were sympathetic, but the dilemma was still theirs to deal with and try to solve. As one midwife explains:

UNIVERSITY of the WESTERN CAPE

*Extract 3,* (Professional Midwife, Age 42)

Sometimes even the plastic aprons are getting finished, even the pads… We are telling them (patient) to bring their own pads but now if the person doesn't have the pads, what must we do? Because you know that person is bleeding already and let's say she is here and has never received a visitor, how do you expect her to get the pads? Also, the nappies for the babies; people are really suffering.



http://etd.uwc.ac.za/

Giving birth without necessary supplies such as pads and new-born nappies is an affront to the right to a dignified childbirth enshrined as an international human right (Lokugamage and Pathberiya 2017). The responsibility to make pads and nappies available to those who cannot afford to buy their own falls on the state. There is something particularly dehumanising about requiring maternity pads and not having access to them—particularly considering that women are routinely shamed when their bodies bleed and "make a mess". This was not a finding in our study, but there are South African findings of disrespectful and punitive treatment of women during childbirth, such as patients having to clean the floors after childbirth as a punishment for "making a mess" (Odhiambo and Mthathi 2011).

In the interviews, nurses and midwives were sympathetic to the conditions of poverty that patients live in such that they cannot access basic supplies needed for childbirth. However, they also raised the issue as creating stress in the clinic. The absence of basic material necessities affects both patients and the staff, influencing the relationship between them and refusing possibilities for reproductive freedoms to be assembled within the clinic space. This refusal is not new. For example, a long history of denying Black women dignity in childbirth has existed in racist, anti-poor nation states (Rucell 2017).

UNIVERSITY of the
WESTERN CAPE

*The Limitations and Possibilities for Realising Compassionate Care*

Nurses' and midwives' position towards in/justice, as stated previously, is dynamic and always in relation to the health system. Throughout this research we have asked what possibilities for reproductive justice midwives can assemble and what the



http://etd.uwc.ac.za/

limitations are. This question has allowed us to consider why compassionate care seems so hard to maintain as common practice. As we have stated in an article looking at the possibilities of compassionate care:

> Both the patient and midwife are entangled within an inherently violent system that treats women's labour and bodies as if they are disposable. When we understand that there is a violence to working under conditions of constant resource shortages and uncertainties then neglect becomes predictable and a constitutive aspect of public maternal healthcare. Without a radical deconstruction and transformation of a system that perpetually devalues or makes invisible social reproduction we can expect to produce the same outcome (Frederici, 2013) - which in this case is substandard care despite a high degree of clinical skill. (Dutton and Knight 2020, 8).

UNIVERSITY of the
WESTERN CAPE

When considering materiality of care, time constraints characterise much of the clinics' operations and staff interaction with patients. Compassionate care is time consuming; it requires nurses and midwives to slow down and attend to patients in an attentive and personable manner. Midwives expressed feeling that their workload was unmanageable, that time did not allow for all that was expected of them and they felt generally underappreciated in the health system. The healthcare worker's time—the aspect that often seems to pit the midwife and patient against one other—is required by patients attending the clinic but also protected by midwives and nurses who feel the demands are too high. In one instance, nurses and midwives scramble to manage increasing amounts of paperwork, high patient volume, and tinkering with broken equipment, while compensating for staff



http://etd.uwc.ac.za/

shortages. Meanwhile, patience dwindles as patients await care. The ways in which midwives guard their time, and how such practice becomes normalised in the clinic, could help us understand why nurses and midwives neglect patients, even when their time is available.

After talking to the nurses and midwives in the clinic and listening to their ongoing struggle to manage their workload, and also witnessing the ways neglect is leveraged against patients, it seems that in some ways, how time is managed is a way to hold onto and exercise power. For one not to give their time to someone else, even by neglecting someone in labour, is also to preserve what is valued. The hierarchical nature of health systems that places patients at the bottom creates conditions where nurses and those receiving care are set against each other. Freedman et al. (2018), a public health writer who has written extensively on the mistreatment of women during childbirth, calls for an examination of "the ways in which hierarchies of power that permeate health systems and the marginalizing demeaning practices that go with those hierarchies are internalized, naturalized and/or normalized" (108). On one hand, through the ongoing devaluing of social reproduction, nurses and midwives feel their time is deprecated and on the other, their time is what patients require. Neglecting a patient who requires care can be understood as one such marginalising and demeaning practice that is naturalised into the health system hierarchy. The devaluing of midwifery work due to its affiliation with care and caring labour (and therefore feminine) is bound up in the ways reproductive labour is erased and negated. Reproductive labour is either not recognised or is poorly recognized in the formal system of exchange; it is often done

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

without the exchange of money (Andaiye 2020). Dignified maternity care not only requires caring labour but also requires that caring labour be valued and even prioritized. Through denying the right to a dignified birth, health care workers participate in the devaluing of reproductive labour; they are not outside the very system that devalues their care.

Compassionate care is not a formalised characteristic of care in the clinic; it is not built into everyday practices nor does the organisation of the clinic support it. This is not to say compassion was absent. The primary researcher witnessed nurses staying past their shift to attend to all patients in the ANC queue and there was often an exchange of food and laughter. On the same evening that she observed a patient in labour being neglected, one of the nurses involved had earlier shared in an interview that she had given an undisclosed amount of her own money to a woman returning for postpartum care. She had told the nurse in private that she had not eaten. Midwives shared stories of counselling women who had experienced gender-based and sexual violence. Some patients were dealing with drug and alcohol addiction and there were occasions where they were under the influence while in labour. Unemployment was extremely common, and many pregnant women did not have a secure place of residence. Midwives spoke frequently of the effects of violence in the communities being served by the MOUs, which included poverty and the lack of employment, on them and the women in their care. The tone of these conversations was rarely of blame or condemnation but more of a deep understanding of the realities of poverty and motherhood under these conditions.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

The compassion observed seemed to take the form of individual acts of kindness rather than part of the standard delivery of maternal healthcare. Those seeking maternity care could therefore not expect compassionate treatment across the continuum of the care received. To practise compassionate care also requires a level of freedom, freedom in the sense that Bhakuni (2021) refers to: that one is not systemically dominated by oppressive hierarchies and other forms of structural violence. Working under constant uncertainty and duress interferes with midwives' relationship to their own freedom and, as Bhakuni (2021) points out, people are only "*relatively* free depending on the extent of non-domination the person enjoys" (5). When midwives act compassionately, they do so amid circumstances not designed for such interactions to flourish.

Individual acts of compassion are in no way solutions to a health system that must be reimagined and transformed. However, in a system predicated on inequality, acts of kindness go against the grain and disrupt the healthcare provider's role in maintaining this dehumanizing system. Healthcare providers recognise the humanity in their patients and resist the devaluing of their own reproductive labour by finding ways of sharing under conditions of duress. Even in considering the limitations of the clinic as a place for compassionate care, when it occurs, it is worth taking the time to explore. Healthcare providers' acts of compassion demonstrate resistance from inside the very systems that devalue the work they do and those they care for.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*Concluding Comments*

In South Africa, obstetric violence is rarely the outcome of policy or guidelines but rather how past and present classed, raced, and gendered hierarchies shape healthcare services. It would be inaccurate to think of nurses and midwives as simply vessels of classist, racist, and patriarchal beliefs, but they are at the interface between discriminatory systems and those multiply affected by systematic violence, including poor, Black women. The clinic is one place where reproductive injustice plays out (Dutton and Knight 2020). This injustice harms those seeking maternal healthcare, including through the material conditions of the clinic. Nurses and midwives are not exempt from this, they too are part of the population that is systematically discriminated against (Jewkes and Penn-Kekana 2015; Kim and Motsei 2002). Their status as midwives gives them power in the healthcare provider/patient relationship but does not protect them from a system built on racism and patriarchy.

UNIVERSITY of the
WESTERN CAPE

Childbirth demands compassionate, humanising care; that this is denied because of economic and social status is a clear mark of injustice. Maternal health facilities in low-resource settings are places where compassion is practised piecemeal, but is extremely difficult to sustain, given the ways inequality dominates the health system at present. When compassionate care is practised in the maternity clinic, it is a demonstration of the possibilities for a reproductive justice that resists systematic domination. That compassionate care is not sustained as a model of care in the clinic requires an examination of the conditions that maternal healthcare exists in, as



http://etd.uwc.ac.za/

suggested by Bhakuni (2021), with her notion of non-domination in reproductive justice. Neglectful acts such as guarding time, withholding care, and shaming are forms of obstetric violence and are inexcusable. They may also be demonstrable forms of surviving a system that constrains and attacks social reproduction in multiple ways (Frederici 2013).

It is in acts of compassion that the knowledge needed to imagine improving the quality of maternity care offered in low-resource clinics is produced and reproduced. Such knowledge production, if we are to learn from it, needs to be free from any romanticised analysis or understanding of what is being assembled and violently unassembled. The possibility of reproductive freedom, which is assembled partially through acts of compassion, also reimagines the value given to social reproduction and caring labour. The relative freedom one experiences in an MOU, both care provider and patient, are regulated, in part, by a lack of recognition that care is essential to life (Andaiye 2020). Without this recognition, freedom within an MOU is always already severely constrained. One of the possibilities for reproductive justice lives through compassionate acts that work against a system of domination that structures much of the South African health system.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

References for chapter 4

Andaiye. 2020. *The Point Is to Change the World*, edited by Alissa Trotz. London: Pluto Press.

Arnold, Rachel, Edwin van Teijlingen, Kath Ryan, and Immy Holloway. 2019. "Villains or Victims? An Ethnography of Afghan Maternity Staff and the Challenge of High Quality Respectful Care." *BMC Pregnancy and Childbirth* 19: 1-12.

Bhakuni, Himani. 2021. "Reproductive Justice: Non-Interference or Non-Domination?" *Developing World Bioethics*, no. April: 1–6.

Bohren, Meghan A., Joshua P. Vogel, Erin C. Hunter, Olha Lutsiv, Suprita K. Makh, João Paulo Souza, Carolina Aguiar, et al. 2015. "The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review." *PLoS Medicine* 12 (6): 1-32.

Bowser, Diana, and Kathleen Hill. 2010. "Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis USAID-TRAction Project.".

Bradley, Susan, Christine McCourt, Juliet Rayment, and Divya Parmar. 2019. "Midwives' Perspectives on (Dis)Respectful Intrapartum Care during Facility-Based Delivery in Sub-Saharan Africa: A Qualitative Systematic Review and Meta-Synthesis." *Reproductive Health* 16: 1-16.

Chadwick, Rachelle. 2017. "Ambiguous Subjects: Obstetric Violence, Assemblage and South African Birth Narratives." *Feminism & Psychology* 27 (4): 489–509.

———. 2018. *Bodies That Birth: Vitalizing Birth Politics.* Oxfordshire: Routledge.

Dutton, Jessica, and Lucia Knight. 2020. "Reproducing Neglect in the Place of Care: Normalised Violence within Cape Town Midwifery Obstetric Units." *Agenda* 34

UNIVERSITY of the WESTERN CAPE



http://etd.uwc.ac.za/

Freedman, Lynn P., and Margaret E. Kruk. 2014. "Disrespect and Abuse of Women in Childbirth: Challenging the Global Quality and Accountability Agendas." *The Lancet* 384 (9948)

Freedman, Lynn P., Stephanie A. Kujawski, Selemani Mbuyita, August Kuwawenaruwa, Margaret E. Kruk, Kate Ramsey, and Godfrey Mbaruku. 2018. "Eye of the Beholder? Observation versus Self-Report in the Measurement of Disrespect and Abuse during Facility-Based Childbirth." *Reproductive Health Matters* 26: 1-16.

Frederici, Silvia. 2013. Women, reproduction, and the construction of the commons. Presented at the Reproducing Values Series, Museum of Arts and Design, New York.

Fried, Jana, Alia Sunderji, Steve Birch, and John Eyles. 2013. "The Reason That I Did Not Go – Determinants of the Use of Antenatal Care Services in South Africa, Two Decades after the End of Apartheid." *Canadian Journal of African Studies* 47 (1): 27–50.

Jewkes, Rachel, Naeemah Abrahams, and Zodumo Mvo. 1998. "Why Do Nurses Abuse Patients? Reflections from South African Obstetric Services." *Social Science & Medicine* 47 (11): 1781–95.

Jewkes, Rachel, and Loveday Penn-Kekana. 2015. "Mistreatment of Women in Childbirth: Time for Action on This Important Dimension of Violence against Women." *PLoS Medicine* 12 (6).

Kim, Julia, and Mmatshilo Motsei. 2002. "'Women Enjoy Punishment': Attitudes and Experiences of Gender-Based Violence among PHC Nurses in Rural South Africa." *Social Science & Medicine* 54 (8): 1243–54.

Lambert, Jaki, Elsie Etsane, Anne Marie Bergh, Robert Pattinson, and Nynke van den Broek. 2018. "'I Thought They Were Going to Handle Me like a Queen but They Didn't': A Qualitative Study Exploring the Quality of Care Provided to Women at the Time of Birth." *Midwifery* 62 : 256–63.




http://etd.uwc.ac.za/

Lappeman, Maura, and Leslie Swartz. 2019. "Rethinking Obstetric Violence and the 'Neglect of Neglect': The Silence of a Labour Ward Milieu in a South African District Hospital." *BMC International Health and Human Rights* 19 no. 30: 1-11.

Lokugamage, Amali U., and S. D. C. Pathberiya. 2017. "Human Rights in Childbirth, Narratives and Restorative Justice: A Review." *Reproductive Health* 14: 1–8.

Odhiambo, Agnes, and Siphokazi Mthathi. 2011. *Stop Making Excuses: Accountability for Maternal Health Care in South Africa*. Johannesburg: Human Rights Watch.

Rucell, Jessica Zerucelli. 2017. "Obstetric Violence & Colonial Conditioing in South Africa's Reproductive Health System." PhD Diss., University of Leeds.

Sabri, Bushra, and Douglas A. Granger. 2016. "Gender-Based Violence and Trauma in Marginalized Populations of Women: Role of Biological Embedding and Toxic Stress." *Physiology & Behavior* 39 (9): 1–16.

Solnes Miltenburg, Andrea, Sandra van Pelt, Tarek Meguid, and Johanne Sundby. 2018. "Disrespect and Abuse in Maternity Care: Individual Consequences of Structural Violence." *Reproductive Health Matters* 26 (53): 88–106.

Department of Health South Africa. 2016. "Guidelines for maternity care in South Africa: a manual for clinics, community health centres and district hospitals. 4th Ed.

Tantchou, Josiane Carine. 2018. "The Materiality of Care and Nurses' 'Attitude Problem.'" *Science, Technology, & Human Values* 43 (2): 270–301.

Villiers, Katusha de. 2021. "Bridging the Health Inequality Gap: An Examination of South Africa's Social Innovation in Health Landscape." *Infectious Diseases of Poverty* 10: 1–7.

UNIVERSITY of the WESTERN CAPE



http://etd.uwc.ac.za/

# Chapter 5: Barriers to Respectful Maternity Care in Cape Town Midwifery Obstetric Units: Midwives speak on delays in emergency transportation

Authors: Jessica Dutton and Lucia Knight

Submitted to *BMC Reproductive Health* on August 5, 2021.

The nurses and midwives who participated in this study all shared their frustrations with the unreliable nature of the emergency transportation services that are to transfer women to a referral hospital in the event of an obstetric emergency. The research participant's felt that delays in emergency transportation were a major barrier to safe and respectful maternity care. This chapter explores how nurses and midwives experience these delays and the blame and trauma that result from having to manage emergencies when an ambulance is not available. Innovate solutions to this problem do exist in South Africa, and recommendations to further explore what this looks like concludes this chapter. In line with the previous chapters, this chapter tells of the emotional toll working in under resourced clinics take on nurses and midwives.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*Abstract*

Background: In promoting respectful maternity care (RMC) for all pregnant people, there is a growing interest in a more holistic understanding of providing care, one that is capable of encompassing factors reaching from the interpersonal relationship of patient and provider to the health system at large. In this paper, we discuss one aspect of the health system - obstetric emergency transportation and how delays in response time act as a barrier to RMC. Reflecting on the perspective of midwives working at midwifery obstetric units (MOUs) in Cape Town, South Africa, the purpose of this paper is to describe the way in which these delays affect midwives professionally and personally, impede their ability to offer quality care to women in labour, and create tensions within the clinic. All of which have a negative impact on women's outcome and experience of childbirth.

Methods: This research consisted of 24 in-depth interviews with nurse-midwives at three separate MOUs in Cape Town. The interviews were recorded, transcribed and inductively coded using ATLAS.ti. Codes were then categorized and themes developed using constructivist grounded theory. The impact on quality of care within the MOUs due to delays in emergency transportation emerged as a central theme within the interviews.

Results: Delays in ambulance services, which transfer patients from the MOU to the referral hospital, place midwives in a position where they must manage obstetric emergencies often beyond their scope of practice. In such situation, midwives experience an unmerited sense of responsibility, expressing feelings of blame, frustration, and injury to the inter-personal relationships within the clinic.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Conclusion: Without access to emergency transportation, negative outcomes are inevitable and achieving RMC is unattainable. The effects of this are far-reaching and extremely burdensome for care workers who will have to step in for health system shortcomings. Delays in emergency transportation within Cape Town public health care facilities deserve urgent attention. This paper concludes with some recommendations of interventions to improve emergency transportation already operational in other South Africa contexts.

*Plain English Summary*

In this paper, we discuss the issue of delays in obstetric emergency transportation as a barrier to respectful maternity care (RMC). Reflecting on the perspective of midwives working at midwifery obstetric units (MOUs) in Cape Town, South Africa this paper describes the ways in which these delays affect midwives professionally and personally, impeding their ability to offer quality care and creating tensions between paramedics, patients and patient's families. Having to manage obstetric emergencies out of their scope of practice, midwives experience an unmerited sense of responsibility and a cascade of placing blame is set into motion. Based on in-depth interviews with midwives from three MOUs, this paper expands on a growing body of literature looking at systemic and structural barriers to RMC, such as failures in obstetric referral systems. In line with this literature, we argue that systemic change is needed to build maternal health services that are capable of providing RMC. This paper also makes some recommendations of interventions to improve emergency transportation already operational in other South Africa contexts.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*Keywords*: emergency transportation, midwifery in South Africa, respectful maternal care

*Background*

Respectful maternity care (RMC) is a woman-centred model of care that prioritizes a person's dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and advocates for informed choice and continuous support during maternity care (1). Housed within human rights, RMC is the evidence-based claim that women's experience of childbirth is a fundamental indicator of quality maternity care services (2). Research shows that within South African maternal health facilities, RMC is not a guaranteed standard and women have reported disrespect and abusive treatment during childbirth (3). The causes of disrespect and abuse during maternity care cannot be reduced to only behavioural problems but are rooted in systemic forms of inequality and structural violence, including inaccessible and under-resourced healthcare (3). RMC requires a health system that can provide safe and reliable services to women. Exploring emergency transportation, a fundamental service to safe maternity care, and its impact on the possibilities of providing RMC allows for more contextual understanding of what drives conflict and disrespectful maternity care.

In South Africa, MOU are staffed by midwives and nurses and provide care for women with low-risk pregnancies. Midwives are trained to provide care across the continuum of maternity care, as well as detect pregnancy related complications and transfer the care to a doctor and local referral hospital when necessary. Doctors



UNIVERSITY of the
WESTERN CAPE
http://etd.uwc.ac.za/

working in other units at the community health centre (CHC) serve as on-call doctors for the MOU, however they are not obstetricians; referral and transportation in the event of an obstetric emergency is still necessary. MOU's are designed to allow for midwives to practice to their maximum potential, while freeing up space in hospital maternity wards for those who experience pregnancy related complications and complications during childbirth (4). Evidence shows this is a safe and cost-effective model of maternity care, but requires efficient infrastructure and a responsive health system (4).

*Methods*

Research design: This study was designed to collect the perspective and narratives of nurses and midwives experiences within their daily lives working in Cape Town MOUs, with an emphasis on their experiences regarding qualify of care. A qualitative research design was best suited to achieve this objective and constructivist grounded theory guided this process. A constructivist version of grounded theory was chosen as it offers a nuanced approach to data analysis through viewing knowledge as located in time, space and situation, taking into consideration how the researcher constructs theory through interacting with the data (9). Grounded theory guided both the study design and data analysis. The study received ethical approval from the University of the Western Cape Biomedical Research Ethics Committee and the Western Cape Department of Health granted permission allowing for access to the CHCs.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Data collection: This study consisted of 24 in-depth qualitative interviews with purposively selected nurses and midwives at the MOUs. The participants were approached by the sister in charge at the MOU prior to the interview for a formal introduction and explanation of the study. The interviews took place within in a private room in the MOU. The interviews were conducted using a semi-structured interview guide, which allowed for the sharing of personal narratives about, but not limited to, quality of maternal health care and RMC. All interviews were conducted in English, the language of nursing and midwifery education in South Africa. All interviews were conducted by the primary researcher: a white PhD student from Canada who trained as a midwife. The researcher's positionality was taken into consideration and potential bias was addressed throughout the study design and openly discussed with MOU management and staff. All interviews were recorded, transcribed verbatim and anonymized.

UNIVERSITY of the
WESTERN CAPE

Data analysis: The transcribed interviews were inductively coded using ATLAS.ti with codes then categorized and themes developed using grounded theory. Grounded theory allowed for the categories to emerge from the data rather than abstract ideas. Categories were identified using descriptive labels that highlighted similarities in events, occurrences, and processes within the data (9). To ensure trustworthiness and rigour an audit trail, peer debriefing, triangulation and reflexivity were carried out throughout the research. The consolidated criteria for reporting qualitative research (COREQ) checklist guided the reporting of this research (10). In addition, the Critical Appraisal Skills Programme (CASP) checklist



http://etd.uwc.ac.za/

(11) was used to insure the study followed systematic and rigorous qualitative methodology and reporting.

