

Women`s experiences regarding poor maternity care in the selected hospitals of Vhembe District, Limpopo Province.

By

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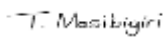
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July 2024.

Declaration

I, Tshiembe Masibigiri, declare that this mini dissertation titled: ***“Women`s experiences regarding poor maternity care in the selected hospitals of Vhembe District, Limpopo Province.”*** Hereby submitted by me, has not submitted previously for a degree at this or any other university, that it is my own work in design and in execution, and that all reference material contained therein has been duly acknowledged.

Signature_____  _____ Date: 2024/07/08

Dedication

I dedicate this study to the following:

God, for seeing me through everything and giving me the strength to complete my studies

My dear husband, Mr. Rosikwa Masibigiri, for the love, encouragement and support through this journey.

My amazing parents Mr. Itani Netshiungani and Mrs. Fulufhelo Netshiungani for always supporting me through everything.

My beautiful children, Bono, Omutondaho and Mulondi, thanks for the support.

My wonderful sister, Mavhungu Tshikumbana, for always standing by me and supporting me through everything.

My supervisor Dr. Mudau, for being so patient, understanding and pushing me to finish.

List of acronyms and abbreviations

ANC	- Antenatal Care
DOH	- Department of Health
PHCP	- Primary Health Care Providers
WHO	- World Health Organization

Abstract

A pregnant woman's life and that of her child largely depend on the care they receive during the critical stage of pregnancy, labour, and postpartum period. Some women question their decision regarding future pregnancies as well as where and with whom they will receive their pregnancy care because of negative experiences that they have had. The aim of this study was to explore the experiences of women regarding poor maternity care services in selected hospitals in Vhembe District, Limpopo province. A qualitative research approach using phenomenology research design was adopted in this study. Pre-testing was conducted. The study population included pregnant women who were admitted in the maternity ward from the selected hospitals. 18 Participants and one hospital (Tshilidzini Hospital) were purposively sampled. Face-to-face interviews were conducted with all sampled participants. Data analysis was interpretative and phenomenological. Measures to ensure trustworthiness which include credibility, conformability, and dependability were applied. Ethical principles were adhered to throughout the study. The study findings are expected to find ways to improve on the quality of maternity care given in public hospitals. Research findings will be presented in research symposia, conferences and published in accredited journals.

Keywords: experiences, maternity care, women, quality

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CHAPTER 1: STUDY ORIENTATION

1.1 Introduction

Every pregnant woman deserves good quality healthcare. It is essential that pregnant women have access to health services along the whole continuum of pregnancy, childbirth, and postnatal care. Anastasi, Borchert, Campbell, Sondorp, Kaducu, Hill, Okeng, Odong and Lange (2015) state that thousands of women and newborns still die from preventable deaths due to pregnancy and childbirth-related complications. Antenatal care (ANC) services provided for by skilled health practitioners are crucial in detecting any complications during pregnancy, caring for any illnesses that may arise during the pregnancy and helps to reduce the chances of maternal death. The World Health Organization (WHO) (2017) requires each stage of maternal health to be positive to ensure that there is a healthy mom and child thereafter. Some women question their decisions regarding future pregnancies as well as where and with whom they will receive their pregnancy care because of negative experiences that they have had. Downe, Finlayson, Tuncalp and Gulmezoglu (2016) contend that women require a positive pregnancy experience by maintaining physical and cultural normality, maintaining a healthy pregnancy for mother and baby by receiving ANC and an effective transition to positive labour and birth

Maternity care refers to any care provided throughout pregnancy, labour, and postpartum period. A woman's life and that of her newborn depend on receiving adequate maternity care (Tripathi, Srivastava, Memon, Nair, Bhemare, Singh and Srivastava, 2019). To ensure the safety of the pregnant woman and that of her child adequate care should be provided during the entire pregnancy, labour period and postpartum.