Participant characteristics: Participants were sampled purposively to ensure heterogeneous representation and to reflect diversity with regards to professional category, age, language, and religious background. Heterogeneous sampling allowed for an exploration into how individual identity impacts practice. Following the procedure of grounded theory, this study sampled until saturation. The study population included all nurses and midwives who worked within the selected MOUs. Other members of staff such as management, security, custodial staff and those working in administration reception were excluded from this study. In total 24 nurses midwives were interviewed for this study. South Africa does not have a direct-entry midwifery programme and therefore all midwives study as nurses, with midwifery as one component of the four- year nursing degree. There is also an option to become an auxiliary nurse, which involves a two-year diploma. An advanced degree in midwifery is offered and is an additional one-year training after completing a four-year degree in nursing. Midwifery education is regulated through the South African Nursing Council (SANC) all those employed as nurses or midwives in government facilities must be registered with SANC. From auxiliary nurses to advanced midwives, nurses from all levels of qualifications were included in this study. However, the quotes presented in this article are taken from interviews conducted with those holding a midwifery qualification.

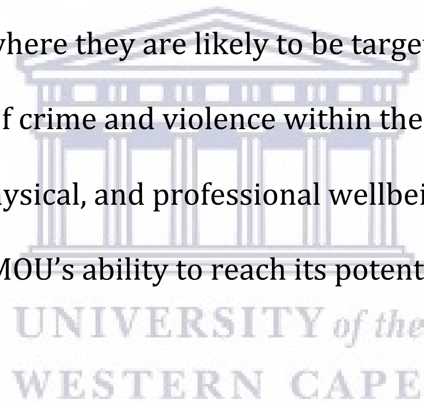
Setting of the Study

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Three MOUs were included in this study located within townships of Cape Town. These communities experience high levels of poverty, unemployment, and violence (6). One clinic is located within a community that is currently experiencing devastating levels of violence due to conflict between rival gangs (7). This context is relevant not only to understanding the socio-economic realities of the communities these CHCs serve but is of particular importance to the issue of emergency transport. High levels of violent crime result in increased demand for ambulance services (8). Additionally, ambulances are currently the target of robbery within these areas with 'red zones' designated within some townships of Cape Town to alert paramedics of areas where they are likely to be targeted and a police escort is necessary (8). High levels of crime and violence within the community affect midwives psychological, physical, and professional wellbeing. These issues are key factors compromising the MOU's ability to reach its potential in quality of care provision.


UNIVERSITY of the
WESTERN CAPE

*Results*

All participants of this study were South African, who identified as Black or Coloured women and varied in age from 24 to 60. Nineteen participants spoke Xhosa, three spoke Afrikaans, one spoke Zulu and two stated English was their first language. 22 participants identified as Christian, with the remaining two stating they were not religious. All nurses and midwives reside in the cape flats area of Cape Town. Fourteen were married and ten stated they were single. 22 of the 24



http://etd.uwc.ac.za/

participants had children. Of the 24 participants twelve were professional nurses, six were axillary nurses, and six were advanced midwives.

A number of themes emerged from the data including the affects of resource shortages in the clinic, staff shortages, the impact of poverty on maternal health, violence and crime with the community, mental and emotional wellbeing of childbearing women, problems with staff/ patient communication and managing emergency complications during and after childbirth. Nurses and midwives often stressed that what made managing emergency complications so difficult and potentially dangerous for women was the unreliable nature of emergency transport. Unreliable emergency transportation is one factor amongst many preventing quality maternal health care in South Africa MOUs. Nurses and midwives expressed apprehensiveness and much concern around this issue and therefore we have dedicated this paper to exploring this specific research finding.

UNIVERSITY of the
WESTERN CAPE

*Perceptions of and frustrations towards EMS*

The respondents reported that poor access to timely emergency transport from the clinic to a referral hospital is a major barrier to quality of care. At one MOU midwives spoke of waiting for up to eight hours for emergency transport to arrive and felt that the situation is worsening – with wait times increasing. At another MOU, a midwife described waiting for four hours for emergency transport to take women to a hospital only fifteen minutes away. According to the participants, delays in emergency transport services are predominately an issue of a high supply demand ratio; i.e. there are too few ambulances for the need in communities served.



http://etd.uwc.ac.za/

Midwives also expressed their discontent with EMS and at times attributed the delays to a perception that the paramedics lacked concern. Midwives stressed their frustration when following up on ambulance dispatch, only to be told that transport was pending without further explanation. As one midwife explains,

> *For how many years have they [the community] been complaining about the poor service [from EMS] they have been rendering? And nothing is being done and no they [the EMS] always say, no the call was at this time or that but at the end of the day you are playing with peoples' lives. If they feel they are not going to respond to the call, they are not going to respond. If they feel like standing in one place, keep the engine on and seem that they are busy or whatever so I think, there needs to be more clarity to where they are at the moment, tracking devices. It's not nice if you book an ambulance and you wait for 5 hours so they need to find where the problem is coming from and taking it from there.*

UNIVERSITY of the
WESTERN CAPE

At times midwives spoke of delays in the transportation of women from the MOU to the referral hospital as result of a personal decision made by the paramedics to take their time. As one midwife states,

> *The paramedics, they are supposed to be like immediate but it takes a while so by the time they get to peoples homes the baby is delivered. And from here (the MOU) as well, getting patients to Somerset Hospital or Groote Schuur Hospital (the referral hospital), they will say, but the patient is in the hospital (the MOU) so it is almost like, what is the rush? The ones out there (not at the MOU) are more at risk of not getting proper care.*



http://etd.uwc.ac.za/

Here a midwife explains what she sees as a misconception held by paramedics that women at the MOU are less in need of emergency transportation because they are already receiving professional care. Alongside frustration, some of the midwives also expressed empathy towards paramedics. They acknowledged that working for EMS is challenging and carries great risk, in particular, in areas where violence and crime are commonplace.

*The emotional toll and stress of managing emergencies inside the MOU*

Women with high-risk pregnancies present at the MOU situated within their community because they do not have transportation to take them to the regional hospital located further away where they were booked for delivery. This meant that women arrive at the clinic requiring services the MOU is not equipped or skilled to offer. In this event, midwives will call EMS to transport the labouring women to a hospital. In some instances, the midwives assisted in the birth of babies of high-risk patients at the MOU, increasing the likelihood of complications. Several participants described a similar situation with women who were not booked at the MOU and had received little to no ANC. These situations placed additional stress on the staff and health system as in many cases, the pregnancy related complications were only detected when the women were already in labour. One nurse explains:

> *Interviewer: Do a lot of women come un-booked?*
>
> *Nurse: A lot, in a week, you've got two or three un-booked patients.*
>
> *Interviewer: And is that stressful?*
>
> *Nurse: Yeah, because she doesn't have anything, no scan, no clinical notes.*



http://etd.uwc.ac.za/

*Nothing. But you have to help that person because this is her hospital. You, you are just an employee and you are here to help them. And you pledged (laughs), you pledged that you will be here. It's very stressful.*

Midwives felt that delays in emergency transport, in addition to adversely affecting their ability to offer patients quality care also takes a toll on their emotional wellbeing. Emergency transport delays often left them feeling helpless and demoralized. The precariousness of managing an obstetric emergency and waiting for EMS is well articulated here:

*That one was my first neonatal death and I wish it was my last. The patient was delayed second stage, she was fully dilated but couldn't push because of maternal exhaustion. So I gave her food, fruits and that sort of thing… Then by 2 o'clock the 45 minutes was up so we called the doctor, you must just book an ambulance. That was 2 o'clock, and by 3 o'clock the patient was still here struggling to push. So we called again to change to a flying squad from an ambulance. 5 o'clock the patient is still there, 6 o'clock the foetal heart is still there. We put the drip, we put in the catheter, we put in everything, we gave her food. She fell asleep and started to snore and we woke her up and ask about the pain but she is fully dilated. So we called the ambulance and then the ambulance was saying,' no we are busy, there are a lot of emergencies and there are few drivers', [they were] full of stories. The night shift came and we handed over everything. Then in the following morning when we came, the night sister told us, we did not have a nice shift today. Why? You know that baby, she ended up dying. What? The ambulance didn't come, the baby came out last night dead. The ambulance came at 10 [pm] and they were so*



http://etd.uwc.ac.za/

*calm like as if things are not an emergency, things like that. From 2 o'clock. With things like that, what must one do? (Midwife, Cape Town MOU)*

Stillbirth as a result of emergency transport delays was not unique to this experience.

*At the end of the day it is very stressful because it's due to you, you blame yourself. And for instance if there is a stillbirth, for example and something could have been done, you know. It was almost like your hands were tied and you couldn't do anything. It is ridiculous. Sometime you feel like taking them yourself, putting them in my car and taking them myself. You know, that is sometimes how I feel. (Midwife Cape Town, MOU)*

Feeling both responsible and helpless, nurses and midwives carry the emotional burden of such a negative outcome.

UNIVERSITY of the
WESTERN CAPE

*Reporting feelings of blame and unrealistic expectations*

As midwives reflected on their frustration with delays, the topic of blame - and that they felt it was often directed towards them - was often discussed. How midwives experience blame varied, some midwives internalized it and carry it with them while others expressed resentment at the way blame is misplaced.

Midwives shared stories of having to uphold respectful behaviour in the face of disrespect and to find ways to manage unmanageable situations. Midwives expressed that often inter-personal relationships can become difficult in the event of an emergency, including their relationship with the patient's family. In one interview, while discussing what leads to patient provider tension, a nurse explains,



http://etd.uwc.ac.za/

*Interviewer: so you feel the problems are mostly…*

*Nurse: the families.*

*Interviewer: the families of the patients?*

*Nurse: Yho! Especially their husbands and boyfriends. Sometimes you send the patient to Tygerberg Hospital (referral hospital) and tell the patient you are going to give birth at Tygerberg, because of the problem. But then when the patient is in labour, they just come here and say no, we do not have transport to go to Tygerberg. Then what are you going to do? What are you going to do? So you must phone the ambulance to take the patient to Tygerberg. Maybe the ambulance takes 5 to 7 hours to come here. Yeah, can you see? They end up giving birth here.*

Nurses and midwives spoke of the anger directed towards them from members of the patient's family in precarious situations. Occasionally family members would attempt to give orders to the nurses, driving further conflict between the parties.

UNIVERSITY of the
WESTERN CAPE

Midwives felt penalized for what was out of their control and that unrealistic expectations of them were exacerbating tensions within the clinic. At times, midwives participated in passing the blame and felt others are responsible for these situations; from the paramedics to women in labour. As one midwife discusses,

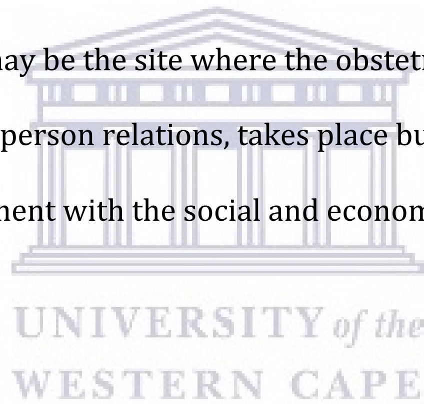
*(They are) high-risk and if something happens you are in trouble. How long did you take to phone the ambulance? You must answer all these sorts of questions, can you see? And there is a problem with the ambulance, I don't know, but they are taking too long. Why can't they (the patient) take their own transport to go*



http://etd.uwc.ac.za/

*there, to save their own lives? They know from antenatal that they are high-risk. So you must take all the blame. It's not nice. Sometimes the husband comes and they just swear at you, but if you swear back, yho!*

Having to manage 'difficult patients' and rude family members was expressed by midwives as part of the job of working in a MOU. Midwives also talked extensively about the difficulties of caring for women who live in poverty and cannot afford the basics, such as food and clothes for the new born, let alone transportation. Midwives demonstrated in-depth knowledge of the community they work and often live in and know very well why women cannot 'save their own lives' due to having no access to transportation. The MOU may be the site where the obstetric emergency, as well as a cascade of negative inter-person relations, takes place but understanding the causes involves an engagement with the social and economic determinants of health.


UNIVERSITY of the
WESTERN CAPE

*Discussion*

This paper reflects the perspectives of nurses and midwives who work within Midwifery Obstetric Units (MOUs) in Cape Town. The study's aim was to broaden our understanding of barriers to RMC, how midwives experience these barriers to quality care provision, and the impact on their profession, emotional state and working relationships. Delays in emergency transportation were identified as a significant barrier to the provision of quality care. This paper reflects on the cyclical relationship between midwifery care in an under-resourced context, the personal toll this takes on midwives and the resulting barriers to RMC.



http://etd.uwc.ac.za/

*Blame as a barrier to building understandings around emergency transportation*

The ways in which delays in emergency transportation operate as a barrier to RMC are twofold; firstly, the lack of timely emergency response denies women the right to the highest quality of care attainable. Secondly, as these results demonstrate, delays are a significant source of stress within the MOU, creating an environment of frustration and adversity. Studies have shown that disrespectful and abusive treatment towards pregnant women is more likely in under-resourced health systems where managing without necessary resources effects staff behaviour in harmful ways (12,13). Delays in emergency transport has the potential to drive disrespectful treatment, and as this study shows, one way in which this can manifest is through midwives having to tend to emergencies outside their scope of practise, setting into motion a series of unfavourable inter-personal interactions. It is understandable that interpersonal relationships in the clinic are more likely to become strained during times of an emergency, but that midwives and nurses described negative relations as systemic raises concern.

UNIVERSITY of the
WESTERN CAPE

The reaction to blame others for instances where no individual can be held accountable, has been found in other studies on RMC and disrespect and abuse during childbirth (14–16). As a barrier to RMC, antagonistic inter-personal relationships in the clinic stand in the way of conversations that expose the root of the problem and move towards systems of accountability. Instead of building an understanding around delays in emergency transportation, midwives suggest that paramedics are ‘running the engine’ and ‘coming with stories’. These statements do not differ greatly from some of the accusations made towards nurses and midwives



http://etd.uwc.ac.za/

when there are breakdowns in the health system. In both cases, frontline healthcare workers are required to explain themselves, suggesting the fault lies in their personal decisions and not a health system in need of repair. When women are blamed, similarly, it is for reasons out of their control, such as lacking transportation and being labelled 'difficult' patients (14). Why women cannot transport themselves to the regional hospital is a socio-economic problem and not a matter of bad decision-making.

*Building a functional referral system in South Africa*

For midwives to provide safe, high quality care, a functioning referral system must already be in place. This involves health system strengthening that is innovative and context specific; where inter-facility emergency transportation delays are recognized and a proactive plan is in place. Effective communication between patient and provider as well as between the clinic staff and EMS is also imperative. Research on emergency referral systems suggests that communication is formalized and built into the protocols for effective emergency transportation systems (17). Context specific solutions are also required to get women with high-risk pregnancies to a regional hospital when their own means of transportation is not available. Other research highlights the need to clearly articulate the compounding issues that create a demand for EMS, such as barriers created by poverty and social inequalities, and begin community dialogue there (18).

Inventive solutions are required and South Africa is not without examples. Currently in the King Cetshwayo district of KwaZulu-Natal there are obstetric ambulances



http://etd.uwc.ac.za/

stationed in four strategic areas to enhance response times (S. Mnqayi, personal conversation, Oct. 12, 2020). Each is stocked with life-saving equipment for obstetric emergencies, some of which is currently unavailable to the MOUs in Cape Town. The non-pneumatic anti shock garment (NASG), a garment worn by women experiencing a post-partum haemorrhage that controls blood loss, delaying shock, is an example of this. The Saving Mothers Report supports the roll-out of NASG to all maternal health clinics (19). Cell phones are used to communicate obstetric emergencies and handed over during shift change. Similarly, evidence from the Free State province suggests an improvement in maternal health outcomes after emergency transportation was earmarked specifically for inter-facility obstetric emergencies (20).

*Strengths and Limitations of this study*

The strengths of this study are that specific systemic barriers to RMC from the perspective of nurses and midwives emerged from the data. Through qualitative research methodology, the interviews conducted allowed for enough time for midwives to explain in details their experiences. Although there has been a recent research interest in including the perspective of health care providers on the topic of RMC, it still remains a gap in knowledge that this study attends to. One of the limitations of this study is that it is not generalizable. Only three MOUs were included and all were located within the Western Cape province of South Africa. The interviews were conducted in English and therefore participants could not speak to their experiences in their first language.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*Implications of results for policy*

This study does not have immediate implications for policy but serves to support recommendations that have been made to the Department of Health of South Africa by the National Committee for Confidential Enquiries into Maternal Deaths through the Saving Mothers Report as well as other research in the field.

*Conclusion*

Delays in emergency transport are a barrier to both the provision and experience of high quality care. To transform maternal health facilities into places that provide RMC, changes need to be systemic and at all levels of the health system. The White Ribbon Alliance, who advocate for RMC, have recently highlighted the need to focus on emergency transportation during childbirth as a fundamental component of achieving RMC. South African evidence demonstrated that improvements to the emergency transport services would reduce maternal mortality (19). Currently, within South Africa, the decline of the institutional maternal mortality ratio (iMMR) is plateauing and health system changes are required if continuing problems are to be addressed effectively, delays in transportation are one such problem (19).

With access to appropriate care, an emergency during childbirth does not necessarily have to be traumatic and result in an adverse outcome. Inadequate infrastructure leads to a cycle of frustration, blame and further breakdowns in an already stressful situation. What midwives expressed repeatedly is that in emergency situations, it is not only blame, but also trauma, that circulates throughout the clinic; none of which is conducive to providing RMC. Functioning

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

models of emergency obstetric transportation need to be explored and implemented in Cape Town MOUs. An efficient and reliable protocol for obstetric emergencies is one of the many actions deserving urgent attention in building a health system where maternal and infant health are key priorities.

*Abbreviations*

ANC: antenatal care; CASP: Critical Appraisal Skills Programme; CHC: community health centre; COREQ - consolidated criteria for reporting qualitative research; DOH: Department of Health; EMS: emergency medical services; iMMR: institutional maternal mortality ratio; MOU: Midwifery Obstetric Unit; NASG: non-pneumatic anti shock garment; RMC: respectful maternity care; SANC: South African Nursing Council

*Declarations*

UNIVERSITY of the
WESTERN CAPE

Ethics approval and consent to participate: The University of the Western Cape Biomedical Research Ethics Committee granted approval of this study and the Western Cape Department of Health granted permission allowing for access to the CHCs. All participants were informed of the study and written informed consent was obtained prior to data collection. All procedures followed were in accordance with the ethical standards of the Helsinki Declaration of 1975, as revised in 2000.

Consent for publication: not applicable

Availability of data and materials: the qualitative interview data collected during the study are not available to the public due to the possibility of individual participants



http://etd.uwc.ac.za/

being identified if all data was made accessible. Sections of anonymized data are available from the corresponding author on reasonable request.

Competing interests: the authors report no conflict of interest.

Funding: This work is based on the research supported by the South African Research Chairs Initiative of the Department of Science and Technology and National Research Foundation of South Africa (grant no. 82769). The authors would also like to acknowledge funding from Belgian Development Cooperation, through the Institute of Tropical Medicine Antwerp.

Research reported in this article was supported by the South African Medical Research Council under a Self-Initiated Research Grant Programme.

Any opinion, finding and conclusion or recommendation expressed in this material is that of the authors and not the funders.

UNIVERSITY of the
WESTERN CAPE

Author's contributions: JD and LK designed the study, JD collected the data and analysed the finding with guidance and input from LK. JD drafted the article with input from LK. Both authors reviewed the article and approved of the final version for submission.

Acknowledgements: The authors would like to gratefully thank the nurses and midwives who participated in this study as well as the facilities management for their cooperation in this research project.

Author's details:

Jessica Dutton (corresponding author)

School of Public Health, University of Western Cape, Cape Town, South Africa.



http://etd.uwc.ac.za/

Orcid iD 0000-0002-206-3153

jessi.dutton@gmail.com

Dr Lucia Knight

Associate Professor

Head of Division of Social and Behavioural Sciences, School of Public Health and Family Medicine, University of Cape Town, South Africa

Professor extraordinaire

School of Public Health, University of Western Cape, Cape Town, South Africa.

Orcid iD 0000-0001-9938-6887

Lucia.Knight@uct.ac.za

http://etd.uwc.ac.za/

References for chapter 5


1. Sethi R, Gupta S, Oseni L, Mtimuni A, Rashidi T, Kachale F. The prevalence of disrespect and abuse during facility-based maternity care in Malawi: Evidence from direct observations of labor and delivery. Reprod Health. 2017 Sep 6;14(1).

2. Miller S, Abalos E, Chamillard M, Ciapponi A, Colaci D, Comandé D, et al. Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. Lancet. 2016;388(10056):2176–92.

3. Chadwick R. Bodies that birth: Vitalizing birth politics. Bodies that Birth: Vitalizing Birth Politics. 2018. 1–226 .

4. Clow SE. Out-of-hospital midwife obstetric units in the Cape Peninsula , South Africa. 2011;(June).

5. Pattinson RC. Safety versus accessibility in maternal and perinatal care. Vol. 105, South African Medical Journal. 2015. p. 261–5.

6. Pijper LK, Breetzke GD, Edelstein I. Building neighbourhood-level resilience to crime: the case of Khayelitsha, South Africa. South African Geogr J. 2020 Aug 12;1–16. Available from: https://doi.org/10.1080/03736245.2020.1807398

7. Ishmail S. Gangs keep Bonteheuwel in runed state. Cape Argus. 2020 Sep; Available from: https://www.iol.co.za/capeargus/news/gangs-keeping-bonteheuwel-in-ruined-state-97d92747-70ec-4858-95c6-0b8e1718ab78

8. Brady L, De Vries S, Gallow R, George A, Gilson L, Louw M, et al. Paramedics, poetry, and film: health policy and systems research at the intersection of theory, art, and practice. Hum Resour Health. 2019;17(1):64. 9.

9. Charmaz K. Constructionism and the Grounded Theory Method. New York: The Guilford Press.; 2008. 397–412

10. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J


UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Qual Heal Care . 2007;19(6):349–57.

11. CASP. Critical Appraisal Skills Programme (2018). Available from: https://casp-uk.net/wp-content/uploads/2018/01/CASP-Cohort-Study-Checklist_2018.pdf

12. Burrowes S, Holcombe SJ, Jara D, Carter D, Smith K. Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: A qualitative study. BMC Pregnancy Childbirth. 2017;17(1):1–14.

13. Sen G, Reddy B, Iyer A. Beyond measurement: the drivers of disrespect and abuse in obstetric care Beyond measurement: the drivers of disrespect and abuse in obstetric care. Sexual and Reproductive Health matters. 2018; 26(1).

14. Afulani PA, Kelly AM, Buback L, Asunka J, Kirumbi L, Lyndon A. Providers' perceptions of disrespect and abuse during childbirth: a mixed-methods study in Kenya. Health Policy Plan. 2020;35(5):577–86.

15. Bradley S, McCourt C, Rayment J, Parmar D. Midwives' perspectives on (dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and meta-synthesis. Reproductive Health.; 2019; 16(116).

UNIVERSITY of the
WESTERN CAPE

16. Rominski SD, Lori J, Nakua E, Dzomeku V, Moyer CA. When the baby remains there for a long time, it is going to die so you have to hit her small for the baby to come out: justification of disrespectful and abusive care during childbirth among midwifery students in Ghana. Health Policy Plan. 2016 32(2).

17. Daniels AA, Abuosi A. Improving emergency obstetric referral systems in low and middle income countries: a qualitative study in a tertiary health facility in Ghana. BMC Health Serv Res. 2020 20(1):32.

18. Oguntunde O, Yusuf FM, Nyenwa J, Dauda DS, Salihu A, Sinai I. Emergency transport for obstetric emergencies: Integrating community-level demand creation activities for improved access to maternal, newborn, and child health services in northern nigeria. Int J Womens Health. 2018;10:773–82.



http://etd.uwc.ac.za/

19. DOH SA. Saving Mothers 2017: 2017.

20. Schoon MG. Impact of inter-facility transport on maternal mortality in the free state province. South African Med J. 2013;103(8):534–7.

http://etd.uwc.ac.za/

# Chapter 6: Isolation during childbirth and the continuous devaluation of caring labour: COVID-19 before and after the pandemic lockdown

Authors: Jessica Dutton, Dr. Michelle De Jong and Prof. Lucia Knight

Submitted to *Sexual and Reproductive Health Matters* as a commentary piece in January 2022

This chapter looks at how denying women a labour companion and experiences of isolation during labour has been normalised in Cape Town MOUs. Labour companions have proved to be very beneficial to women throughout labour and childbirth and contribute positively to the clinic environment. That women are denied companionship during labour is a form of mistreatment. This chapter situates this problem within the ways in which reproductive labour is devalued and care work is overlooked as nonessential – a central concern to this study.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Introduction

This commentary explores lack of privacy, companionship and labour support in midwifery obstetric units (MOUS) in South Africa. Although these are ongoing issues affecting the quality of care women receive, for a short window of time women's experiences of childbirth was receiving attention, through media and research during the height of the COVID-19 pandemic. In this period issues such as denying women labour and birthing companions were raised as possible human rights violations in many parts of the world (1,2). Restrictions due to COVID-19 were often understood as exceptions as a result of a public health crisis. However, experiences of isolation and labouring without a companion did not begin with the pandemic in South Africa, and have been documented as an ongoing issue (3). This piece considers these issues within the context in which reproductive labour is devalued and care work is overlooked as nonessential. This commentary argues that in fact the opposite is true and reproductive labour is the work that maintains life. We consider ways that individual MOUs have tried to improve care in their facility as well as possibilities for new efforts to be made. We recognise the difficulties of sustaining new ideas for improved care when clinics do not have the support of the state. We argue that efforts must be made to value reproductive labour in all its forms and that hierarchies, which place caring work at the bottom of the scale, need to be dismantled.

*Isolation during childbirth: predating COVID-19*

Throughout the COVID-19 pandemic, worldwide, maternal health facilities and labour wards had to abruptly adapt to new and changing regulations (4,5). The



UNIVERSITY of the
WESTERN CAPE
http://etd.uwc.ac.za/

effects of constant amendments to safety protocols and rapid policy change is only recently becoming clearer as research results become available (1,6,7). During the pandemic, there was an increase in media interest in the experiences of women during childbirth and the conditions of the labour ward (8,9). Women spoke openly about their experiences of heightened anxiety during childbirth due to feeling unsafe, uncared for and alone (8,9). Restricting the number of people in the labour ward due to COVID-19 protocol meant that women were often denied birthing companions, adding to the isolation they experienced (2,4,10). In South Africa (SA), COVID-19 restrictions affected an already overstretched health system and exacerbated existing tensions. Experiences of isolation during childbirth in SA labour wards did not begin with the pandemic and has been well documented as an ongoing issue (11). This problem speaks to the lack of resources dedicated to health care in SA but also, as we discuss in this paper, demonstrates the ways in which the labour of caring is consistently undervalued. In this commentary we use the terms reproductive labour and caring labour interchangeably to speak about all the work that goes into caring for *others* including the work to care for biological and survival needs as well as the provision of relational and emotional support. This work is often overlooked and often denigrated as unskilled, menial and unprofessional. Caring labour is typically gendered as women's work and thought of as domestic, whether done in the home or not (12). The versatility and other skills required for caring labour are often unrecognised.

Using data from research conducted among nurses and midwives in Midwifery Obstetric Units (MOUs) in Cape Town, South Africa in 2019, we have explored

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

barriers to quality maternal health care from the perspective of care providers in other publications (3). Focusing on isolation during childbirth and the lack of support, companionship, and privacy women receive suggests a continuum of inadequate care, highlighted by the pandemic, but in reality an older story. The state's continual neglect of maternal health care in South Africa violates women's rights to a safe childbirth and puts the burden of quality care on individual facilities and healthcare providers (3,13,14). We therefore consider why MOUs have struggled to provide privacy and labour companionship, and we discuss some of the efforts made to offer women better labour support.

*Labouring alone without privacy: restricting companionship in MOUs*

This research consisted of 24 in-depth qualitative interviews with purposively selected nurses and midwives working in Cape Town MOUs to discuss their perspectives on the quality of care provided and experiences of working in maternity care. We also conducted 24-hours of observation at each MOU. The nurses and midwives who participated in the study felt that the quality of care was generally lacking and a number of reasons were given for this, including the physical space of the clinic. In many maternity wards in SA, women share a common room during much of their labour, which is usually referred to as the antenatal room within the labour ward. This is a shared room for women in their first stage of labour. This is usually the longest stage of labour as cervical dilation can be a lengthy, slow and painful process. The standard process within the MOUs, participating in this study, was that women move to a semi-private space (rooms divided by curtains) when they are in the second stage of labour (full cervix

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

dilation). Sharing a common room during the first stage of labour means that privacy is limited and in an effort to provide even minimum patient privacy, family members are often denied entry until the patient has reached the second stage of her labour. Providing privacy during labour and childbirth is evidence-based practice - it is essential to ensuring women's autonomy (15). However, in a common room, shared by all women in labour, privacy even without the presence of family members or a labour companion is compromised. As researchers, we had a view of women in labour as did anyone passing through the labour ward.

Studies have shown that both having a labour companion and privacy leads to better birth outcomes and improves birthing experiences (15) . Denying women companionship and privacy during labour and childbirth is a form of mistreatment, and a recent study conducted across different low and middle-income countries showed that the absence of a labour companion may also increase the likelihood of other forms of mistreatment during labour and childbirth (16). Childbirth is not something women commonly want to do in isolation, a companion of choice provides support required but can also act as an advocate for her in a labour ward that is busy and understaffed (17,18). Women who labour with a companion of their choosing are less likely to require pharmaceutical pain relief and the presence of a companion has been shown to enhance the physiological process of labour (16). When labour companionship is denied, more care work is required by the staff in the clinic and within a busy, under-resourced facility, care labour is neglected for the completion of clinical tasks. .

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

The qualitative results suggest that some of the nurses and midwives did not feel that providing emotional support was part of their job and although they all agreed that respectful care was important, their definition of respectful care was not homogenous. While some expressed in-depth knowledge about respectful maternity care, others gave a brief response referencing an unavailing 'patient first' policy. All participants expressed that explicit mistreatment would not be tolerated in the facility but their feelings on providing labour support such as encouraging women to move and change positions during labour and childbirth were not necessarily understood as part of their work. From observations of the clinic, communication between the provider and patient was not always kind or compassionate and women who did not have a companion were not clearly receiving emotional or other forms of support outside of clinical care.

*Without state support: the pitfalls of doula programmes in MOUs*

UNIVERSITY of the
WESTERN CAPE

Individual clinics did make efforts to provide better labour support. We saw initiatives taken within one of the MOUs to address issues of labour support and lack of companionship through a volunteer doula programme. Doulas are trained birthing coaches who offer emotional support during labour. They are not clinically trained and within this context, their services were provided for free. This idea is a noble one and doulas are often an excellent source of emotional intelligence and support (19). Labour support programmes have been run in low-income communities of New York City and Baltimore in the US, where Black women can access a doula services free of charge. Research findings show that some positive changes have come from this programme, however they also show that these



http://etd.uwc.ac.za/

services create a dependency on doulas working for unlivable wages (20). These findings highlight that providing doulas without pay is not only a problem of sustainability but demonstrates a lack of commitment from the state to financially support these initiatives. As a result, doulas, for no pay, pick up the slack of the state and provide a service that ought to be the state's responsibility. Doulas are helpful in the short term for a few women but solutions that address how caring labour currently lacks status and recognition cannot be achieved through volunteerism at a small scale.

*Planning one's birth: possibilities of working together*

In efforts to take action at the micro level, birth plans could be one possibility for clinics to work within women attending the clinic for maternity care. Birth plans are written descriptions of the processes and plans about what matters to a women during her childbirth and is discussed with care providers. The research results suggest that birth plans were not a part of the care model in any of the MOUs. Birth plans are commonly understood as something for middle-class women – for a particular segment of the population where the experience of childbirth is assumed greater importance. A birth plan could be valuable to women in the MOUs because they allow women the opportunity to express what they want and the work required (18). This would allow women the opportunity to discuss labour companionship and practical plans to promote support and companionship during childbirth. It is possible that to overcome barriers to companionship in the first stage of labour, a female labour companion, which could be a partner, mother, sister, grandmother, aunt, trusted friend or neighbour could be considered within the birth

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

plan. Giving women the space to think about what support matters to them during childbirth while attending antenatal care would also function as an opportunity for the clinic to push back against harmful norms that devalue both care labour and the reproductive rights of women who are economically disadvantaged. Normalizing procedures such as birth plans will not fix the problems facing maternity wards in SA nor address the larger structural barriers, however, they do explicitly consider care and what work is required by clinic staff as well as other people of the patient's choosing.

*The value of reproductive labour*

Much of the work involved in reproductive labour is invisible - listening to others and demonstrating compassion through small actions such as eye contact and encouraging words cannot be documented in the way clinical care can (such as taking a woman's blood pressure or reading an ECG scan). Reproductive labour is essential to life but 'not part of the formal system of exchange' (21 p.110); meaning that this labour goes largely unseen and often unpaid (21). Reproductive labour exists in multiple forms (caring for people in hospitals, child rearing, and cleaning people's homes). It is not just in the labour ward where reproductive labour is devalued, it is devalued through our refusal to see what it contributes to society (12). Perhaps if providing emotional support during labour was valued as a skill, and not one easily mastered, nurses and midwives would be more willing to perform such duties, and actions such as denying labour companions would become unjustifiable.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Harsh lockdowns due to the pandemic led to increased isolation and had devastating effects on people's mental health (22). Care providers were particularly affected and reported deteriorating emotional and psychological wellbeing throughout the pandemic (23). A recent study has suggested a connection between trauma and burnout experienced by heath care workers in maternal health facilities in SA and the decrease in quality of care offered to patients (6). This again demonstrates the necessity of supporting this important work. The COVD-19 pandemic highlighted society's dependency on reproductive labour in all areas of life but the social and economic hierarchies, which rank labour and put caring labour at the bottom of the scale remained the same.

*Conclusion*

For a window of time, women's experience of childbirth was discussed in a broader circle attracting some media attention (10). In SA, as for most of the world, policy has reverted back to allowing labour companions in maternity wards but the limitations that existed previously still apply (4). COVID -19 is not the beginning point for women experiencing neglect or isolation during labour and childbirth in maternal health facilities, which perhaps explains why no real change came from this issue being reported more openly during COVID-19. Systemic change is needed to shift our current system of value, which currently privileges productivity over reproductive labour. Where clinics make efforts to recognize reproductive labour as valuable, they are deserving of support. As the doula example above demonstrates, these efforts are complicated and sustainability is difficult to achieve in the absence of state support. More effort is needed to include women into care models that

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

facilitate open dialogue about the realities of childbirth in the clinic. Allowing women a labour companion at all times of their maternity care can be worked into this model as well as a birth plan where woman care share what they want for themselves. This however, does not relieve the state of their responsibility to provide financial and organizational support. MOUs in Cape Town will continue to work under conditions that deny birth companions until there are resources provided to offer women a clinic that can support true privacy. Honouring reproductive labour could take maternity care down a new path of more just social relations.

*Acknowledgements*

The authors would like to thank all of the nurses and midwives who participated in this study , giving their time during a busy schedule, as well as the management at the community health centre for their approval of this study and cooperation.

UNIVERSITY of the
WESTERN CAPE

*Funding Details*

This work was supported by the South African Medical Research Council under a Self-Initiated Research Grant Programme and the South African Research Chairs Initiative of the Department of Science and Technology and National Research Foundation of South Africa under grant no. 82769.

*Conflict of interest*

The authors report there are no competing interests to declare.

References for chapter 6

1. Aydin E, Glasgow KA, Weiss SM, Khan Z, Austin T, Johnson MH, et al. Giving



http://etd.uwc.ac.za/

birth in a Pandemic: Women's Birth Experiences in England during COVID-19. BMC Preg & Childbirth. 2022;22:304

2. Schaaf M, Boydell V, Van Belle S, Brinkerhoff DW, George A. Accountability for SRHR in the context of the COVID-19 pandemic. Sex Reprod Heal Matters. 2020;1–0.
3. Dutton J, Knight L. Reproducing neglect in the place of care: Normalised violence within Cape Town Midwifery Obstetric Units. Agenda. 2020;34:1
4. Reingold RB, Barbosa I, Mishori R. Respectful maternity care in the context of COVID-19: A human rights perspective. Gyne & Obstetrics. 2020
5. Nash JC. Home Is Where the Birth Is: Race, Risk, and Labor during COVID-19. Yale J of Law & Fem. 2020;32:2
6. Pattinson R, Fawcus S, Gebhardt S, Soma-Pilay P, Niit R, Moodley J. The impact of COVID-19 on use of maternal and reproductive health services and maternal and perinatal mortality. SA Health Review. 2021.
7. Eri TS, Blix E, Downe S, Vedeler C, Nilsen ABV. Giving birth and becoming a parent during the COVID-19 pandemic. Midwifery. 2022;109.
8. Hoek S. On Giving Birth During a Pandemic in South Africa. Daily Maverick. 2020; Available from: https://www.dailymaverick.co.za/article/2020-12-31-on-giving-birth-during-a-global-pandemic-in-south-africa/
9. Mary F. The preventable trauma of COVID childbirth. Bhekisisa: Centre for Health Journalism. 2020. Available from: https://bhekisisa.org/article/2020-08-12-the-preventable-trauma-of-covid-childbirth/
10. Sadler M, Leiva G. COVID-19 as a risk factor for obstetric violence. Sex & Repro Health Matters. 2020;28:1
11. Lappeman M, Swartz L. Rethinking obstetric violence and the "neglect of neglect": the silence of a labour ward milieu in a South African district hospital. BMC in health & human rights. 2019;19:30
12. Henry C. The Abstraction of Care: What Work Counts? Antipode. 2018;50;2
13. Honikman S, Fawcus S, Meintjes I. Abuse in South African maternity settings is a disgrace: Potential solutions to the problem. South African Med J. 2015;105(4):284.



http://etd.uwc.ac.za/

14. Chadwick R. Raising concerns : Quality of care in maternal health services in South Africa. 2014;8:4

15. Bohren MA, Tunçalp Ö, Miller S. Transforming intrapartum care: Respectful maternity care. Best Pract Res Clin Obstet Gynaecol. 2020;67:113–26.

16. Balde MD, Nasiri K, Mehrtash H, Soumah AM, Bohren MA, Diallo BA, et al. Labour companionship and women's experiences of mistreatment during childbirth: Results from a multi-country community-based survey. BMJ Glob Heal. 2020;5:1–10.

17. Cohen Shabot S. We birth with others: Towards a Beauvoirian understanding of obstetric violence. Euro J of Women's Studies. 2020;28:2

18. Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2013;2013:7.

19. DOSA (Doulas of South Africa). Become A Doula in South Africa [Internet]. 2022. Available from: https://dosadoulas4.wixsite.com/dosa-doulas/become-a-doula

20. Nash JC. Birthing black mothers: Birth work and the making of black maternal political subjects. Wsq. 2019;47(3–4):29–50.

21. Andaiye. The point is to Change the World. Trotz A, editor. London: Pluto Press; 2020.

22. Vindegaard N, Benros ME. COVID-19 pandemic and mental health consequences: Systematic review of the current evidence. Brain Behav Immun. 2020;89:531–42.

23. Dawood B, Tomita A, Ramlall S. The mental health impact of Covid -19 on healthcare workers in KwaZulu-Natal Province , South Africa. Plos One. 2022;17:5

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

# Chapter 7: Reinforcing and Reproducing Perceptions of Women Seeking Care: “bad’ attitudes and obstetric violence in Cape Town Midwifery Obstetric Units

Authors: Jessica Dutton, Michelle De Jong, & Lucia Knight

Submitted to *Feminism and Psychology* in September 2022

This chapter looks at the ways in which obstetric violence manifests through reproducing and reinforcing harmful stereotypes about women who are poor and seeking maternity care. Understanding how these constructions manifest and impact patient provider relations contributes to the overall understanding of what drives obstetric violence. Also, central to this chapter is how nurses and midwives attempt to protect and distance themselves from overwhelming realities in the clinic through seeing patients as the ‘other’. Demonstrating the importance of paying attention to midwives experiences, this chapter works to understand why nurses and midwives adopt harmful constructions of women seeking care and how this is a complicated method of dealing with the sometimes overwhelming realities of caring for people from socio-economically disadvantaged communities.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*Abstract*

Obstetric violence takes multiple forms across the continuum of maternity health care. One way in which obstetric violence manifests, is through reproducing and reinforcing harmful stereotypes about women who are economically disadvantaged seeking maternity care. This study explores how nurses and midwives reference harmful notions about their patients as rude, having bad attitudes, being irresponsible and uncooperative. We discuss how these constructions are not created by nurses and midwives, but exist in society more broadly, but are applied within the clinic to *other* some women as 'bad' patients. This article also explores how nurses and midwives can experience a sense of helplessness with regards to the conditions in which their patients live and how this is intertwined with their perceptions, Nurses and midwives cannot help their patients get out of the socio-economic conditions in which they live but they can internalise a hierarchical positioning with their patients, that at minimum provides a barrier and protection from getting too emotionally involved. Exploring how the perpetuation of harmful constructions that patients from economically disadvantaged communities are 'bad' helps us understand how the conditions that normalise obstetric violence are maintained.

*Introduction*

The quality of maternity care women receive in health facilities has been a growing concern within reproductive health and rights. It is considered evidence-based practice that women's experience across the continuum of maternity care be taken

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

into consideration alongside the clinical aspects of care, when determining if care is of a good standard (Tunçalp et al., 2015). Women's relationships to their maternal health facility and providers play a central role in their experience of care (Tantchou, 2018). Reports of mistreatment towards women across the continuum of maternity care within health facilities have been highlighted as a significant barrier to quality of care (Bowser & Hill, 2010). Most commonly referred to as disrespect and abuse during childbirth or obstetric violence, mistreatment of women in maternal health facilities has received specific attention in research that seeks to better the quality of maternal health care (Bohren et al., 2020). The term disrespect and abuse during childbirth is rooted in public health discourse, whereas obstetric violence is the preferred terminology within sociology and feminist work on the issue (Chadwick, 2021). Disrespect and abuse during childbirth and obstetric violence take multiple forms, from physical violence and verbal assault to women being denied care and neglectful treatment on behalf of healthcare providers. Acts to shame, deny privacy, and dehumanize pregnant and labouring women are also forms of such abuse. Disrespect and abuse and obstetric violence also happen at the level of health systems, through structural factors such as under-resourcing maternity clinics to the point where there is not enough staff or supplies to provide women with a safe childbirth experience (Bohren et al., 2015). Obstetric violence has been defined as a particular form of gender-based violence because it is directed at women because they are women ( Chadwick, 2021). This paper demonstrates how notions of gender-based violence pervade into how society thinks and talks about pregnant women, therefore we will refer to obstetric violence throughout.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Evidence of obstetric violence in South Africa (SA) has been documented in a number of studies. A report submitted to the South African Commission of Gender Equality (Rucell, Chadwick, Mohlakoana-motopi, & Odada, 2019), states that women seeking care in SA's public maternal health system have been subjected to physical abuse such as slapping, pinching and applied pressure to the fundus during active labour. Verbal abuse has been noted in a number of studies, where women are shamed and humiliated by nurses and midwives throughout their maternity care (Rucell, 2017). Neglect is a common form of mistreatment within labour wards, leading to experiences of isolation, panic, and in some cases, birthing without a care provider (Dutton & Knight, 2020; Lambert, Etsane, Bergh, Pattinson, & van den Broek, 2018). Patients have been denied privacy, a labour companion of choice, and their right to informed consent (Bradley, McCourt, Rayment, & Parmar, 2019). Obstetric violence has been linked to an increase in maternal and newborn mortality and morbidity, as well as leaving women traumatized after childbirth (Chadwick, 2018). Improving the quality of care women receive in South African maternal health services will require a transformative approach to how the current system operates and incorporate a model of compassionate care that meets patient expectations and standards.