1.2 Background of the study

WHO (2017) introduced guidelines to ensure maternal and newborn care, which each country can implement in accordance with its own available resources. These guidelines were set in place to ensure that each stage of pregnancy, labour and postpartum is a positive experience where a woman and her baby can reach full potential of well-being and health. The sole aim is the reduction of maternal deaths which can be preventable by timely management by skilled health professionals in a supportive environment. WHO seeks to not only end preventable maternal deaths but to also reduce maternal injury and disability and to promote health and wellbeing. This can be done by providing women with respectful and high-quality maternal health. ANC guidelines should be in line with these needs to provide a positive pregnancy experience for women. Those

who provide ANC services should also be aware of these needs with every pregnant woman they encounter.

Midwives in many countries are trained key providers who provide care and a wide range of services before, during and after the labour process. Tikkanen, Gunja, Fitzgerald and Zephyrin (2020) conducted a study on 10 developed countries and state how the United States of America could be considered a high-income country with a high maternal mortality rate largely due to maternal care workforce composition because they have a lower supply of midwives and obstetrics and gynecology. Basic affordable care largely covers hospital-based care which does not include the services of a midwife; that care is mostly covered by private care. Women are provided comfort and care so that their labour process is smooth. Most women often note how mental health issues and breastfeeding aid were not addressed though their labour process was safe and satisfying with good maternal care. Hospital births are advocated to over home births.

In a study conducted in Australia by Hargreaves, Young, Prior and Aytin (2022) most women felt isolated and confused by the care they received from their caregivers. There was no effective communication between the women who were giving birth and their caregivers, and those who were not giving birth for the first time stated how they did not feel prioritized and indicated that they would have preferred having gone to a different hospital where private care might have been different from the maternity care they had been receiving in public hospitals. Women expressed their feeling as being trapped because the midwives who provided for the care would mostly talk about them and not to them, the overall experience was not found to be pleasant.

In the Netherlands, primary care is provided by midwives and general practitioners and secondary care is provided by midwives and gynecologists and provided for mostly in the hospital setup. Wiegiers (2009) states that the care path that women follow throughout pregnancy, childbirth and postpartum period is what has produced such a high level of quality care. Maternity care in the Netherlands is very different from most countries, there is high percentage of home births as opposed to hospital births; primary care is provided for unless the women have health complications and concerns only then will secondary care be sought. Primary care providers will attend to the women during labour and post-partum stage. The level of safe childbirth deliveries with no complications is very high, and women experience a high level of quality care. The Netherlands is a developed country with adequate care services readily and easily available as part of their healthcare system, this in turn makes it easier for primary and secondary providers to provide good quality care for their patients.

Redshaw, Martin, McGlynn and Harrison (2019) conducted a study in England and majority of the women expressed how they felt they had received adequate care during pregnancy and labour; they felt proper communication had been established with them during labour and the birth. However, once they had given birth majority of women indicated that health professionals treated them as though they were no longer important.

In India, private sector constitutes a considerable proportion of institutional deliveries providing 80% of all output patient care and 60% in patient care; quality of the care being received in the private sector was assessed and it was concluded that the overall quality of maternal care in private healthcare facilities is very poor and limited especially clinical standards related to management of complications. Global evidence has shown that pregnant women being offered better quality during childbirth can avert up to 1.49 million maternal and newborn deaths and significantly improve maternal and newborn survival (Tripathi et al., 2019).

In accordance with partnership for maternal, newborn and child health (2005) which was established in accordance with the WHO standards which were established in 2017, global maternal mortality ratio is estimated to have fallen by 38% between the years 2000- 2017, 94% of all maternal deaths occur in low and lower-middle income countries. Maternal mortality increases by 11% in conflict zones. It is estimated that almost half of under 5 deaths occurred during the neonatal period and 19 million stillbirths will take place before 2023 with many resulting from disruptions from health and social services. Implementing policies and programs that are more gender responsive in the health care system are actions that can reduce preventable maternal newborn, and child mortality and morbidity.

Ayanore, Pavlova and Groot (2016) conducted a study conducted in Ghana showed how there is still a problem with adequate prenatal and postnatal care. Women in the North and upper regions of Ghana stated how they received less care, there was a shortage of skilled attendance, drugs were not readily available and there were poor efforts in accountability for improving quality and equity care.