UNIVERSITY of the
WESTERN CAPE

Our research focuses on providers' perspective of barriers to quality maternity care in South Africa's public health facilities. With the data we have collected from nurses and midwives working at public midwifery obstetric units (MOUs) in Cape Town (CT), we have previously written about the ways in which women are neglected during maternity care as a systemic form of violence (Dutton & Knight, 2020, 2022).



http://etd.uwc.ac.za/

Our research has also looked at resource shortages, particularly the absence of transportation in the event of an obstetric emergency, as a form of mistreatment (Dutton & Knight, Forthcoming). Refusing women birth companions during labour due to limited space in the labour ward is another example of institutional mistreatment of women in public health facilities we have addressed (Dutton, De Jong & Knight, Forthcoming). These studies have all included a significant consideration of the normalization of obstetric violence in SA in the public health system. A number of other studies have pointed to the institutionalization of obstetric violence, disrespect and abuse, and reproductive injustices that are normalized in maternal health care facilities (Chadwick, 2017; Jewkes, Abrahams, & Mvo, 1998). Studies have looked at this issue from a historical perspective to consider the ways in which colonial and apartheid conditioning has structured the health system and the legacy of racism and anti-Blackness that still penetrates health care today (Rucell, 2017). Feminists have illuminated how patriarchy has normalized violence against women and has provided a useful explanation of institutionalized obstetric violence (Rucell, 2017). Building on this previous work on the topic, this research seeks to understand why and how obstetric violence happens. In an article published in 2019, that investigates drivers of disrespect and abuse during childbirth, the authors ask, "what exactly are the mechanisms by which internalisation and normalisation happen?" (Freedman et al., 2018 p.116). This query has framed the ways we have approached the 'difficult patient' as it is used by the nurses and midwives in this study. We explore this question and how the notion of a 'difficult patient' references discriminatory and gendered ideas of

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

pregnancy and motherhood of economically disadvantaged women, perpetuating existing barriers to quality care for women who already face multiple hardships. Our intentions are not to remove the agency of women seeking maternity care; they are capable of being difficult, displaying bad attitudes, and acting irresponsibly. Our objective in this paper is to point out how labels such as, 'difficult', 'uncooperative' and 'women with bad attitudes' are designated to particular women for behaviour that is appropriate during pregnancy, labour, and childbirth.

*Background*

Currently SA struggles to provide the majority of women with quality maternal health care (Chadwick, 2017). Reports of obstetric violence in SA are not uncommon (Chadwick, 2016; Kruger & Schoombee, 2010). Women have reported abusive treatment within the public health system - a study from an often-overcrowded hospital in Cape Town found that neglect and lack of patient-provider communication in the labour ward is frequent (Lappeman & Swartz, 2019). Other studies report verbal abuse and acts of shaming that compromise women's safety and dignity (Rucell, 2017). As Chadwick explains, "birth politics are inextricably shaped by these sociomaterial inequalities and historical legacies. The health system, in particular, continues to be plagued by the aftermath of apartheid and racial inequalities that materialize as sharp differences in health infrastructure and resources between the state-funded public sector and the private health care sector" (Chadwick, 2018 p 4-5). Approximately 83 percent of the population rely on public maternal health in South Africa which is failing the women it sets out to serve



UNIVERSITY of the
WESTERN CAPE
http://etd.uwc.ac.za/

(Chadwick, 2017). The vast majority of those who access public health maternity services are Black women who cannot afford the costs of care in the private health sector (Rucell, 2017). Within the South African health system a woman's socioeconomic status greatly determines the quality of maternal health care she will receive (Chadwick, 2014; Chadwick, 2018). Public maternity care facilities are commonly under resourced and overcrowded and research has shown that structural problems are a driver of obstetric violence in SA(Lappeman & Swartz, 2019).

*Midwifery care in the Midwifery Obstetric Units*

The following offers a brief description of the protocol within the average MOU in CT, Western Cape. This summary is not to offer a complete overview of all maternity care offered in the MOU but rather serves to provide context to the circumstances presented in the findings. Nurses and midwives carry a wide range of responsibilities in the MOU and offer care for women during pregnancy, labour, childbirth, and postpartum. It is advised that women start attending antenatal care (ANC) in their first trimester, before 12 weeks pregnant. During their initial appointment, women are 'booked' at the MOU for further care unless complications outside the midwifery scope are detected, where the patient would be referred to a doctor at a referral hospital. It is advised that women attend eight ANC appointments for routine care. During ANC women are provided with a list of maternity and newborn supplies that they are to bring with them when they present at the MOU in labour. This list includes maternity pads, change of clothes, newborn

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

clothes, newborn blanket, nappies, and food. According to South African maternal health policy, women are also advised at this time that they are entitled to bring a birth companion with them, who will support them through childbirth. Throughout labour, clinical care includes checking women's blood pressure, heart rate, and temperature, vaginal examinations, as well as continual foetal heart monitoring. Women are to remain in the MOU for a minimum of six hours after childbirth and discharged if both the women and newborn are healthy. Women return to the clinic two to four days after they are discharged from the MOU for postpartum care.

*Methods*

This exploratory qualitative study consisted of 24 in-depth interviews with purposively selected nurses and midwives at MOUs in and around CT in the Western Cape province of South Africa. Participants were sampled purposively to ensure heterogeneous representation and to reflect diversity with regards to professional cadre, age, language, and religious background. They were selected through referral and discussion with the facility manager or head of the MOU. Following the procedures of grounded theory, this study sampled until saturation. The study population included all nurses and midwives who worked within the selected MOUs were included in this study.

The interviews took place within the clinic in as quiet and private a space as was possible within a busy MOU, during times when either the MOU was quiet or the provider was not currently working, after hours or at break times. A full informed consent process was undertaken prior to the interview. All interviews were

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

conducted in English, which is the language of nursing and midwifery education in South Africa, by the primary researcher, who herself has midwifery training and practical experience. Ethical approval was obtained from the University of the Western Cape Biomedical Research Ethics Committee and permission to conduct this research was received from the Western Cape Department of Health.

The transcribed interviews were inductively coded using ATLAS.ti with codes then categorized and themes developed using grounded theory approaches to analysis. Grounded theory is an inductive approach to research that seeks to generate middle-range theory that is specific to the context and 'grounded' in the data (Charmaz, 2011). Being 'grounded' ensures that theory is developed in the social world rather than in the abstract (Charmaz, 2008). Categories were described using descriptive codes that identified similarities in events, occurrences, and processes within the data (Charmaz, 2008). To ensure trustworthiness and rigour an audit trail highlighting all steps of the data analysis, peer debriefing, and reflexivity were performed at every stage of the research..

*Findings*

This article explores the ways in which nurses and midwives discuss their relationship with women seeking care at the MOU where they work. The descriptions given of this relationship were not homogenous however a recurring theme was that patients were sometimes frustrating. Patients could be referred to as 'irresponsible' or 'difficult'- that they displayed 'bad attitudes' and did not take responsibility for their own care. Descriptions of the hardships women seeking care

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

have experienced due to socio-economic disparities and poor living conditions were narrated through a language that constructs women as the creators of their own problems. Patients were talked about as having bad attitudes because they were indifferent to their own health needs, which was interpreted as a refusal to help themselves. Failing to attend ANC and not arriving at the clinic prepared for childbirth were offered as examples of careless behaviour.

*Patient's 'bad attitudes' as a barrier to quality of care*

When asked to explain what they experience as barriers to quality care within the MOU, 'difficult patients' or patients' attitude were often mentioned. Nurses and midwives spoke of how 'difficult patients' made for additional stress and difficulty in the clinic and affected their daily work. In many of the narratives shared, nurses and midwives were willing to root the topic of 'difficult patients' in larger more complex problems. Nurses and midwives explained that patients' negative behaviour was an outcome of poverty, a lack of support from family members, adolescent pregnancy, and possible substance abuse. Nurses and midwives explained how this compounded their stress and levels of burnout and spoke of having to balancing their professional tasks in the clinic as well as acting as 'social workers' for their patients. This did not necessarily translate to more compassionate care on behalf of the health care provider but offers useful insight into how nurses and midwives come to make sense of their patients, their work environment, and themselves as health care professionals. While nurses and midwives at times spoke fondly of their patients and that caring for pregnant women from economically disadvantaged



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

communities was a professional motivation; 'difficult patients' was often described as a burden and out of the nurses or midwives' control.

*Referencing and reinforcing constructions of 'bad attitudes'*

Nurses and midwives at times, described women seeking care at the MOU as if a bad attitude was a characteristic of living in poverty. As if there is some essential connection between the two and that coming from an economically disadvantaged community somehow explained patient's unwillingness to co-operate. As one midwife suggests,

> *Township patients, they have the tendency of giving us attitudes in ways that you cannot tolerate at times, it is too much. I don't know why they are doing that to us sometimes. Here they will come unbooked [for childbirth], defaulting on ART [antiretroviral treatment] but when we are asking the patient a question, they will do this to you [looks at me up and down wearing a judgmental face]. Our patients they do not listen. They do not follow their responsibilities, it's all about that they have got rights, but, you [they] need to be responsible although you have got rights. I don't think that they understand that rights goes with the responsibility. They have got attitude. (advanced midwife, Cape Town)*

The perceived refusal of women to take responsibility for their own health was a recurring complaint amongst nurses and midwives when they spoke about the difficulties they encountered with their patients and was referred to as an example of non-cooperation. According to the research participants, patients displayed 'bad'



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

attitudes by refusing to listen and acting irresponsibly. From the perspective of nurses and midwives this has a direct impact on the patient-provider relationship and leaves staff feeling frustrated and over-burdened.

The idea that women who come to the clinic seeking care can be irresponsible, indifferent to their own health needs, and do not listen is further articulated in the following quote given by a midwife,

> *Another thing is, there is also a challenge that most of our clients that we see, they already come with attitude and you find that even before, they are defensive. So to speak, even before you say anything. So, it has been a challenge that the patients that we are dealing with, it is as if we are responsible for their care. They don't have any responsibility whatsoever about their own health, their own education. It's like they put everything on us so they don't want to take any responsibility, to do anything towards helping themselves. Even if you are sharing information about their health with them, it's like you are talking and they are listening but it is just coming in this side and going out the other side because you can tell them and then say, what did I say? You find that they won't know. They are not listening. And we speak the same language as most of them, they speak Xhosa and we speak Xhosa with them but because they have that mentality that you are responsible for my life so it doesn't matter. (professional nurse, Cape Town)*

That women at the clinic seeking care bring an attitude with them was a constructed narrative nurses and midwives used to explain difficult provider-patient

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

relationships. A common thread throughout nurses and midwives' narratives is that they must carry, often unmanageable, amounts of responsibility in the clinic. As the quote above demonstrates, nurses and midwives feel the care labour is one-sided and this is not sufficient for quality care, as women attending the clinic too must bear responsibility. The perception that women do not listen left midwives feeling more overwhelmed. One midwife shared her experience of working in ANC and the frustrations with women not following instructions

> *And you must always ask do you understand, do you have any questions. So you must always explain so that whatever knowledge they get outside doesn't confuse them. Because, my darling when they go outside there, they hear things! They drink things you have never heard of! Because every morning we stand in front of them and we teach them, why we need the urine, why we must do the blood pressure, why we must do the weight, why you must do this and this and this. But once they get out of that gate, they forget what you have told them. They want to drink muti [traditional medicine/home remedies], they want to drink this and that and then they come at 9 months with no foetal heart, no foetal movement and you don't understand. You always tell them, if your baby did not move for a day, the following day do not wait, come straight to us. You find they have waited 5 to 6 days, no foetal movement. By this time the baby is already macerated into pieces. So, it is the knowledge outside versus what you tell them inside, you understand? So, it is very difficult and you try by all means to explain to them. (professional nurse, Cape Town)*

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

This was not the only time that nurses and midwives expressed that patient's unwillingness to listen could lead to serious risks to their health and safety. The midwife quoted above described such events as the reasons for her inability to provide quality care in the clinic and that it creates ongoing frustrations between staff and patients. Nurses and midwives expressed their frustration with the patient for not being booked for childbirth during ANC, which was also mentioned in a previous quote. From the midwives perspective, booking for childbirth is not only exclusively the responsibility of the patient, but necessary for quality care and a safe childbirth for the woman and her newborn. Booking is a process that is usually done during a woman's initial ANC appointment when her expected date of delivery is determined and information is shared with the labour ward. Then the patient is considered 'booked' at the clinic. During one conversation a nurse explained the clinic policy that anyone who presents at the MOU has a right to care, regardless of prior booking, and her frustration with caring for women who have not received ANC:

UNIVERSITY of the
WESTERN CAPE

> *Nurse: Even if they come unbooked you have to help that person, you have to help that person.*
>
> *Researcher: Do a lot of women come unbooked?*
>
> *Nurse: A lot, um, in a week, you've got two or three unbooked patients… she doesn't have anything, no scan, no clinical notes. Nothing. But you have to help that person because this is her hospital. You are just an employee and you are here to help them. And you pledged (laughs), you pledged that you will be here.*



http://etd.uwc.ac.za/

*It's very stressful. (auxiliary nurse, Cape Town)*

Having to 'help' patients in situations where the nurse feels the patient has not taken responsibility for their own care is articulated with some indignation and certainly expressed as a stressful part of their job. Without ANC, quality of care is compromised, however, the nurse is expressing not only a frustration with this but with the expectation that she must fulfil her role regardless of the situation and that this is a reflection of how she, as a nurse is valued in the health system. She states that the clinic belongs to the patient and she is 'just an employee', suggesting that she is not as valued. Whether the attitude problem was described as a show of lack of respect for the nurses and midwives or the refusal to listen and take responsibility, from the viewpoint of the health care provider the 'difficult patient' stands, implicitly and explicitly, as a central barrier to quality of care and destructive to the midwife-patient dyad.

UNIVERSITY of the
WESTERN CAPE

*Moralism over compassion: a response to women in labour*

Nurses and midwives expressed that women who arrive at the clinic without a labour companion meant more time must be dedicated to caring for the woman's emotional and psychological needs, which is additional to their clinical responsibilities. A nurse at one of the clinics shared with me what she understands as a link between women not listening to instructions during labour and her inability to manage the pain of contractions and childbirth.

*And few patients come to give birth with someone, they come alone and now you have to give support AND do the clinical things. People come alone and*



http://etd.uwc.ac.za/

*they don't listen. You have to explain, don't be naked in front of the others. Patients go under the bed and you have to document that the patient went under the bed because if someone comes in and sees the patient you can get in trouble. So, you document everything. When women arrive and are admitted you have to explain that the pain is going to get worse, but they are not prepared for labour and don't know what will happen to them. They are primips [women having their first baby], so they don't know and they are not prepared for the pain. (professional nurse, Cape Town)*

This story begins with the midwife stating that patients do not listen and that this explains their behavior rather than assessing how the absence of a birth companion may be the fundamental problem in this situation. Stories of women arriving alone and without a birth companion were common in the description nurses and midwives gave of their work in the labour ward. Nurses and midwives stated that if they did not step in and offer labour support, these women would go without. Behaviour such as going under the bed, lying on the floor or removing all their clothes was interpreted by nurses as disruptive, uncooperative and even disrespectful behaviour. Women who have not given birth before and are not accompanied by a birth companion, according to the nurses and midwives interviewed, are more likely to have a negative birthing experience for these very reasons. However, compassion does not seem to be extended to the patient's particular situation, of going into labour without a companion but rather they are labeled as a potential liability to the nurses and could get the nurses into trouble. When the patient is an adolescent, emotional and psychological care can be even

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

more challenging. When asked about some of the more difficult experiences within the patient-provider relationship, one nurses stated:

> *I think most of the time [discussing the more difficult relations with patients] we are dealing with teenage pregnancy, sometimes they are getting pregnant and they are getting hit by the boyfriend so they came with their anger. Normally they must stay here at least six hours after (giving) birth but sometimes the family, they don't come to fetch them so they are developing anger towards the nurses, some of them. Sometimes you ask them questions, they don't feel like talking to you. I think it's because of the negligence of the families…I think when they are falling pregnant they are underage, sometimes you find out that the patient is 17 years (old) and she is p2 (second pregnancy), she is not married, she is not well educated, some of them they don't have parents, they don't have a place to stay. Even the boyfriend is gone, can you see. So that are the problems they are experiencing. (nurse, Cape Town MOU)*

UNIVERSITY of the
WESTERN CAPE

In many of the descriptions of their patients, nurses and midwives told of the extremely challenging living conditions of pregnant women and new mothers. At times nurses and midwives expressed that patient's refusal to listen or demonstrations of anger is the result of their life experiences and living conditions. Sexual abuse, intimate partner violence, lack of support from family members and poverty were often talked about when nurses and midwives described the violence their patients experience that can contribute to negative behaviour in the clinic.



http://etd.uwc.ac.za/

*The role of disadvantage and poverty in constructing and reconstructing women as 'difficult'*

Deep-rooted problems in the community were often expressed as a major barrier to quality of care in the MOUs. A senior midwife recounted a difficult experience with a patient. She framed this story, firstly, by telling us that her community is unhealthy,

> *Number one, our community is a sick community so by being sick all their problems, they vent it to us as nurses and we as nurses don't have anybody on our side when the client complains. I will make an example of this one girl who was unbooked [has received no antenatal care or any previous contact with the clinic before arriving in labour], she was here on a Sunday morning, she was here on tik [methamphetamines], very cheeky. You can see she hasn't washed, ask her have you washed? How can I come to the hospital and haven't washed? But you can see she hasn't washed and then we ask her, like everyone who comes in labour, we have to do a vaginal examination and that is the thing that the patients don't like. You insist that they do it because when you phone and you present [to the doctor], the doctor won't take the story if you don't know the [cervical] dilation, and that is a problem because you cannot force the patient because the patient is going to say you are rude to her but on the other side the doctor is going to want to know how far dilated she is. (advanced midwife, Cape Town)*

The absence of community wellness is used to explain to the researcher how deeply difficult the midwife's role is when she is faced with the repercussions of, what she

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

sees as, social illness. The midwife expresses that she feels as though nurses do not have the adequate support to cope with what they experience in the clinic environment. One way this lack of support manifests is through the midwives compromised positioning between the patient and the doctor. Her responsibilities include caring for a woman who is refusing a vaginal examination (which is within her rights to do) and a doctor who requires this information to provide clinical care. Unable to satisfy both the patient and the doctor, the midwife expresses a dissatisfaction with the patient and interprets the patient as the cause of the problem. The midwife's frustration with this predicament seems to be intensified by her interpretation of this patient who has not washed and appears to be using tik (a term commonly used in SA for methamphetamines*)*. Questioning a patient about their hygiene could be a very humiliating experience for the patient and seems unnecessary given the woman is in already in labour. This quote demonstrates the line between care and concern on one side and actions that are punitive on the other. Substance abuse was seen as a major problem affecting the community and a contributing factor to bad attitudes amongst adolescent patients especially. A nurse sums up some of her negative experiences caring for young women, stating,

> *With the young ones, what I have noticed, if is those who are giving us attitude is the ones who are using substances. Tik [methamphetamines], they are using tik and alcohol most of the time so it is difficult. (professional nurse, Cape Town)*

Drug use was at times woven into the narrative of a 'difficult' patient. Caring for women in this state was understood as exacerbating an already strained and under-resourced clinic environment. Nurses and midwives were often able to explain the

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

broader context as to why women may use substances and poverty was seen as a central cause.

Caring for women who live in sometimes quite extreme levels of poverty was often discussed and described as a barrier to quality care because of the obstacles that come with poverty. When asked about their relationship with patients, one nurse replied,

> *But the patients are the most problematic here and they don't want to be questioned. We tell them when you come to the clinic, you must bring all your stuff along. You must bring pads, you must bring all those things that you think you are going to use [during labour]. If you ask maybe where are your [maternity] pads? She is going to turn. She is going to be an animal. As if you don't have to ask where are your pads. (auxiliary nurse, Cape Town)*

Nurses and midwives were well aware of the socio-economic conditions of the community they serve and why some women would not be able to afford these basics, however some still spoke of the tension this creates and as a problem women bring onto themselves and the clinic. That the clinic could not provide maternity pads for women who cannot bring their own supplies also highlights how resource stricken the MOU's were. The nurse states that patients do not want to be questioned, but does not seem to make the connection between such defensiveness and the patient provider relationship. The patient is deemed problematic for not wanting to be blamed for what is out of her control; that she cannot afford basic maternity supplies for labour. Instead of empathizing with the patient and

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

recognizing that this many be experienced with shame, she patient is labelled a problem.

Nurses and midwives often talked about running out of essential supplies (sheets and gloves) and having to navigate care using broken equipment. Having to juggle a low resource setting with patients who cannot bring their own basic supplies was expressed as divisive. Nurses and midwives are justified in their frustrations with the clinic, however much of the descriptions of patients came across as punitive and moralistic.

*Discussion*

The nurses and midwives in this study did not invent the labels used to describe their patients, nor are they unique to South Africa (Filby, McConville, & Portela, 2016). In the health care environment, 'difficult women' or the 'uncooperative patient' are tropes used to quickly conjure up an already constructed image of poor, often young, pregnant women, who are on the receiving end of society's moralistic judgment (Filby et al., 2016; Gomez, Mann, & Torres, 2018; Marks, 1994). Obstetric violence takes multiple forms including discursive violence, and includes the ways in which labeling a woman as irresponsible and difficult instead of offering a more accurate description that speaks to her state of being (experiencing intense pain, physically exhausted, distressed, overwhelmed) acts to dehumanize patients and deny them compassion (Bradley et al., 2019).

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*Dismantling the notion that patients are difficult*

The ‘difficult patient’ obscures the realities of the clinic and places the blame on pregnant and birthing women, relying on stereotypical notions of women seeking maternity care. Nurses and midwives characterized women seeking maternity care as difficult if they appeared to not be listening to instructions or failing to adhere to maternal health recommendations, namely not booking to give birth at the MOU. These were referred to as examples of the ways in which some women are not taking responsibility over their health and pregnancy. Nurses and midwives are correct to be concerned with regards to women having no ANC throughout their pregnancy (Pattinson, Hlongwane, & Vannevel, 2019). Concern, but not judgment, for substance abuse, adolescent pregnancy and the degree that a patient is prepared for childbirth are valid. However, reducing the cause of such issues to a negative attitude places the problem on the individual and does not allow for a broader, more nuanced, engagement. Studies have drawn attention to how Black women are stereotyped as uncooperative and/or untrusting and as a result, denied care by their healthcare providers. Such outcomes are the direct result of the ways in which social inequity and racism harm Black women and denies them their right to quality maternity care (Bradley et al., 2019; Gomez et al., 2018).

*Beyond ‘difficult patients’ and ‘bad attitudes’: considerations of context*

*The socio-economic status of women seeking maternity care*

Nurses and midwives acknowledged that some of their patients are experiencing extremely difficult living conditions and that this was a likely cause of their



http://etd.uwc.ac.za/

behaviour. Rates of gender-based violence are extremely high in the communities served by the MOUs that participated in this study and nurses and midwives spoke of the effect this can have on pregnant women (Jewkes et al., 1998) . Nurses and midwives spoke empathetically of women who do not have support from a partner or other family members and cannot access the basics such as food and maternity supplies. Such hardship was also discussed with some annoyance, as nurses and midwives felt this results in their own situation becoming precarious and additional stress was brought upon them when women were 'not prepared' for childbirth and then making the situation worse by not cooperating or listening to instructions. Presenting at the clinic unwashed or without the necessary maternity supplies can be found in other studies as a supposed sign of disrespect towards the health care providers and built into the misconceptions of pregnant women living in conditions of poverty (Chadwick, 2018; Moyer et al., 2016). This misconception offers a possible insight into how nurses and midwives may shift blame onto their patients when there is so little they, or their patients, can do about the socio-economic situations they live in.

UNIVERSITY of the
WESTERN CAPE

A particular frustration of the midwives seems to build from the lack of power to better the conditions of the clinic and the community where the clinic is situated. These are often the same communities where the nurses and midwives themselves reside and they too experience high levels of violence within their daily lives. Within these difficult situations, which are out of the nurses' control, they opt to control what they can. Part of the power a nurse or midwife holds is having control over how people behave in the clinic. A nurse's power is demonstrated through uniforms,



http://etd.uwc.ac.za/

control over access and care, and their ability to reprimand patients (Campbell et al., 2015). Policing behaviour in the clinic creates a relational opposition between the nurses and the women seeking care, and nurses are able to reposition themselves as no longer passive victims of structural violence but as active, in control and providing solutions. The behaviour of patients is then measured using, often unreasonable, expectations of subservience, expanding the distance between midwives and patients, casting them as victims of structural violence and a population needing to be controlled.

*The MOU and clinic environment*

Nurses and midwives expressed that resource shortages carried a great impact on their everyday experience of the clinic, however, they did not make an explicit connection between resource shortages and patient's experiences or 'negative attitudes'. Through uncomfortably long wait times, broken beds, lack of privacy, disrespectful treatment and neglect they are undervalued and made to shoulder the problems within the health system (Chadwick, 2018; Dutton & Knight, 2022). That they cannot afford private care is exploited and used to justify care that does not meet their standards. Nurses and midwives did not talk about difficult patients as something that develops within the clinic, but rather that the bad attitude was something that patients brought with them into the clinic. One midwife shared that the negative attitudes are expressed even before she can *say anything*; that it is the patient that is rude upon arrival. In a previous article that looks at neglect in CT MOUs, we discussed observations of the ANC wait room, how women can wait all



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

day for their appointment, and a drastic shift in mood was observed as the day passed. In the morning hours, patients and ANC staff alike seemed pleasant but frustrations would grow with time (Dutton & Knight, 2020). Problems such as long wait times often due to staff and resource shortages, leave women feeling neglected and pushed aside. Becoming restless, annoyed, and on–edge seems a reasonable responses to these conditions. That they are pregnant or holding a newborn, often sitting on a bench (in post-natal care) and already experiencing a level of discomfort was only at times factored into nurses and midwives description of the bad attitudes they discussed.

The construction of 'bad' women (read: poor) can also be contextualised within broader discourses of middle-class exceptionalism and prejudice. Declaring that women in poverty who choose to reproduce are somehow a burden on society is couched in racist-classist nationalism that serves to protect middle-class interests rather than advocating for the wellbeing of all (Gomez et al., 2018; Ocen, 2017). Policing economically disadvantaged women's reproduction is a form of obstetric violence. This is not to say nurses' actions are always explicitly violent but rather that what informs and inspires harmful stereotypes of pregnant poor woman as 'bad' is predicated on the idea that the middle-class are morally positioned for motherhood and societal greater good in a way that working class women are not (Campbell et al., 2015).  The perception that poor women are burdensome to the system has a social and historical legacy and spans beyond the borders of SA(Gomez et al., 2018; Morison, 2021). Perpetuating the construction that these women do not

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

care for themselves and behave irresponsibly acts to skew our understanding of women in need of compassionate care and how this can be achieved.

The historical and social processes that have gone into constructing poor Black women as bad patients require there also be a good patient, to measure and judge the bad patient against (Campbell et al., 2015). 'Good' patients are calm and friendly, passive and accepting; they listen, follow directions, and show trust in their health care practitioner. In the South African context good patients, when thinking about patients through a lens of moralistic classism, are middle-class and can pay for private health services. They also have the option to have elective cesarean and choose to have pain medications administered by epidural. They are not viewed as a burden on the health system and their health issues are often understood as solvable. Even in the case where the 'good' patient's illness is not medically solvable, the patient's socio-economic status is unlikely to be an impediment.

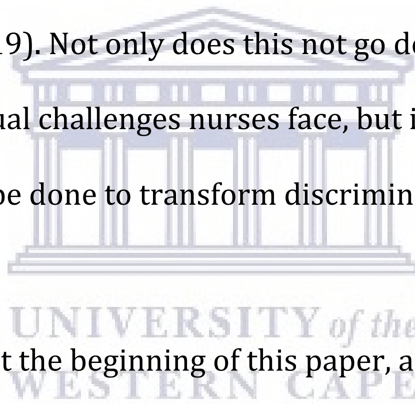
UNIVERSITY of the
WESTERN CAPE

In a maternity ward, expecting women to perform the behavior of a 'good' patient, especially when in labour, is unreasonable. Women in labour who may not have the necessary support and are in pain cannot easily follow orders and instructions. Maintaining a calm disposition can be a great challenge and trust of their health care provider cannot be assumed. In such cases, labelling the patient as bad has more to do with reinforcing well-worn stereotypes than it does with the situation at hand. Without the good/ bad patient binary, the woman in labour is a patient in need of care; her actions are a display of what she feels in the moment and not her moral status.



http://etd.uwc.ac.za/

Laws and policy can play a role in changing long-standing norms and beliefs but transforming gender norms does not stop there. As a study on disrespect and abuse in maternity care from Tanzania finds, "transformation in the relationship between women and providers of childbirth services cannot be compelled by the operation of law. It will have to be built from the ground up through creative efforts to challenge settled patterns of behaviour and deeply entrenched health system structures, that marginalise and abuse" (Freedman et al., 2018 p. 118). There is an idea that circulates in some research and public discourse that if only nurses and midwives were kinder and more sympathetic to the women in their care the situation would improve (Bradley et al., 2019). Not only does this not go deep enough into the issue and disregards the contextual challenges nurses face, but it distracts us from the harder work that needs to be done to transform discriminatory beliefs about who is a socially desirable mother.


UNIVERSITY of the
WESTERN CAPE

We return to the question at the beginning of this paper, asked by Lynn Freedman in her article about drivers of obstetric violence, barriers to respectful maternity care, and how power operates in health systems, she asks, But what exactly are the mechanisms by which internalisation and normalisation happen? (Freedman et al., 2018). One mechanism is the normalization that there exists 'socially undesirable reproducers' (Gomez et al., 2018; Morison, 2021) a moral judgement based on a woman's socio-economic conditions. Such women fall onto the wrong side of the good/bad mother binary and their problems are not going to be fixed through bettering maternal health care alone. Punishing pregnant poor women for being poor will continuing on for as long as social inequality remains the norm and classist



http://etd.uwc.ac.za/

racist values go unchallenged in society. These women are often tired and uncomfortable, not only due to the conditions within the clinic, but because poverty is exhausting. Nurses and midwives cannot help their patients get out of the socio-economic conditions in which they live but they can internalise a hierarchical positioning with their patients, that at minimum provides a barrier and protection from getting too emotionally involved. This also means that the empathy and compassion, and the additional work that would come with that, gets left behind.

http://etd.uwc.ac.za/

References for Chapter 7

Bohren, M. A., Adu-Bonsaffoh, K., Irinyenikan, T. A., Maung, T. M., Balde, M. D., & Tunçalp, Ö. (2020). Mistreatment during childbirth – Authors' reply. *The Lancet*.

Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Gülmezoglu, A. M. (2015). The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLoS Medicine*, *12*(6).

Bowser, D., & Hill, K. (2010). Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis USAID-TRAction Project.

Bradley, S., McCourt, C., Rayment, J., & Parmar, D. (2019,). Midwives' perspectives on (dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and meta-synthesis. *Reproductive Health*. 16 (116)

Campbell, C., Scott, K., Skovdal, M., Madanhire, C., Nyamukapa, C., & Gregson, S. (2015). A good patient? How notions of "a good patient" affect patient-nurse relationships and ART adherence in Zimbabwe. *BMC Infectious Diseases*, *15*(1), 1–11.

Chadwick,.R. (2014). Raising concerns : Quality of care in maternal health services in South Africa, African Journal of Midwifery and Women's Health*8*(4). 77

Chadwick, R. (2017). Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives. *Feminism & Psychology*, *27*(4), 489–509.

Chadwick, R. (2018). *Bodies that birth: Vitalizing birth politics*. *Bodies that Birth: Vitalizing Birth Politics*.

Chadwick, R. (2021). Agenda Empowering women for gender equity Breaking the frame : Obstetric violence and epistemic rupture article Breaking the frame : Obstetric violence and epistemic rupture.

UNIVERSITY of the WESTERN CAPE



http://etd.uwc.ac.za/

Chadwick, R. J. (2016). Obstetric Violence in South Africa. *SAMJ*, *106*(5).

Charmaz, K. (2008). *Constructionism and the Grounded Theory Method*. New York: The Guilford Press.

Charmaz, K. (2011). Grounded Theory Methods in Social Justice Research. *The SAGE Handbook of Qualitative Research*,

de Kok, B. C., Uny, I., Immamura, M., Bell, J., Geddes, J., Phoya, A. (2020). From Global Rights to Local Relationships: Exploring Disconnects in Respectful Maternity Care in Malawi, Qual Health Res. *30*(3), 341–355.

Dutton, J., & Knight, L. (2020). Reproducing neglect in the place of care: Normalised violence within Cape Town Midwifery Obstetric Units. *Agenda*, *34*(1), 14–22.

Dutton, J., & Knight, L. (2022). *Sexual and Reproductive Justice: From the Margins to the Centre*. (J. . Morison, T. & Mavuso, Ed.). Lexington Books.

Filby, A., McConville, F., & Portela, A. (2016). What Prevents Quality Midwifery Care? A Systematic Mapping of Barriers in Low and Middle Income Countries from the Provider Perspective. *PloS One*, *11*(5)

Freedman, L. P., Kujawski, S. A., Mbuyita, S., Kuwawenaruwa, A., Kruk, M. E., Ramsey, K., & Mbaruku, G. (2018). Eye of the beholder? Observation versus self-report in the measurement of disrespect and abuse during facility-based childbirth. *Reproductive Health Matters*, *26*(53), 107–122.

Gomez, A. M., Mann, E. S., & Torres, V. (2018). 'It would have control over me instead of me having control': intrauterine devices and the meaning of reproductive freedom. *Critical Public Health*, *28*(2), 190–200.

Jewkes, R., Abrahams, N., & Mvo, Z. (1998). Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science & Medicine*, *47*(11), 1781–1795.

Kruger, L., & Schoombee, C. (2010). The other side of caring: abuse in a South African maternity ward. *Journal of Reproductive and Infant Psychology*, *28*(1), 84–101.



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

Lambert, J., Etsane, E., Bergh, A. M., Pattinson, R., & van den Broek, N. (2018). 'I thought they were going to handle me like a queen but they didn't': A qualitative study exploring the quality of care provided to women at the time of birth. *Midwifery*, *62*, 256–263.

Lappeman, M., & Swartz, L. (2019). Rethinking obstetric violence and the "neglect of neglect": the silence of a labour ward milieu in a South African district hospital. *BMC International Health and Human Rights*, *19*(1), 30.

Marks, S. (1994). *Divided Sisterhood: race, class and gender in South African nursing profession*. Witwatersrand university Press.

Morison, T. (2021). Reproductive justice: A radical framework for researching sexual and reproductive issues in psychology. *Social and Personality Psychology Compass*.

Moyer, C. A., Rominski, S., Nakua, E. K., Dzomeku, V. M., Agyei-Baffour, P., & Lori, J. R. (2016). Exposure to disrespectful patient care during training: Data from midwifery students at 15 midwifery schools in Ghana. *Midwifery*, *41*, 39–44.

Ocen, P. A. (2017). Birthing injustice: Pregnancy as a status offense. *George Washington Law Review*, *85*(4), 1163–1223.

UNIVERSITY of the
WESTERN CAPE

Pattinson, R. C., Hlongwane, T.& Vannevel, V. (2019). Challenges to improve antenatal and intrapartum care in South Africa. *South African Medical Journal*, *109*(11b), 15–19.

Rominski, S. D., Lori, J., Nakua, E., Dzomeku, V., & Moyer, C. A. (2016). "When the baby remains there for a long time, it is going to die so you have to hit her small for the baby to come out": justification of disrespectful and abusive care during childbirth among midwifery students in Ghana. *Health Policy and Planning*, *32*(2)

Rucell, J., Chadwick, R., Mohlakoana-motopi, L., & Odada, K. E. . (2019). United Nations Special Rapporteur on Violence Against Women Submission was compiled by researchers: Obstetric Violence in South Africa, 1–19.



http://etd.uwc.ac.za/

Rucell, J. Z. (2017). *Obstetric Violence & Colonial Conditioning In South Africa's Reproductive Health S*ystem. Leeds University (PhD dessertation)

Tantchou, J. C. (2018). The Materiality of Care and Nurses' "Attitude Problem." *Science Technology and Human Values*, *43*(2), 270–301.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357.

Tunçalp, Ö, Were, W., MacLennan, C., Oladapo, O., Gülmezoglu, A., Bahl, R., … Bustreo, F. (2015). Quality of care for pregnant women and newborns-the WHO vision. *BJOG: An International Journal of Obstetrics & Gynaecology*, *122*(8), 1045–1049.

http://etd.uwc.ac.za/

# Chapter 8: Inter-personal level factors influencing disrespectful treatment towards women seeking care in South African midwifery obstetric units

Authors: Jessica Dutton, Michelle De Jong & Lucia Knight

Submitted to *PLOS Global Public Health* in September 2022

This chapter explores interpersonal level factors that contribute to disrespectful treatment of women. The paper revisits the findings from previous papers while considering an additional finding -the absence of informed consent in the clinic. This paper also considers these findings in relation to Bradley et al.'s (2019) theoretical framework on drivers of disrespectful care from the perspective of midwives to organize and discuss acts of disrespectful care that emerged from this research. Instances of empathetic care, where clinic staff recognise patients are part of their community and show compassion is revisited. Returning to this work on kindness as resistance explored in chapter 4, the possibilities of disrupting uneven relations of power through compassion are considered.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*Abstract*

This paper explores interpersonal level factors that contribute to disrespectful treatment of women attending midwifery obstetric units (MOUs) in Cape Town, South Africa from the perspective of nurses and midwives. In-depth interviews with nurses and midwives and 24 hours of observation of the MOUs antenatal care wait room or nursing station was conducted. Nurses and midwives discussed a number of different reasons to why disrespectful treatment happens within the clinic at the micro, meso and macro level. We have focused on the factors at the interpersonal level, as this paper is concerned with the how nurses and midwives describe their relationship with patients in the clinic and what about these relationships stands in the way of respectful maternity care. The findings showed that the ways in which nurses and midwives constructed their patients- as having negative attitudes and being uncooperative, intentional neglectful treatment, and performing unconsented intimate examinations were normalized within the MOU. We have used the White Ribbon Alliance charter on respectful maternity care to define disrespectful treatment and Bradley et al.'s (2019) theoretical framework on drivers of disrespectful care to organize the disrespectful care emerging from our findings. This theoretical framework divides micro level drivers into two relevant categories; maintaining midwifery status and power and control. We discuss our finding with regards to these categorisations and contribute to the much-needed conversation on these complex and complicated issues. We also look at instances where clinic staff refuse to *other* patients and demonstrate empathetic care. When clinic staff recognise patients are part of their community and show compassion we see the

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

possibilities of disrupting the uneven relations of power that drive disrespectful care.

*Introduction*

The importance of a positive childbirth experience has gained attention within global public health over the last decade (1). The right to dignified care is considered an international standard and promoted through a number of different policies globally (2–4). Research on disrespectful treatment towards women seeking maternity care has provided insight into the ways in which this problem affects women all over the world. The White Ribbon Alliance's (WRA) charter on respectful maternity care has shaped a rights-based approach to challenge disrespectful treatment during childbirth in health facilities. Respectful maternity care is defined by ten human rights for women and their newborns and the following rights speak directly to our study: the right to freedom from harm and ill-treatment, the right to information, informed consent, and respect for their choices and preferences, the right to privacy and confidentiality, the right to be treated with dignity and respect, the right to equality, freedom from discrimination and equitable care, the right to healthcare and to the highest attainable level of health, the right to liberty, autonomy, and self-determination (2). The respectful maternity care charter defines our approach to respectful maternity care in this study.

In South African public health services, the quality of maternity care remains low despite some local efforts to improve it (5–7). About 83 percent of women seeking maternal health care attend government facilities, and the vast majority are from



http://etd.uwc.ac.za/

economically disadvantaged communities (8). Inequality in South Africa is extreme and this is reflected in all areas of health care, including maternity (9). In 2012, the maternal mortality ratio in the public health system was estimated to be 333 deaths for every 100,000 live births. To offer some context, the maternal mortality ratio in the South African private sector in 2012 was reported to be approximately 40 deaths per 100,000 live births (9). Studies measuring the impact of COVID-19 on maternal health report that maternal mortality has increased since 2020 and that South Africa, like the rest of the world, has become more unequal (10,11). Research on disrespectful treatment within the public health system is needed to address inequality and contribute to positive change within maternity care.

The WRA respectful maternity care charter highlights the serious ways in which women's rights are infringed upon, sometimes overtly and at other times through the ritualized and normalised practices in the clinic. Bradley et al. (2019) propose a theoretical framework that outlines the drivers of disrespectful care during childbirth that gives a number of meso level drivers (see Figure 1 below), as well as three macro level drivers, which are structural inequality, health system – policy and drivers and colonial legacy. Drivers of disrespectful treatment at the health system, national, and international levels include, in the South African context, the ways in which the health system still perpetuates apartheid era structures of inequality, the hierarchy of the medical model, the medicalization of childbirth, and global systems of inequality that negatively effect women in the global south. These cannot be ignored in the wider conversation on disrespect and abuse and although

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

not the focus of this paper, are interconnected to interpersonal level drivers of disrespect and abuse in multiple ways (12,13)

The focus on provider's perspectives on disrespectful care has grown over the last few years, and continues to contribute to our understanding the problem of disrespectful care more holistically, and it is our intention to contribute to this production of knowledge (14–18). Focusing on what drives these behaviours and actions allows for us to ask and discuss why these actions occur and to understand them in more depth than simply nurses acting badly.

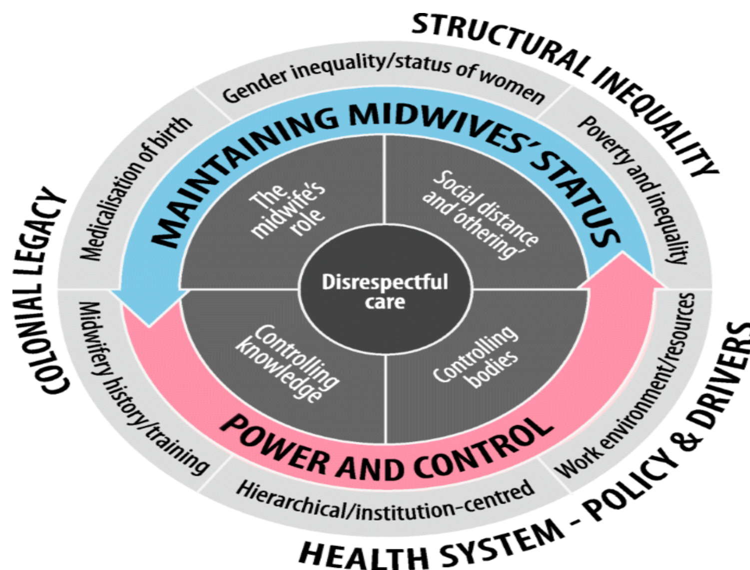



**Figure 1. Conceptual framework of the drivers of (dis)respectful care in the sub-Saharan Africa context. Bradley et al. (2019).**

*Methods*

This study is designed using grounded theory and follows the steps of a constructivist grounded theory protocol. Grounded theory is an inductive approach to research that seeks to generate middle-range theory that is specific to the context



http://etd.uwc.ac.za/

and 'grounded' in the data. (19) This exploratory qualitative study consisted of 24 in-depth interviews and 24 hours of observations at each MOU. The interviews were conducted using a semi-structured interview guide, however, because the aim was to collect personal narratives, the participants were encouraged to speak on topics of their choice with the limitation that it was related to quality of maternal health care. All interviews were conducted in English, which is the language of nursing and midwifery education in South Africa, by the primary researcher, who herself has midwifery training and practical experience.

*Study Sites*

The three MOUs selected for this study are located in townships of Cape Town South Africa. MOUs are midwifery led clinics located within a community health centre. The interviews took place within the clinic in as quiet and private a space as was possible within a busy MOU, during times when either the MOU was quiet or the provider was not currently working, after hours or break times. Observation took place in the antenatal waiting room or the nursing station (located in the labour ward of the MOU).

Typically the MOU functioned with two midwives and two to three nurses on site. From the hours of eight until five management was present, including a sister in charge, who oversaw the clinic. There is always a doctor on call but no doctor is present full time in the clinic. The MOU manages low-risk pregnancies and deliveries. In the event of an obstetric emergency, women are transferred to a referral hospital. MOU's provide antenatal, intrapartum, and postnatal care free of



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

charge. All clinics were located in areas of Cape Town highly effected by poverty, high crime and gender-based violence (20). All clinics had security measures at the entrance to protect staff and patients inside.