Despite the substantial gains in survival of maternal deaths in Sub-Saharan Africa there are still 1 million deaths and 1 million stillbirths still occurring in this region. In a country like Tanzania, Clinical practice guidelines for maternal health were assessed and revealed that, according to Barker (2017) mothers and their newborns often receive poor quality due to the gap of quality care between increased utilization of care without the expected corresponding gains in survival. For the quality of care of the services being provided to improve most rural hospitals would have

to increase predictability of health facility readiness as this was identified as a fundamental condition for maternal and newborn care provision. Other aspects that had to improve include Improvement of topics with a high degree of fit and existing Practice; Run charts using local data to monitor progress and monitoring and coaching individual health facilities. Once improvements of the Clinical practical guidelines can be met, it assists health workers in practice to be able to provide better care and thus leads to quality improvements for mothers and newborns in their care. The national department of health South Africa (2017) states that its main mission is to improve the health status of all South Africans by preventing illnesses and diseases, promoting a healthy lifestyle, and constantly trying to improve the health care delivery system by ensuring equality, access, efficiency, and quality. The guidelines of maternity care in South Africa (2016) stipulates that every health care provider who is administering care to a pregnant woman must show respect and genuine interest in their clients, without being rude, arrogant, dismissive, or judgmental. This quality of care must be provided regardless of a poor working environment or perceived unsafe practices by pregnant woman. The guideline also sets out specific level of care which should be employed by district and regional hospitals; these levels of care include the following: ANC for high-risk women; antenatal ultrasound; treatment of pregnancy problems; 24-hour labor and delivery services; postnatal care and postoperative service; Counselling and support services.

According to the Maternal child and women`s health draft policy document 655 Of 2012 their main aim is the protection and promotion of health for mothers and children; by raising the status of women, their safety, health, and quality of life. The objectives of this draft were set out to provide high quality primary, secondary and tertiary care for pregnant women and their newborns. Ensuring that the interests and comforts of pregnant women and their newborn are at the forefront. The main priority of this specific health status is to decrease maternal and perinatal mortality, decrease the prevalence of preterm delivery and low birth weight.

Luhailima, Mulaudzi and Phetlhu (2015) indicate how certain factors such as nurses' involvement in decision making, a feeling of self-fulfillment when achieving a goal of safe delivery of services and sense of responsibility in being able to have the freedom to make their own decisions might improve the level of quality care nurses can offer their patients. The Working environment of rural hospitals in Vhembe District is poor with inadequate resourced and thus leading to nurses being demotivated to perform at their level best and provide quality care.

A study by Ramavhoya, Maputle and Lebesa (2022) indicates that maternal guidelines in South Africa are mainly administered by midwives who serve as primary health care providers to provide

maternity healthcare services. Although these primary health care providers (PHCP) are offered training on how to administer the maternity guidelines, there is still poor implementation of the guideline's services. Issues such as lengthy waiting time for patients, lack of human resources and poor involvement of the community influence the quality of care being provided which should be in accordance with maternal guidelines.

1.3. Problem statement

PHCP such as midwives and doctors are trained to provide individual care to pregnant woman, monitor the health and wellbeing of the mother and the baby, give health education, and aid during labour and childbirth. The guidelines for maternity care in South Africa (2016) provides steps of the standard of care that PHCP can provide. Doctors take an oath where they swear to first do no harm and to always put the needs and safety of their patients first (SAMDA, 2020). Nurses also take the Florence Nightingale pledge where they swear to maintain honor and dignity by caring for the needs of their patients to the best of their ability. Despite those Oaths, the researcher has observed that the service being provided by PHCP is very poor and public health care workers are mistreating their patients.