*Study participants, recruitment, and sampling*

This study included purposively selected nurses and midwives working at MOUs. South Africa has a nurse – midwifery education programme therefore all midwives study as nurses, with midwifery as one component of the four-year nursing degree. There is also the option to become an auxiliary nurse, which involves a two-year diploma. An advanced degree in midwifery is offered as an additional one-year training after completing a four-year degree in nursing. Midwifery education is regulated through the South African Nursing Council (SANC) all those employed as nurses or midwives in government facilities must be registered with SANC. From auxiliary nurses to advanced midwives, nurses from all levels of qualifications were included in this study. Other members of staff such as management, security, custodial staff and those working in administration reception were excluded from this study. Participants were sampled to ensure heterogeneous representation and to reflect diversity with regards to professional cadre, age, language, and religious background. They were selected through referral and discussion with the facility manager or head of the MOU. Following the procedure of grounded theory, this study sampled until saturation.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*Data Analysis*

Interviews were recorded and transcribed by the primary researcher. The transcribed interviews were inductively coded using ATLAS.ti with codes then categorized and themes developed using grounded theory approaches to analysis. Being 'grounded' ensures that theory is developed in the social world rather than in the abstract (21). Categories were described using descriptive codes that identified similarities in events, occurrences, and processes within the data (21). To ensure trustworthiness and rigour an audit trail highlighting all steps of the data analysis, peer debriefing, and reflexivity were performed at every stage of the research. The lead researcher referred to the consolidated criteria for reporting qualitative research (COREQ) checklist for interviews to ensure rigour and to guide the reporting of this research (22).

UNIVERSITY of the
WESTERN CAPE

*Ethical Approval*

Ethical approval was obtained from the University of the Western Cape Biomedical Research Ethics Committee and permission to conduct this research was received from the Western Cape Department of Health. A full informed consent process was undertaken prior to the interview.

*Results*

According to the nurses and midwives who participated in the study there are a number of inter-personal factors contributing to disrespectful care within the MOU. The key themes that emerged and relate to disrespectful care and its drivers are: the normalisation of neglect, the perception of patient attitudes and the absence of



http://etd.uwc.ac.za/

informed consent within the model of care practiced within the MOU. There were also inter-personal factors that acted to disrupt uneven relations of power within the clinic. When compassionate acts did occur they were not necessarily sustainable but offer a more holistic outlook of the MOU.

*Normalised neglect in the MOU*

The postnatal area within two of the three clinics where research was conducted was a fairly open space connected to the labour ward. Only one clinic had a separate room for women who had just given birth. The primary researcher would pass by woman lying in hospital beds holding their newborn on the way to the nursing station where interviews were conducted. Apart from a few routine checks on the patient, there was very little engagement between these women and the clinic staff. The primary researcher did not observe any attempt to make the new mother more comfortable or assist with her newborn as she sat in the hospital bed. For the most part, the mothers and their newborns appeared alone with the exception of an occasional visit from a family member or partner.

In one case, the primary researcher observed a man politely confront the clinic staff about his partner, who had recently given birth, and was very uncomfortable and cold. He was requesting to take his partner home because she did not appear to be receiving any attention from the nurses and midwives. After a lengthy conversation the staff agreed to discharge her early. This was not an eventful conversation and appeared to be a very standard experience. Everyone appeared respectful and calm, a typical situation during a cold evening in the MOU. The patient who was



http://etd.uwc.ac.za/

eventually discharged early was not the only new mother in the postnatal area and others did not appear any more comfortable or cared for.

The primary researcher observed situations of neglect that were much more explicit than this, however the above description summarizes the general mood of the MOU – little engagement between patient and providers, uncomfortable small beds for women in active labour and postpartum, cold temperatures during the winter and a generally unwelcoming atmosphere. This may not constitute an obvious case of neglect but rather speaks to the conditions where neglect could be normalized and a lack of care was the standard practice.

During the interviews nurses and midwives spoke, often passionately, about their concern for the quality of care that is offered due to understaffing. During one of visits to the clinic, the primary researcher was speaking to four nurses and midwives who were seated in the nursing station for their dinner. This was during an evening shift without the presence of management, during conversation, when the primary researcher spoke the term 'quality of care' one midwife responded with a laugh and said, '*what quality of care? Do you think we can offer quality of care here?'.*

Quality of care was spoken about as an impossibility and at times, when there is a heavy patient load and few staff, it is. However, at the time when this comment was made, the clinic load appeared to be manageable. In addition, during the observation made above, there were women in the postnatal room who seemed, from the perspective of the observer, to be left alone while the nurses sat in the nursing



UNIVERSITY of the
WESTERN CAPE
http://etd.uwc.ac.za/

station. For some context, it is also important to note that the patients in the postnatal room did not have the option of an epidural during labour and only Pethidine is administered for pain relief, which is effective for up to four hours. It is very likely that the women in the postnatal room, gave birth within the last six hours with no pain relief at all. This is not raised to make a judgement call towards birthing without pain medication, or rather this is a topic for another paper, but to highlight why the lack of interaction between patients and care providers was observed as inhospitable and uncaring.

*When women do not conform to the idea of a 'good' patient*

Another way in which disrespectful treatment occurred was through constructing women as uncooperative 'bad' patients. Nurses and midwives spoke of patients as having bad attitudes, not taking responsibility for their own health, and not cooperating. Holding such beliefs demonstrates how constructed ideas of a 'bad patient' or 'bad woman' pervades into nurses and midwives' opinions of their patients (23). Nurses and midwives spoke of women not booking for labour by attending antenatal care as an example of this poor behaviour and refusal to take responsibility for their health. As one midwife states,

> *Township patients, they have the tendency of giving us attitudes in ways that you cannot tolerate at times, it is too much. I don't know why they are doing that to us sometimes….Here they will come unbooked, defaulting on ART [antiretroviral therapy] but when we are asking the patient a question they will do this to you (looks at me up and down wearing a judgmental face). Our patients they do not*



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

*listen. They do not follow their responsibilities, it's all about that they have got rights but you need to be responsible although you have got rights. I don't think that they understand that rights goes with the responsibility…they have got attitude. (Midwife, Cape Town MOU)*

Throughout the interviews, midwives shared their knowledge about the socio-economic and psycho-emotional states of women in their care and how this may affect their behaviour. However, this depth of comprehension seemed to be pushed aside when it came to describing patients.

*But the patients are the most problematic here… And they don't want to be questioned. We tell them when you come to the clinic, when you feel the pain that comes and goes every minute, every five minutes maybe. You must bring all your stuff along. You must bring pads, you must bring all those things that you think you are going to use. If you ask maybe where are your pads? She is going to turn something to you. She is going to be an animal. As if you don't have to ask where are your pads. (Nurse, Cape Town MOU)*

Clinic staff know very well that many of their patients cannot afford to buy maternity supplies and to ask, why they do not have the supplies with them is a redundant and offensive question. Such questions, in which responding would force women to admit their own poverty is uncompassionate, especially where nurses and midwives demonstrate an understanding of and sensitivity to the inequality in South Africa and the poverty of their patients. To refer to a women in labour as behaving like an animal is demeaning and illuminates how characterizations of



UNIVERSITY of the WESTERN CAPE

http://etd.uwc.ac.za/

women as anything other than a human, who is experiencing severe pain, lacks compassion. Relying on harmful constructions is a form of mistreatment and reproduces harmful beliefs towards women at a time when they most require respectful care.

*Giving birth, vaginal examinations and informed consent discussions*

Childbirth involves vaginal examinations (VEs) and other clinical practices that are intimate. This is why an informed consent discussion (ICD), between the provider and patient, beforehand is crucial. The term discussion is important, as this signifies there is room for a response and questions from the patient; it's a two-way conversation. ICDs are also an important aspect of upholding the WRA charter of respectful maternity care as a woman's right to knowledge (2). During the interviews with nurses and midwives, the absence of an ICD before clinical practises that involve exposing and touching (with hands or instrument) a woman's vagina were referred to, but not acknowledged to be mistreatment. However, from the data collected, it is clear that there was a discrepancy between the guidelines, which require women be informed of what will happen during childbirth and any examinations that are done to their body, and what was happening in the clinic. Midwives spoke about patients 'thinking' they were being abused during a VE or when told to open their legs during childbirth. They suggested that patient's responses were a misunderstanding and what they interpreted as abuse was routine care and not an act of abuse. The following quotes demonstrate this logic:

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*The patients are admitted and say we are doing this (hold two fingers up, demonstrating a VE). 'Are they assessing how far the baby is, I am not being told?' [quoting mothers in labour]. They don't know what is happening and they think that they are being abused. There are a few patients that have bad memories from a long time ago, maybe being hit so they come with that belief to the clinic. But that is few. (Midwife, MOU Cape Town)*

The midwife in this quote is describing how women are unaware of what is happening during a VE and explicitly stating that they are not being informed of what a VE is, nor what information the examination provides. The midwife is suggesting that some patients may have had abusive experiences in a maternity ward or elsewhere, where they were perhaps hit and therefore conclude that they are being abused again. The midwife is stating that the root of the problem is that some patients 'come with that belief to the clinic' (that they may be abused) rather than seeing this as a situation where a patient is not being informed and has not been given the information about what a VE is. Another nurse noted that this assumed misconception that patient held regarding VEs being abuse was due to a lack of education in ANC.

*Nurse: In active labour, every 2 hours or so (frequency of VEs). But the education women receive in ANC does not extend to what will happen in labour. Women can react badly to a VE and call it abuse. Interviewer: Do you think more education is needed in ANC that talks about what will happen during labour, VE's and pain. Things like this?*



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

*Nurse: Yes, because they don't know and then they call it abuse. (Nurse, MOU Cape Town)*

The problem, according to the nurse and midwife, is that the woman being examined lacks an understanding of clinical practice and what is involved in routine care; that she has misread the situation and no harm has actually been done. That the women seeking care did not know what was happening shows that no ICD was had. The absence of informed consent before a VE speaks to what is considered to be required for quality care and what gets left out as less important. Midwives also spoke of the pressure from doctors, who have higher status in the medical system, and this contributing to unconsented VEs. Having to report quickly to someone who is understood as senior was privileged over allowing time for women to feel safe and comfortable. One midwife explains,

*…like everyone who comes into labour, we have to do a vaginal examination and that is the thing that the patients don't like. You insist that they do it because when you phone and you present, the doctor won't take the story if you don't know the dilation, and that is a problem because you cannot force the patient because they patient is going to say you are rude to her but on the other side the doctor is going to want to know how far dilated she is. (Midwife, MOU Cape Town)*

The midwife acknowledges that this procedure is not liked by patients but does not seem to consider how the VE is conducted and the role communication can play in improving the experience for women. Another example of where there seemed to be

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

a lack of communication and informing women to what was happening was during active labour. There were times, in the interviews, when discussing childbirth and how women responded to having to position themselves where nurses and midwives described overt forms of mistreatment, and as the following quote demonstrates, acts of verbal assault and tactics of humiliation were used to force a women to open her legs during childbirth.

> *We do have those who do not want to open (their legs). I had this patient two weeks ago and she didn't want to open at all and she was contracting. I was like there is no way I can help you if you don't want to open and that is the only way I was going to know and she was like I can't, I can't. And one of the sisters came in and shouted, hey you have opened your legs before, for your boyfriend… She has to, we talked to her and finally she did and sometimes we have to call the mother and open the legs by force, especially if the baby wants to come out and then we have to force her to open her legs. And some of them were raped and that is why they don't want to open their legs and some of them are just scared. (Nurse, MOU Cape Town)*

UNIVERSITY of the
WESTERN CAPE

The context the nurse is describing is of a woman in active labour and experiencing severe pain. The nurse wants the patient to deliver her newborn and before the woman positions her legs to allow birth, another nurse verbally assaults her. The nurse in the interview reflects on the situation stating that the woman's reaction (keeping her legs closed) could be the result of previous sexual abuse or a strong fear of giving birth. Instead of allowing time for the patient to position herself to give birth, she is hurried and forced to do so. This is an example of mistreatment



http://etd.uwc.ac.za/

during childbirth and a direct violation of the woman's human rights. Nurses and midwives also often shared with the primary researcher that many of their patients have experiences of sexual violence, which makes an ICD before an intimate examination incredibly important.

The above quote was not representative of all nurses and midwives. At a separate clinic, when discussing the topic of how nurses and midwives force women to open their legs during childbirth, a nurse expressed her disagreement with this kind of behaviour and rather promoted an approach that allows women to take their time and do what feels best for them. The nurse stated,

> *…why are you (causing a) struggle for people, no! You just leave the nature to happen, don't open people's legs, the baby will come, whether the legs are closed, the mother will open the legs when the baby will come. No mother will deliver the baby with the closed legs so just let the baby, leave the mother if she wants to scream, leave the mother to scream because you are not experiencing what this lady is feeling. (Nurse. Cape Town, MOU)*

UNIVERSITY of the
WESTERN CAPE

Forcing women to open her legs was never a prompted conversation. Whether it was normalised as care or raised as something not to be done, it came up in response to what nurses and midwives felt were barriers within the clinic to respectful maternity care. In both regards, this suggests awareness that it happens and in some cases is common.



http://etd.uwc.ac.za/

*Empathetic care*

When women fell outside of the behaviour of a 'good' patient they were not always met with stigma or *othering*. One nurse when describing why women come to the clinic not having booked demonstrates this. Not booking is a term used for women who have not yet received ANC or booked in with the labour ward on their expected date of delivery. She states,

> *In the community, you find that she just lives down the road but she hasn't booked. And I am not going to be racist but it is my people. And also last week a nice girl said to me 'before you scold me', and I said 'why would I scold you', but she came with that, 'because I am late and I should have booked early'. So I say,' why do you say this' and she says 'no that is what they say out there, if you go late, you know in the community, you are going to be scolded by the nurses'. She already came so prepared, you know, 'I just started a new job and I didn't even want to tell them that I am pregnant, so okay and that is why I booked so late'. There are valid reasons, there are. (Nurse, MOU, Cape Town)*

The patient is explaining that she was afraid to come to the clinic because she should have already begun ANC and she fears being scolded by the nurses. The nurse learns that the woman is recently employed and for this reason has not been coming to the clinic. The nurse wants me to understand that there are valid reasons for women in the community, why her people do not book. By the way she speaks, she seems aware that I have heard about women not booking as a problem and a



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

barrier to quality care and wanted to give a more complicated picture of the issue, one that did not blame women.

In some cases, nurses and midwives expressed a mix of feelings. They shared their frustration with women not listening to instructions but resisted seeing the patient as an *other*. As a midwife explains,

> *I don't know what system you can use to make them understand. I don't know, maybe it is the hormones that are confusing them, but it's our people, black people.*

Reflecting on the field notes from this interview, the primary researcher described the midwife as very animated and although she talked of feeling frustration and stress (mostly with other staff) she was never angry and appeared to have a general enthusiasm for her job and a caring disposition towards her patients. In the above two quotes nurses and midwives are speaking about patient's inabilities to conform to a 'good' patient but their reaction was not anger and through acknowledging them as 'my people' or 'our people' an intimation of shared community is expressed and a refusal to distance their patients as *others* acting badly.

The following was an observation made by the primary researcher and took place in the ANC waiting room. A woman who clearly worked in the clinic, wearing scrubs, walked into the room. She told the room, with 27 women awaiting antenatal appointments that she loved them and then preceded to speak to them in isiXhosa. Pregnant women at times laughed with comfort during the woman's presentation and it appeared to be a compassionate atmosphere. Her demeanour did not appear

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

to be paternalistic, nor did she seem to be infantilizing the women sitting. She finished her talk in 15 minutes and before exiting the room looked at me and asked me to come with her. She took me to her office, next to the antenatal room and introduced herself; she was a community health worker (CHW) and an HIV counsellor at the MOU. She asked me who I was and I explained the study, because she was not a nurse or midwife we did not conduct a formal interview but I did ask her what she was saying to the pregnant women. She explained that she gives the same talk everyday that she is in the clinic and teaches the patients about how to care for themselves, about HIV and intimate partner violence. We left her office and walked by the pregnant women and she told them again, 'I love you' and everyone laughed. She was not a nurse but engaged with the staff frequently and although I could not understand what was being said, she seemed to respect and be respected by everyone in the clinic. I did not observe such enthusiasm again while conducing this research. I did however witness other moments of community, mutual respect and kindness.

UNIVERSITY of the
WESTERN CAPE

*Discussion*

The results above explore the interpersonal interactions within the MOU from the perspective of providers, three of the four are examples of disrespectful care: normalising neglect in the MOU, constructions of the 'bad' patient and the absence of ICDs*.* These are aligned with the micro-level of the Bradley et al. (2019) framework and we would argue are largely driven by a need to maintain midwives' status and a need for power and control within the MOU. The fourth theme, the refusal to *other*



http://etd.uwc.ac.za/

and demonstrate empathy helps us understand behaviours in the clinic that represent respectful care.

*Environments of Neglect*

A neglectful environment within the MOU seemed to be the norm with little effort noted to increase women's comfort, even when feasible. While staff cannot control the physical environment, offering emotional support was often possible. As observed here, women being left alone, before and shortly after childbirth, without support or much assistance is not uncommon in low-resource maternity clinics in South Africa (24,25).

The neglect of patients happens for different reasons and intent varies. When more intentional neglect occurs such as nurses and midwives ignoring women in labour and postpartum, this could be interpreted as a way of ensuring that the midwives' and providers' status at the top of the hierarchy is maintained and that all are made aware of this. Thereby reinforcing their role and ensuring that there is social distance between the provider and patient (12).

Research from South Africa and other low- and middle income countries reports that women have called for nurses assistance during and after childbirth only to be ignored and treated with silence (24,26). Patients report feeling vulnerable and powerless as a result of neglect (9). This carries harmful psychological implications and increases the risk of a negative childbirth outcome, denying women's right to a positive birthing experience (27).

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Neglect also acts to control women's bodies, and the knowledge they require, as clearly articulated by Bradley et al. (2019) as resulting from power and control by providers in the MOU (12). Instead of a sense of empowerment, neglect leaves women unsure of what to expect from their care providers and their bodies during labour. Communication and reassurance are central to women feeling informed and providing them with some control over their own body (12). Neglect discourages women from asking questions and seeking guidance, and evidence suggests that nurses and midwives can treat women as if they are bystanders during their own childbirth experience (12). During labour, women's own bodies can be a great source of knowledge and intuition can guide a woman into positioning her body in ways that provide relief from physical pain (28). However, this requires a supportive environment, where women feel comfortable, their intuition is respected and the resulting physical changes are facilitated (28).

UNIVERSITY of the
WESTERN CAPE

Neglecting women during labour works to 'invisibilise' them (12). This is a violent form of mistreatment and denies women their right to self-determination (9). Intentional neglect therefore works to maintain nurses' and midwives' status and controls bodies and knowledge. Neglect is a direct infringement on the rights to respectful maternity care as it denies women information, the highest attainable level of health (2). Actions such as forcing a woman to call for help while in labour completely disregard their dignity, a violation the WRA has specifically stated as an act of disrespectful care (2).



http://etd.uwc.ac.za/

*Reinforcing negative perceptions of the 'bad patient'*

There is a hierarchy within the medical model that situates nurses and midwives below doctors but above patients and this is maintained by strict boundaries such as uniforms, titles and communication style (23). Our observations show that there is little tolerance for blurring these boundaries in the MOU and they are reinforced by providers themselves (12). When women seeking care do not conform to expectations and confirm this hierarchy they are likely to be reprimanded and dismissed as 'bad' patients - difficult, irresponsible, and uncooperative. 'Bad' patients are those who may present with not medically treatable problems that are related to the socio-economic conditions such as poverty and violence. They are then constructed *as other,* allowing providers to maintain a critical distance and justifying their possible mistreatment (12). Labelling women as 'bad' because they are from the township and asking demeaning questions of them, where they are forced to articulate their own poverty, violates the charter for respectful maternity care (2). Such ill treatment is discriminatory, as women are being stereotyped for not conforming to unrealistic expectations and as a result of their socio-economic background.

This confirms Bradley et al.'s (2019) argument in their theoretical framework that to maintain one's status, characteristics that could construct patients as socially inferior could be used to justify this hierarchy (12). Our study results differed somewhat from other studies in South Africa, which found that race was used to create social divisions in the health facility(12). In our study, all participants (providers) were Black, as were all their patients, and although race did come up in

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

the interviews it was never used to discriminate. Class on the other hand was, at times, used to *other* women seeking maternity care and resulted in them being labelled as uncooperative and irresponsible.

*Vaginal examinations and the absence of informed consent discussions*

That women were unaware of what VEs are or why they are having one speaks to nurses and midwives' failure to provide women with an ICD prior to the procedure. VEs are part of standard care but require constant communication, thorough ICDs, permission and information about the purpose of the VE. Nurses and midwives explained that women may think they are being abused when, according to the research participants, they are just doing their job and collecting information that is required for clinical care.

Having a VE done without consent can be a traumatic and violent experience (29). The same goes for forcing women to open their legs during labour and childbirth. Although nurses and midwives may feel torn between collecting required clinical information for the doctor and the patient's comfort, this does not justify an unconsented VE or forcing their legs open. Nurses and midwives in this study as well as those in other studies justified unconsented care by referring to the health and safety of the foetus (30–34). There are times when an ICD is impossible, such as in the case of an emergency, however, this study, as others have done, is concerned with the ways in which consent is not applied in routine care (35–37).

Another study conducted in labour wards within Cape Town have found the lack of communication and the normalization of silence as the most significant barrier to

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

quality of care (25). Withholding knowledge through silence is a method of control as is performing a VE without an ICD. It is also a method of controlling bodies, by denying information about what is happening and performing unconsented procedures (12). Forcing women to open their legs has been observed elsewhere too (38). At one clinic nurses and midwives did demonstrate the knowledge that this was a violation of a woman's right to autonomy, they expressed an understanding of women's control over their body and the birthing process. Therefore despite unconsented care and forcing women to open their legs being normalised and nurses and midwives not seeing this as a violation, that some nurses and midwives demonstrate knowledge about this as a violation suggest that this norm can be challenged.

During the interviews, midwifery and nursing education was often discussed and learning about ICDs did not feature in the conversation. If ICDs are not built into midwifery education it is unlikely that they will become an ingrained part of clinical practice. ICDs are not a simple conversation, they require the ability to condense a great amount of knowledge into a clear and concise informative discussion. They continue throughout the process and leave opportunity for patients to express concerns and ask questions. Their inclusion requires a model of care that prioritizes women's autonomy and builds a patient provider relationship based on communication and mutual respect (39,40). Further research is required to understand how ICDs feature in the curriculum of nursing and midwifery education in the South African context.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

*Empathetic care*

Although this study focused on barriers to respectful maternity care as the right of women seeking maternity care, the issues discussed also carried a direct and damaging impact on nurses and midwives in their daily lives at the MOU. We did not get the sense that nurses and midwives enjoyed that their patient's felt abused or uncomfortable. It may also be a conflicting experience to treat someone in a manner that imposes what power one has access to over another, especially when, at times, in the health care setting doctors and managers do the same to nurses (41). Nurses and midwives do not clearly occupy either side of a victim perpetrator binary and this is complicated by macro level factors– namely the lack of resources in the clinic and the ways in which gender inequality affects the nursing and midwifery profession (42,43). Despite this, nurses and midwives do act as perpetrators of disrespectful and even violent care as the examples above show, but seeing them as strictly perpetrators does not acknowledge the complexities shaping the interpersonal relationships in the MOU or facilitate finding solutions to these problems.

Examples of this complexity were highlighted in empathetic care and the refusal by nurses and midwives to treat their patient as the *other*. Bradley et al's framework points out the power of the medical hierarchy and the control it has on structuring maternal health care facilities (12). In our study nurses and midwives spoke about their patients in ways that maintained their position over women seeking care. Despite examples of control and maintenance of hierarchy, nurses and midwives have not lost their ability to identify with the women they care for. They saw their

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

patients as part of their community, talking about 'my people' or 'our people', a signifier of social unification, demonstrating a shared community and empathy, even while frustrated with the patients actions. Identifying with and understanding their patients' challenging socioeconomic conditions may have played an important role in facilitating empathetic treatment, however, it did not always guarantee respectful care as some of the participants described instances of disrespectful treatment or discriminatory attitudes despite also expressing understanding and identification. The observation of the CHW perhaps offers further insight into what drives mistreatment by nurse and midwives. In the hierarchy of the clinic, a CHW sits below nurses but above patients, in a non-clinical role, providing health promotion and counselling. She is therefore not part of the medical hierarchy and not liable if there are errors or complications. As a counsellor and community member she is well aware of the living conditions of pregnant women but her job is not to diagnose and treat. Perhaps this allows for greater kindness and empathy. A CHW is free from the pressures of the hierarchy of the medical model and this is not to suggest that nurses and midwives take on a less clinical role but points to the need to challenge hierarchical relationships in health care settings. That perhaps there are other ways maternity care can be provided that exists outside the need for hierarchies.

*Recommendations*

Bradley et al.'s place the medicalisation of childbirth as a meso-level driver of disrespectful treatment. While not a focus within this paper, it is clearly related to interpersonal relations and hierarchies within our low-resource MOUs. More

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

research is required on ways in which all staff members (from management to CHWs) challenge the hierarchy of the medical model and find ways to support each other. Challenging the hierarchy of the medical model could come in the form of compassionate care. Carrying out this research will involve engagement with key stakeholders and those already dedicated to implementing respectful maternity care. Understanding the role of empathetic and compassionate care in the MOU can facilitate and support efforts already in place. A network that connects people and projects implementing respectful maternity care needs to be developed within South Africa in the efforts to learn from and support a model of care that is not based on hierarchical relationships but of compassion for patents and nurses alike.

Bradley et al.'s theoretical framework of disrespectful treatment during childbirth helps us understand how denying women an ICD before performing an intimate examinations is a method of controlling knowledge and controlling women's bodies. Such control feeds into how nurses and midwives situate themselves within the hierarchy of the clinic. Dismantling a hierarchy that is so engrained into the health system will take time. However, in the efforts to start we could look at how health care providers communicate with patients and address problems such as withholding information. This could begin with looking at ways changes in nursing curriculum could foster in a respect for ICDs. Including in-depth education on performing ICDs could help shift the current norms of withholding information. Perhaps nursing curriculum could begin a transformative approach to how knowledge is understood and that power also lies in the ability to share information.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

This could be a power that produces new sets of rewards that resist oppressive forms of controlling both knowledge and bodies.

Neither of these recommendations will be successful without a deep consideration of the emotional side of nursing and midwifery. The daily toll of working within communities where pregnant women do not have the basic necessities cannot continue to be underestimated. Nurses and midwives do not enter the profession with the intentions of someday committing harm onto their patients (44). Care providers require support that the current health system within South Africa does not provide. This support needs to be worked into a model of care that empathises with care providers and the pressure they are put under on a daily basis.

*Conclusion*

This paper, through working with Bradley et al.'s (2019) conceptual framework of drivers of disrespectful care we have discussed inter-personal factors and how they bar respectful maternity care within the clinic (12). We have focused on intentional neglect, reinforcing stereotypical beliefs of patients as 'bad', and the absence of ICD's during VE and childbirth. We have applied the WRA respectful maternity care charter to express how these acts violate women's rights. We follow our exploration into inter-personal factors that create barriers to quality of care with discussing how, at times, clinic staff resist modes of *othering,* We wrap up this paper with recommendations that express the need to build a South African network around respectful maternity care and how ICDs could be incorporated in nursing curriculum as a method of transforming how knowledge is understood. Built into

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

our understanding of challenging factors that prevent respectful maternity care is the need to simultaneously support nurses and midwives and recognise the emotional hardships of being on the frontline of a health system in trouble.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

References for chapter 8

1. Chadwick R. Obstetric Violence in South Africa. SAMJ. 2016;106(5).

2. Respectful Maternity Care: the universal rights of childbearing women. The White Ribbon Alliance. 2011.

3. Oladapo O, Tunçalp Ö, Bonet M, Lawrie T, Portela A, Downe S, et al. WHO model of intrapartum care for a positive childbirth experience: transforming care of women and babies for improved health and well-being. BJOG 2015; 125(8).

4. World Health Organization. Standards for improving quality of maternal and newborn care in health facilities. 2016.

5. Limpopo maternal CARE. Resectful Maternity Care. 2022. Available from: https://www.limmcare.co.za/projects/respectful-maternity-care-rmc

6. Schoon MG. Impact of inter-facility transport on maternal mortality in the free state province. South African Med J. 2013;103(8).

7. Pattinson RC, Hlongwane T, Vannevel V. Challenges to improve antenatal and intrapartum care in South Africa. South African Med J. 2019;109(11b).

8. Chadwick R. Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives. Fem Psychol. 2017; 27(4).

9. Chadwick R. Bodies that birth: Vitalizing birth politics. London: Routledge. 2018.

10. Pattinson R, Fawcus S, Gebhardt S, Soma-Pilay P, Niit R, Moodley J. The impact of COVID-19 on use of maternal and reproductive health services and maternal and perinatal mortality. South African Medical Research Councel, 2021.

11. Hawkes S, Allotey P, Elhadj AS, Clark J, Horton R. The Lancet Commission on Gender and Global Health. Lancet. 2020;396.

12. Bradley S, McCourt C, Rayment J, Parmar D. Midwives' perspectives on

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

(dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and meta-synthesis. Reproductive Health. 2019; 16(116).

13. Miller S, Abalos E, Chamillard M, Ciapponi A, Colaci D, Comandé D, et al. Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide.The Lancet. 2016;18.

14. Burrowes S, Holcombe SJ, Jara D, Carter D, Smith K. Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: a qualitative study. BMC Pregnancy Childbirth. 2017;17(1).

15. Dzomeku VM, Boamah Mensah AB, Nakua EK, Agbadi P, Lori JR, Donkor P. "i wouldn't have hit you, but you would have killed your baby:" Exploring midwives' perspectives on disrespect and abusive Care in Ghana. BMC Pregnancy Childbirth. 2020;20(1).

16. Filby A, McConville F, Portela A. What Prevents Quality Midwifery Care? A Systematic Mapping of Barriers in Low and Middle Income Countries from the Provider Perspective. PLoS One. 2016;11(5)

17. Moridi M, Pazandeh F, Hajian S, Potrata B. Midwives' perspectives of respectful maternity care during childbirth: A qualitative study. PLoS One. 2020;15(3).

18. Adolphson K, Axemo P, Högberg U. Midwives' experiences of working conditions, perceptions of professional role and attitudes towards mothers in Mozambique. Midwifery. 2016;40.

19. Charmaz K. Grounded Theory Methods in Social Justice Research. SAGE Handb Qual Res. 2011.

20. Brady L, De Vries S, Gallow R, George A, Gilson L, Louw M, et al. Paramedics, poetry, and film: health policy and systems research at the intersection of theory, art, and practice. Hum Resour Health. 2019;17(1)

21. Charmaz K. Constructionism and the Grounded Theory Method. New York:

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

The Guilford Press.; 2008

22. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Heal Care. 2007;19(6)

23. Campbell C, Scott K, Skovdal M, Madanhire C, Nyamukapa C, Gregson S. A good patient? How notions of "a good patient" affect patient-nurse relationships and ART adherence in Zimbabwe. BMC Infect Dis. 2015;15(1)

24. Mapumulo S, Haskins L, Luthuli S, Horwood C. Health workers' disrespectful and abusive behaviour towards women during labour and delivery: A qualitative study in Durban, South Africa. PLoS One. 2021;16.

25. Lappeman M, Swartz L. Rethinking obstetric violence and the "neglect of neglect": the silence of a labour ward milieu in a South African district hospital. International Health and Human Rights. 2019; 19(30).

26. Bohren M, Vogel J, Hunter E, Lutsiv O, Makh S, Souza, JP, Aguir C, Coneglian FS, Araujo Diniz AL, Tuncalp O, Javadi D, Oladapo O, Khosla, R, Hindin M, Gulmezoglu AM. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. PLoS Med. 2015;12(6).

27. Beck CT. A Secondary Analysis of Mistreatment of Women During Childbirth in Health Care Facilities. J Obstet Gynecol Neonatal Nurs. 2018;47(1).

28. Savage JS. The Lived Experience of Knowing in Childbirth. J Perinat Educ. 2006;15(3).

29. Adu-Bonsaffoh K, Mehrtash H, Guure C, Maya E, Vogel JP, Irinyenikan TA, et al. Vaginal examinations and mistreatment of women during facility-based childbirth in health facilities: Secondary analysis of labour observations in Ghana, Guinea and Nigeria. BMJ Glob Heal. 2021;5.

30. Bobo FT, Kasaye HK, Etana B, Woldie M, Feyissa TR. Disrespect and abuse during childbirth in Western Ethiopia: Should women continue to tolerate? PLoS One. 2019;14(6).

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

31. Okedo-Alex IN, Akamike IC, Okafor LC. Does it happen and why? Lived and shared experiences of mistreatment and respectful care during childbirth among maternal health providers in a tertiary hospital in Nigeria. Women and Birth 2021;34(5).

32. Warren CE, Njue R, Ndwiga C, Abuya T. Manifestations and drivers of mistreatment of women during childbirth in Kenya: implications for measurement and developing interventions. BMC Pregnancy Childbirth. 2017;17(1).

33. Rosen HE, Lynam PF, Carr C, Reis V, Ricca J, Bazant ES, et al. Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa. BMC Pregnancy Childbirth. 2015; 15(306).

34. Lambert J, Etsane E, Bergh A-M, Pattinson R, van den Broek N. 'I thought they were going to handle me like a queen but they didn't': A qualitative study exploring the quality of care provided to women at the time of birth. Midwifery. 2018;62.

35. Bohren MA, Mehrtash H, Fawole B, Maung TM, Balde MD, Maya E, et al. How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. Lancet. 2019;394.

36. Colley S, Kao C-H, Gau M, Cheng S-F. Women's perception of support and control during childbirth in The Gambia, a quantitative study on dignified facility-based intrapartum care. BMC Pregnancy Childbirth..2018; 18(1).

37. Afulani PA, Phillips B, Aborigo RA, Moyer CA. Person-centred maternity care in low-income and middle-income countries: analysis of data from Kenya, Ghana, and India. Lancet Glob Heal. 2019;7(1).

38. Bowser D, Hill K. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis USAID-TRAction Project. 2010

UNIVERSITY of the WESTERN CAPE



http://etd.uwc.ac.za/

39. Smith MK, Levy KS, Yudin MH. Informed Consent During Labour: Patient and Physician Perspectives. J Obstet Gynaecol Canada. 2018;40(5).

40. Cook AM. Midwifery perspectives: The consent process in the context of patient safety and medico-legal issues. Clin Risk. 2016;22(1–2).

41. Vagharseyyedin SA. Nurses' perspectives on workplace mistreatment: A qualitative study. Nursing and Health Sciences. 2016;18.

42. Dutton J, Knight L. Sexual and Reproductive Justice: From the Margins to the Centre. Morison, T. & Mavuso J., editor. Lexington Books.; 2022.

43. Dutton J, Knight L. Reproducing neglect in the place of care: Normalised violence within Cape Town Midwifery Obstetric Units. Agenda. 2020;34(1).

44. Morales XB, Enciso Chaves LV, Yepes Delgado CE. Neither medicine nor health care staff members are violent by nature: Obstetric violence from an interactionist perspective. Qual Health Research. 2018;28(8).

http://etd.uwc.ac.za/

# Chapter 9: Discussion

This study aimed to better understand what drives obstetric violence within Cape Town Midwifery Obstetric Units (MOUs) from the perspective of nurses and midwives. In doing so, I aimed to contribute to theory and propose new ways of supporting respectful maternity care. This discussion focuses on how the results chapters of this thesis come together to contribute to theory, our understandings of reproductive justice and how it can be applied as a research framework to better understand the perspective of health care providers regarding their profession and daily working lives. This discussion, building upon ideas that were developed within the above chapters, emphasises that clinics in this context operate under duress. This thesis contributes to the theory of reproductive justice by examining the relationship between the clinic under duress, the politics of care and violence. Before concluding, the limitations of the study and recommendations for further research and engagement will be considered.

UNIVERSITY of the
WESTERN CAPE

This study applied an already existing theoretical lens, reproductive justice, to these findings and sought to broaden how this theory can be applied and understood. The work explores whom the recipients of justice can be within a reproductive justice framing, in an effort to move towards the realization of justice for everyone in the MOU. I have carried out this work with a focus on one of the key elements to the reproductive justice framework -the right to give birth free from harm, including state harm (1). Reproductive justice theory foremost considers the rights of birthing women and mothers and rightly so. For women and mothers to be safe, they need



http://etd.uwc.ac.za/

access to appropriately resourced maternal facilities with staff that are skilled and possess the emotional disposition to deliver safe and effective care. The analyses presented in this thesis attempt to understand the patient – provider – health facility entanglement in thinking about reproductive justice and considers how care is always already relational. To think about care as relational does not deny any one person's autonomy but illuminates the multiple people, power relations, and material objects involved in the care that takes place in the maternity ward. In unpacking the relational nature of care, violence became a recurring theme in the narratives of participants. Violence is enacted towards individuals, but it also impacts the relationships that exist in the clinic and the clinic itself and impedes the realisation of respectful maternity care. Acknowledging that nurses and midwives are possible victims of violence, including structural violence in the form of resource shortages or gendered violence, seen in the devaluing of reproductive labour, is critical in order to unveil the multiple forms and effects of violence in this context.

UNIVERSITY of the
WESTERN CAPE

The rest of this discussion outlines the key findings that tell of a clinic under duress through exploring the ways in which resource shortages, violence and caring labour are entangled into the daily working lives of nurses and midwives employed in the public health services in Cape Town. The findings around resource shortages, violence, and caring labour were often enmeshed and had direct and indirect impacts on each other. For analytical purposes, these findings will be presented separately below, however, the relationships between these three concepts will be flagged throughout.



http://etd.uwc.ac.za/

*Resource shortages*

That public health maternity care facilities are under-resourced is well known and that this impacts the quality of care a clinic can provide has been recognized (1–3). This study contributes to this knowledge by offering an exploration into how these circumstances are experienced by nurses and midwives and how this impacts their understanding of and ability to provide quality care. The concept of 'materiality of care' is applied to explain the ways that it shapes the management of daily life within the health facility (4). Materiality of care highlights the ways in which unpredictable clinic spaces influence the behaviours of care providers. Not knowing if there will be enough staff to tend to women during childbirth, unreliable emergency transportation, and missing supplies and equipment shape the quality of care a nurse or midwife can provide. What is perceived as a negative work attitude could also be the outcome of dealing with these constant uncertainties and the emotions that develop from this, such as fear, anxiety, and exhaustion (5,6). Fears, such as those about losing a patient or being blamed for a bad outcome and held responsible for situations that are not within their individual control, are part of working within a clinic that is not sufficiently resourced. Working under duress creates an environment of constant uncertainty about what could happen over the course of one's shift.

The results also explored a lack of privacy, an ongoing issue associated with resource shortages within South African labour wards (Chapter 6). Lack of privacy is mainly due to the physical structure of the building that houses the labour ward, which is not large enough to incorporate individual rooms for women in labour.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

Even constructing partitions within the ward appeared to be beyond the budget dedicated to public maternal health in South Africa. Without the possibility of providing women with privacy, nurses and midwives demonstrated an understanding that this violates women's rights, however there was often nothing that could be done to change this. Before care was even initiated, limitations are placed on realising respectful maternity care in the MOU.

Resources outside of the facility also impacted on quality of care. The results found that emergency transport was not reliable and it could take hours for an ambulance to arrive to transport a woman to a referral hospital (Chapter 5). This was something providers focused on and identified as a significant barrier to quality care, about which they expressed great concern. The lack of reliable emergency transportation also added to the sense of unpredictability and fear for providers.

The combined effects of working in a poorly resourced environment, the emotional consequences, and the way in which these impact on providers' ability to provide respectful maternity care cannot be ignored. There are real effects on providers' behaviour caused by the stress of practicing midwifery in the absence of all the necessary equipment, supplies, and support. In addition, they also operate within an atmosphere of uncertainty about the implications of resource or support scarcity. This uncertainty was expressed as a constant worry and fear and operates as a barrier to quality of care.

*Violence*

Another key theme emerging from the results is violence, which is often normalized

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

and is therefore part of the daily life in the MOU. The findings explore how MOUs become spaces where abuse, such as neglecting a woman in labour or verbally abusing her, were normalised. Neither regret nor repercussions for such actions were observed or spoken of and as long as a negative outcome was avoided, abuse in the labour ward went without raising concern.

This study was not designed to assess or explore the obstetric violence that takes place in private hospitals of South Africa, but that is not to say it does not exist. Research on obstetric violence in private care facilities provides evidence that, although the violence takes different forms such as extremely high rates of caesarean sections, it is happening without raising much public concern (7). This suggests that, as a number of scholars whose work on obstetric violence have argued, obstetric violence happens to women because they are women and violence against women is systemic and often met with impunity (1,2). Nurses and midwives can neglect a woman in labour because neglecting the needs of women is the norm within their local context and community, at the level of the state, and globally (8). The idea that MOUs are different is inconsistent with the reality that gender discrimination has no boundaries. It does not stop at the doorway of an institution because that institution is supposed to be a place of care.

One important finding was that violence was facilitated through the ways in which nurses and midwives' constructed their patients. They reproduced harmful stereotypes of poor women and especially poor women who reproduce (Chapters 7 and 8) by calling these women uncooperative or accusing them of arriving at the clinic with 'bad attitudes'. The literature highlights that nurses and midwives did not



UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

invent such notions of women who access public maternity care but are speaking from within a discourse that constructs some women as 'socially desirable reproducers' (9). Here violence takes the form of gender, class, and racial discrimination within the clinic. Referring to women during childbirth as uncooperative and behaving poorly acts as both a driver of obstetric violence as it reproduces gender stereotypes of poor women who are reproducing and an act of disrespectful care in itself, as women are being treated in a particular way based on the idea that they are uncooperative. This research notes, that, it would be inaccurate to think of nurses and midwives as simply vessels of classist, racist, and patriarchal beliefs, but they are at the interface between discriminatory systems and those affected by systematic violence, including poor, Black women (Chapter 4) (14). When nurses and midwives treat a woman in labour as if she is not cooperating or is being a bad patient, the practice of compassion or respect is very unlikely. Understanding the ways in which labelling particular patients as 'bad' perpetuates a violence that affects how women are treated but also how they exist discursively within language around who is a socially desirable mother.

*Caring labour*

The normalisation of gender discrimination impacts nurses and midwives through their lives as women, as well as rendering their work and profession as being of little value (10) . The devaluation of caring labour, a fundamental aspect to nursing and midwifery, is situated within women's inequality. Care work or reproductive labour is understood as women's work and therefore given less status and

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

paradoxically understood as less of a contribution to the economy as compared to other forms of labour (see Chapters 3 and 4). This is a violent paradox because without caring labour, no other form of labour could exist. As Honor Ford-Smith states so precisely, “the absence of care is death”(9 p.xxxi). Gender inequality and discrimination takes multiple forms and for the interests of this research it acts to normalize obstetric violence while also degrading caring labour for its association with women’s work.

To achieve maternity care safe from harm, including state harm, the stories from nurses and midwives raise the question of what kind of care is needed? Most writing on respectful maternity care assumes a common understanding of care. It is understood that to achieve a better standard of care, all forms of mistreatment must be eradicated – and this is a noble and worthy goal. How this is achieved, however, involves a careful consideration of how we understand care. Within the literature on respectful maternity care, training of midwives on how to be compassionate is sometimes recommended (11). This approach sees mistreatment of women in maternity care as predominantly a problem with nurses and midwives behaviour and that better care can be work shopped into practise. Respectful maternity care training may be useful however it will not address the problems of a clinic under duress and how such conditions shape care. This thesis has attempted to formulate an understanding of care within conditions of duress, which goes beyond individual behaviour and places care within the context of the clinic. In doing this, care becomes political, which is further discussed below.

UNIVERSITY of the WESTERN CAPE



http://etd.uwc.ac.za/

This research highlights how acts of kindness and compassion of health care providers act as a form of resistance against a system that manufactures conditions of duress (Chapters 3, 4 and 8). It is important to focus on these acts of resistance and find ways to support nurses and midwives who act with compassion. It is also important to see these situations as learning opportunities and explore the motivations for these acts of compassion as well as the knowledge and skills which they require. However, this should in no way romanticise compassionate care within a violent system. Placing the requirement on nurses and midwives to constantly have to resist a system that harms both them and their patients in order to be compassionate seems unjust. The term violent care may be useful in an attempt to respond to these issues. Placing violence next to care removes the polarization of the terms and care is no longer the antidote to violence but sees care as something that is happening within a context of and alongside violence (12). The term violent care resists the moral reflex to assume that care can solve the problems created by violence. When everyday violence exists in its multiple forms – structural, systemic, gendered, racist, anti-poor – it becomes more complicated, but absolutely essential, to practice compassion. In an MOU in an economically disadvantages community rife with violence, the responsibility of compassion falls on nurses and midwives and this study emphasizes that they are being asked to do this with little support from those without an in-depth understanding of what it means to provide compassion within such a violent context.

Resource shortages, violence and caring labour offer a way to think about the key findings of this study. When considered on their own or through the ways they

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

interact, they each speak to the barriers to reproductive justice within the South African public health system. They also describe what it means for a clinic to be constantly under duress. Solutions to these issues are complicated and structural violence is difficult to fight. It involves more than strengthening the health system and requires transformation on a global level. However, there are strategies, which could be taken to begin the process of bringing about the kind of change that is necessary for the achievement of reproductive justice.

## 9.1 Recommendations

Working towards reproductive justice and creating spaces where women can birth free from harm will involve the overwhelmingly hard work of creating clinics that are no longer spaces where fear regulates emotions and actions, while simultaneously resisting the normalization of violence against women. These recommendations suggest how the findings of this research can inform possible next steps.

UNIVERSITY of the
WESTERN CAPE

- Conversations about neglect within maternal health facilities have to happen *with* nurses and midwives. This will be a complicated process and involve much consideration about how such conversations happen. A way of talking about the emotional response to working without resources and the required infrastructure (such as emergency transport) is required, that takes seriously how nurses or midwives are able to perform their jobs when feeling fearful, anxious and uncertain of what to expect. This should not take the form of conventional research where the nurse is the research subject but rather



http://etd.uwc.ac.za/

should find ways to open up new forms of communication and facilitate participatory approaches (13). It is important also to address the fact that neglect has become normalized and is sometimes carried out with intent. Planning such research and possible future interventions requires the consideration of the notion of a safe space and that this cannot be assumed to be the same for researchers and for the nurses and midwives working in the South African public sector (Veronica Mitchell, Medical Research, Faculty of Health Sciences, UCT, 2022). Much of the psychological analysis of care and care work has been developed in the global north. Addressing neglect of patients by nurses and midwives within the South African and other sub-Saharan African contexts will require an approach that bases its psychological understanding of emotions such as fear on theory developed in this context. This is not to argue for an essentializing approach that assumes a sameness of African people, but rather to recognize that some of what goes on within the labour ward is context specific and requires contextually informed solutions. Nurses and midwives need to be part of this process rather than the subject of research.

UNIVERSITY of the
WESTERN CAPE

- Maternal health facilities need to be made more hospitable places starting with Antenatal Care (ANC). Conditions such as gestational hypertension are causing avoidable maternal deaths and this will continue to be a problem if women do not attend ANC. Adolescent and youth friendly services which are currently clearly outlined in the National Adolescent and Youth Health Policy (2017), although without reference to specific and safe provision of antenatal



http://etd.uwc.ac.za/

and maternal care, should be a priority. How this can be achieved requires the input of health care providers, pregnant adolescents and young mothers. Nurses and midwives referenced young women as patients they have the most trouble with. If this relationship is fraught, it will deter women from coming to ANC and receiving the care they require(14). Another focus of ANC should be preparing women for labour, including the importance of a labour companion of their choice. Conversations with women regarding who will be there to support them during labour and childbirth need to become part of routine care. During ANC women need to be informed of what labour will involve including the possible need for vaginal examinations. This could be done by a community health worker in the ANC waiting room, where women usually sit for hours.

- Labour wards/spaces need to accommodate labour companions during labour and childbirth. Linked with the above recommendation, this begins at ANC. The Department of Health should be responsible for providing the funds for installing curtains in the rooms where women labour. Having a labour companion has multiple benefits and is evidence-based practice that no woman should be denied. A Cochrane review on perceptions and experiences of having a labour companion during childbirth found positive results (15). Labour companions support women in different ways during childbirth such as offering informational support, bridging communication gaps between health care providers and patients, providing non-pharmacological pain relief, acting as advocates, offered encouragement and

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

reassurance that can help women feel more in control during childbirth (15). Labour companions provide continuous physical presence, which can create a more comfortable environment for women and give them a sense of familiarity and safety (15). Research conducted in Mozambique and Ethiopia has found that the presence of a birth companion can lessen the chances that women are mistreated in the labour ward (16,17). Having a companion present who is able to offer emotional support also relieves nurses and midwives from being the only ones present to offer such comfort to women. Labour companions are an economically feasible way to improve the experience of childbirth for women in South Africa and the current barriers to companionship during labour need to be overcome.

UNIVERSITY of the
WESTERN CAPE

- Research is required into the ways in which the nursing and midwifery curriculum addresses education about informed consent discussions, especially when performing intimate examinations, including proposals for how this can be more comprehensively taught so that it becomes the norm in practice. This would be the starting point for normalizing ICDs within midwifery care. Much research on mistreatment of women during childbirth found non-consensual care to be a problem (18–21). Addressing this will involve a change to the norms of current practice and will take time, but this should not deter an effort to create the type of care where consent is built into clinical procedures and part of how they are practiced. A 2019 study on quality of care in South African maternal health facilities found the lack of communication between care providers and patients to be a major barrier



http://etd.uwc.ac.za/

(22). Emphasising informed consent is one way to improve communication between women and their care providers and usher in a more caring environment than exists now in the labour ward.

- Throughout this research it has become apparent that respectful maternity care is a fractured subject within South Africa, there are pockets of interested researchers, practitioners, and programmes but they do not come together. We need to better learn from each other with regards to what is being done regarding obstetric violence. This will require the creation of a South African network to take forward the work on respectful maternity care and stopping obstetric violence. One way to do this would be to design and implement a nation-wide research project to create this network and provide accessible information about the different projects in the country.
- Changing societal beliefs about the value of care work is an ongoing process that takes dedication even when there appears to be no positive change. Making care work matter involves transformation and therefore the effort needs to be made in all institutions and across society. COVID-19 has highlighted the importance of reproductive labour and it was greatly unsettling to see how this did not impact the priorities of the state (8). For the majority of the world's population, and certainly for those in positions of care work, life has become more precarious (8). Reproductive labour lies at the heart of reproductive justice, we cannot have children or raise children free from harm in a society that consistently devalues the work it takes to keep humans alive (8).

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

## 9.2 Limitations of this study

There were a number of limitations of this study, firstly because of the study design and the type of in-depth analysis performed on the data, the sample size was small and only included three MOUs in townships of Cape Town, Western Cape. The Western Cape is the only province that has MOUs within their community health centres and labour wards that are located within hospitals may produce different findings. Although these findings showed similarities to other research carried out in South Africa, these finding are not completely generalisable to other locations. However, this was never the intention of the research and instead it provides an important in-depth analysis of the situation in one setting, which may not be transferable to other settings without consideration of the contextual differences in locations. However, working within an under-resourced clinic, encountering violence and the devaluation of caring labour is not an experience unique to the clinics within this study and the ways in which these findings affect nursing and midwifery practise can be applied more broadly.

Applying a reproductive justice theoretical framework offered a particular view of obstetric violence and out of this emerged the need to highlight reproductive labour as central to achieving reproductive justice. Another framework would have led to a different analysis and produced a different set of conclusions. The attention I paid to the devaluation of reproductive labour and how this harms maternity care also comes from my background, of having midwifery experience. I approached this



UNIVERSITY of the
WESTERN CAPE
http://etd.uwc.ac.za/

research with a particular empathy towards nurses and midwives, which shaped the analysis and produced findings that were supportive of nurses and midwives, even when they may be in the wrong. To apply a reproductive justice theoretical framework to the entire MOU and not just the patients also contributed to recommendations that are not punitive and rather seek to work with nurses and midwives, which may seem counter to a human rights approach that would prioritise holding nurses and midwives accountable.

## 9.3 Conclusion

This study explored drivers of obstetric violence in three South African MOUs from the perspective of nurses and midwives. Based on the narratives shared by the study participants and observations of the MOU a number of drivers were identified. The ways in which the lack of resources affected midwifery care and led to mistreatment such as neglect (Chapters 3 and 4) was a central finding within this project. The association between a lack of resources and low quality of care is not a novel finding, however this thesis attempted to address a gap in the ways in which this problem is analysed and understood. Through exploring how the lack of resources creates a context of constant uncertainty and the ways in which nurses and midwives had to navigate missing supplies, broken equipment, and working while under-staffed created a context where neglect was normalised. Chapter three and four also consider how nurses and midwives manage to demonstrate compassion within a system that maintains conditions of duress. This compassion

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

however was unlikely to be sustainable over long periods of time as the stress and fear of a bad outcome overrode attempts to deliver respectful maternity care.

Chapter five focuses on what was often described as a central barrier to quality of care within the clinic and this was the unreliable nature of transportation to a referral hospital in the event of an obstetric emergency. This again highlighted the constant uncertainty that nurses and midwives work within and the unfair sense of responsibility, feelings of blame, frustration, and injury to the inter-personal relationships within the clinic. Chapter six looked at the how the clinic space and the lack of curtains or rooms for patients forces staff to choose between privacy or labour companions for their patients. Privacy tends to be prioritised and women labour without the support of a companion until they are ready to give birth. The only emotional support that women will receive in this situation throughout the often long hours of contractions will have to be provided by nurses and midwives. Adding to their workload, nurses and midwives did not always feel that emotional support was part of their responsibilities.

UNIVERSITY of the
WESTERN CAPE

Chapter seven and eight explore inter-personal level factors of mistreatment during maternity care. Focusing on the construction of patients as women with bad attitudes, the absence of informed consent and intentional neglect of patients. Chapter eight uses Bradley et al.'s (2019) theoretically informed framework of drivers of mistreatment from the perspective of midwives to situate inter-personal level factors within a micro, meso, and macro understanding of the different kinds of drivers (23). Applying a theoretical framework to our findings allowed for a



http://etd.uwc.ac.za/

connection to be made between daily events that occur in the clinic and structural and systemic forms of violence that shape so much within the health system.

The discussion section above brings these findings together and, applying a reproductive justice framework, highlights the ways in which the devaluation of reproductive labour is entangled into drivers of mistreatment of women and the under-funding of maternal health facilities. The invisibility and devaluation of reproductive labour is a form of discrimination against women that drives other forms of gendered discrimination (10). As this thesis points out throughout the different articles, when the state fails to recognise care as work then professions such as nursing and midwifery are negatively affected. It is understandable why caring labour will get side-lined in favour of clinical care, especially when time is limited and the number of responsibilities placed on nurses and midwives exceeds their capabilities. This thesis has also highlighted the ways in which the patients of the MOUs in this study are seen as 'socially undesirable reproducers' (9) and the effect this has on maternity care in South Africa. For women to be granted their right to birth free from violence, maternal health facilities will need to become places that constantly resist harmful perceptions of the women who seek care and this will involve working closely with nurses and midwives and together find ways to better support those who carry out the labour of caring for others on a daily basis in highly challenging contexts.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

References for chapter 9


Rucell JZ. Obstetric violence & colonial conditioning in South Africa's reproductive health system. University of Leeds; 2017.

2. Chadwick R. Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives. Fem Psychol. 2017(4):489–509.

3. Honikman S, Fawcus S, Meintjes I. Abuse in South African maternity settings is a disgrace: Potential solutions to the problem. South African Med J. 2015;105(4):284.

4. Tantchou JC. The Materiality of Care and Nurses' "Attitude Problem." Sci Technol Hum Values. 2018;43(2):270–301.

5. Dutton J, Knight L. Reproducing neglect in the place of care: Normalised violence within Cape Town Midwifery Obstetric Units. Agenda. 2020;34(1):14–22.

6. Dutton J, Knight L. Sexual and Reproductive Justice: From the Margins to the Centre. Morison, T. & Mavuso J., editor. Lexington Books.; 2022.

7. Daniels N. Obstetric-risk objects: A multi-site, feminist ethnography of privatesector obstetric, maternal and unborn, caring concerns in Cape Town. University of Cape Town (PhD dissertation). 2021.

8. Feredercici S. COVID-19, capitalism, and social reproduction in crisis. Lancaster: Centre for Alternatives to Social and Economic Inequalities. Department of Sociology, Lancaster Univeristy; 2021.

9. Gomez AM, Mann ES, Torres V. 'It would have control over me instead of me having control': intrauterine devices and the meaning of reproductive freedom. Crit Public Health. 2018;28(2):190–200.

10. Andaiye. The point is to Change the World. Trotz A, editor. London: Pluto Press; 2020.

11. Arnold R, Van Teijlingen E, Ryan K, Holloway I. Villains or victims? An


UNIVERSITY of the WESTERN CAPE



http://etd.uwc.ac.za/

ethnography of Afghan maternity staff and the challenge of high quality respectful care. BMC Pregnancy Childbirth. 2019 Aug 22;19(1).

12. Harney S, Moten F. On Violence. Akademic der Kunste der Welt, editor. Berlin; 2022.

13. Baum F, MacDougall C, Smith D. Participatory action research. J Epidemiol Community Health. 2006;60(10):854–7.

14. Abrahams N, Jewkes R, Mvo Z. Health care-seeking practices of pregnant women and the role of the midwife in Cape Town, South Africa. J Midwifery Womens Health. 2001;46(4):240–7.

15. Bohren M, Berger B O, Munthe Kaas H,Tunçalp Ö. Perceptions and expereinces of labour companions: a qualitative evidence synthesis.Cochrane Database Syst. Rev. 18:3(3) 2019.

16. Galle A, Manaharlal H, Cumbane E, Picardo J, Griffin S, Osman N, et al. Disrespect and abuse during facility-based childbirth in southern Mozambique: a cross-sectional study. BMC Pregnancy Childbirth. 2019 22;19(1).

17. Bobo FT, Kasaye HK, Etana B, Woldie M, Feyissa TR. Disrespect and abuse during childbirth in Western Ethiopia: Should women continue to tolerate? PLoS One. 2019;14(6).

18. Kassa Z, Tsegaye B, Abeje A. Disrespect and abuse of women during the process of childbirth at health facilities in sub-Saharan Africa: a systematic review and meta-analysis. BMC International Helath and Human Rights.. 2020; 20(23).

19. Abuya T, Sripad P, Ritter J, Ndwiga C, Warren CE. Measuring mistreatment of women throughout the birthing process: implications for quality of care assessments. Reprod Health Matters. 2018;26(53):48–61.

20. Shimoda K, Leshabari S,. Horiuchi S. Self-reported disrespect and abuse by nurses and midwives during childbirth in Tanzania: a cross-sectional study.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

BMC Pregnancy and Childbirth. 2020: 20(584).

21. Asefa A, Bekele D, Morgan A, Kermode M. Service providers' experiences of disrespectful and abusive behavior towards women during facility based childbirth in Addis Ababa, Ethiopia. Reprod Health. 2018;15(1):4.

22. Lambert J, Etsane E, Bergh A-M, Pattinson R, van den Broek N. 'I thought they were going to handle me like a queen but they didn't': A qualitative study exploring the quality of care provided to women at the time of birth. Midwifery 62.

23. Bradley S, McCourt C, Rayment J, Parmar D. Midwives' perspectives on (dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and meta-synthesis., BMC Reproductive Health. 2019l; 16(116).

http://etd.uwc.ac.za/

# Appendices

## Appendix I: interview guide

**Interview Guide**

**Participant Interviews**

**(nurses/midwives)**

**Standard Information:**

Name:

Position:

Date of interview:

Consent form signed: yes / no

**Questions:**

1. Can you tell me about your day-to-day life?
2. How do you think your day-to-day life affects your job as a nurse/midwife?
3. Can you tell me about your background (your childhood, your family, where you grew up, your schooling, any significant memories)?
4. What about your personal history (your past) do you think has influenced your career as a nurse/midwife?



http://etd.uwc.ac.za/

5. Do you think your personal life, currently and your background, influence your relationship with pregnant women in the clinic?

http://etd.uwc.ac.za/

# Appendix II: Ethical approvals

**Health impact Assessment**
**Sub-Directorate: Health Research**
Health.Research@westerncape.gov.za
tel: +27 21 483 0866: fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_201801_008
ENQUIRIES: Dr Sabela Petros

**University of Western Cape**

**Robert Sobukwe Road**

**Bellvile**

**Cape Town**

**7535**

For attention: Ms Jessica Dutton, Dr Lucia Knight

Re: **Exploring the drivers of obstetric violence from the perspective of nurses and midwives throughout the continuum of maternal health care in Midwifery Obstetric Units in urban Western Cape.**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact following people to assist you with any further enquiries in accessing the following sites:

| | | |
|---|---|---|
| **Khayelitsha (Site B) CHC** | **Mr David Binza** | **021 360 5207** |
| **Gugulethu CDC** | **Mr Lunga Makamba** | **021 633 0020** |

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).



http://etd.uwc.ac.za/

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report **(Annexure 8)** to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

**DR J EVANS**

**ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT**

**DATE:** 23/05/2018

http://etd.uwc.ac.za/

Western Cape Government

Health

**Health impact Assessment**

**Sub-Directorate: Health Research**

Health.Research@westerncape.gov.za

tel: +27 21 483 0866: fax: +27 21 483 9895

5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001

www.capegateway.gov.za)

REFERENCE: WC_201801_008

ENQUIRIES: Dr Sabela Petros

**University of Western Cape**

**Robert Sobukwe Road**

**Bellvile**

**Cape Town**

**7535**

For attention: Ms Jessica Dutton, Dr Lucia Knight

Re: **Exploring the drivers of obstetric violence from the perspective of nurses and midwives throughout the continuum of maternal health care in Midwifery Obstetric Units in urban Western Cape.**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact following people to assist you with any further enquiries in accessing the following sites:

| | | |
|---|---|---|
| **Khayelitsha (Site B) CHC** | **Mr David Binza** | **021 360 5207** |
| **Gugulethu CDC** | **Mr Lunga Makamba** | **021 633 0020** |

Kindly ensure that the following are adhered to:

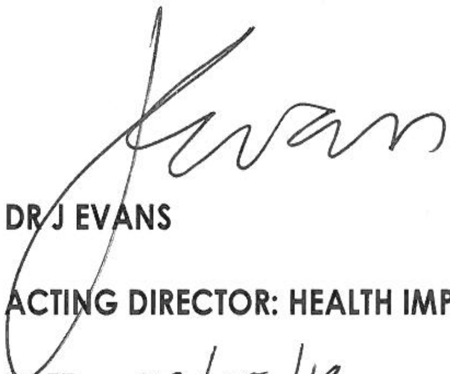
1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator

http://etd.uwc.ac.za/

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely



**DR J EVANS**

**ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT**

**DATE:** 09/05/18

http://etd.uwc.ac.za/

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 2988/2948
F: +27 21 959 3170
E: research-ethics@uwc.ac.za
www.uwc.ac.za

07 December 2017

Ms J Dutton
School of Public Health
**Faculty of Community and Health Sciences**

**Ethics Reference Number:** BM17/10/6

**Project Title:** Exploring the drivers of obstetric violence from the perspective of nurses and midwives throughout the continuum of maternal health care midwifery obstetric units in urban Western Cape

**Approval Period:** 07 December 2017 – 07 December 2018

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

**Please remember to submit a progress report in good time for annual renewal.**

*The permission from the Provincial Health Department must be submitted for record keeping purposes.*

The Committee must be informed of any serious adverse event and/or termination of the study.

*Ms Patricia Josias*
*Research Ethics Committee Officer*
*University of the Western Cape*

***PROVISIONAL REC NUMBER -130416-050***

FROM HOPE TO ACTION THROUGH KNOWLEDGE.



http://etd.uwc.ac.za/

## Appendix III Publications and Conference Presentations

*Publications*

Dutton. J, Knight. L, 2020 'Reproducing neglect in the place of care: Normalised violence within Cape Town Midwifery Obstetric Units' In *Agenda.* South Africa.

Dutton. J (2013) 'Layers of Violence: Media Reporting on Infant Rape in South Africa'. In Marcia Texler Segal and Vasilikie Demos (eds.) *Gendered Perspectives on Conflict and Violence: Macro and Micro Settings. Advances in Gender Research.* Emerald Publishing Group, Ltd. University of Minnesota.

*Conference Presentations*

Public Health Association of South Africa (PHASA) Conference, Durban, South Africa. September 11-14, 2022. Presentation title: A theoretical framework to understand barriers to quality of care: the experiences of nurses and midwives in three Cape Town MOUs.

International Conference on Gender Studies in Africa Theme: Africa and Gender Studies: Celebrating 30 Years of Transformation & Reimagining the Future. Makerere University, Kampala Uganda. February 23 – 25, 2022. Paper title: The Position of Midwives: what to make of research on obstetric violence in Africa.

Society of Midwives of South Africa Congress. Pretoria, South Africa. August 21-24,

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/

2019 Paper title: Systemic barriers to quality maternal health care: the lived experience of midwives

Priorities in Perinatal Care Conference, Hartenbos, South Africa. March 12, 2019 Paper title: Managing uncertainties: understanding how materiality of care affects nurses and midwives in three midwifery obstetric units in Cape Town, South Africa

African Health Agenda international Conference, Kigali, Rwanda. March 5-7, 2019 Poster/presentation title: Exploring Barriers to Quality of Care in South African Midwifery Obstetric Units: The Perspective of Nurses and Midwives

Society of Midwives of South Africa Congress. Bloemfontein. August 28- 31, 2018 Paper title: What drives disrespect and abuse amongst nurses and midwives throughout the continuum of maternal health care in midwifery obstetric units in urban Western Cape: PhD research proposal.

Abortion and Reproductive Justice Conference, Rhodes University. July 8-12, 2018 Paper title: Reproductive justice as a theoretical framework for research on health systems in the African context.

UNIVERSITY of the
WESTERN CAPE



http://etd.uwc.ac.za/