On the 6th February of 2021, the researcher was admitted in the maternity ward in one of the hospitals in Vhembe where she gave birth and suffered from excessive blood loss after birth and two nurses refused to help her saying they were still busy; this led to the researcher losing consciousness and only then was care provided for her. The media reported an incident where a 29-year-old pregnant woman was refused entry into Madimbo clinic, Vhembe District and as a result gave birth alone outside in the rain and cold; because of this the baby died (Montsho, 2021). Experiences such as these are occurring often, the study will therefore show how these experiences of pregnant women within hospitals in Vhembe affects the woman and woman's health, the health of her baby and show how policy and safety guidelines are not being followed by healthcare workers.

1.4. Rationale of the study

Maternal care is essential in ensuring the health and wellbeing of a pregnant woman's life and that of her child. Many studies have been done in assessing how maternal healthcare services can be implemented to ensure quality care for pregnant women (Ramavhoya, Maputle and Lebese, 2022). However, poor implementation of maternal guidelines still exists. This study could help the DOH in addressing issues such as preventable maternal deaths, complications during childbirth, provide counselling and supportive services and avoid lengthy waiting time.

There is no known study about women's experiences regarding maternity care services in selected hospitals in Vhembe District.

1.5. Significance of the study

Understanding the experiences that women face while seeking professional medical healthcare may show just how poorly women are treated by healthcare workers, during one of the most difficult stages of life (childbirth). These experiences may also shed light into why child mortality and maternal death is so high in Vhembe District, Limpopo province. This might give the healthcare relevant information as to how to treat patients with respect and humanity; and to best reduce the number of death cases that occur during labour and childbirth. The DOH may gain insight as to how PHCP treats their patients and hopefully bridge the gap between the current care being provided and the implementation of maternity guidelines. This information may help the government improve the quality of healthcare services being provided to pregnant women thereby ensuring the health and safety of pregnant women and their unborn child.

1.6. Purpose of the study

The study purpose was to explore the experiences of women regarding maternity care services in selected hospitals in Vhembe District, Limpopo province.

1.7. Objectives of the study

- To explore the experiences of women regarding maternity care services in selected hospitals in Vhembe District, Limpopo province.
- To describe the experiences of women regarding maternity care services in selected hospitals in Vhembe District, Limpopo Province

1.8. Definition of concepts

- **Experiences**

The conscious contact of facts or events that can be lived or observed (Hesse, 2022). In this study experience refers to how a woman has lived through any maternity care service in the selected hospital in Vhembe District, Limpopo province

- **Women**

It is an adult female (Collins, 2012). Meyer (2016) refers to women as biological, anatomical and genetic identity. In this study, a woman refers to a pregnant woman who has just given birth in a public hospital in Vhembe District, Limpopo Province.

- **Maternity care services**

Maternity care services refer to any care provided pregnancy, labour, and postpartum period. According to the guidelines of maternity care in South Africa (2016) maternity care is provided to all pregnant women in South African and is a free service that is there to enhance the basic needs of primary health of pregnant women. In this study maternity care services will mean any form of service rendered by health care workers to pregnant woman during labour and postpartum period.

1.9. Organization of chapters

- Chapter 1: Introduction and background of the study
- Chapter 2: Literature review is discussed
- Chapter 3: Methodology of the study
- Chapter 4: Results of the study
- Chapter 5: Discussion of the findings
- Chapter 6: The summary, conclusion, recommendations and limitations of the study presentation

1.10. Summary of this chapter

This chapter describes the study background and the problem statement that prompted it to be conducted. It also stated the study purpose and the research questions. The study's significance is discussed as the research objectives. The next chapter will focus on a literature review.

CHAPTER 2: LITERATURE REVIEW

Title: Women`s experiences regarding maternity care services in the selected hospital of Vhembe District, Limpopo Province: a systematic review.

Abstract

Background

Maternal health is essential in ensuring pregnant women receive adequate care to give birth to healthy babies. In South Africa, maternity care services are being provided to pregnant women to ensure the health and safety of the women and their unborn babies.

Objectives

This study undertakes a systematic review of literature on pregnant women`s experiences of the maternity care that they have received during childbirth. A review of the past decade has been done to explore what maternity care services are and what has been the experiences of pregnant women regarding maternity care services they received guided by PRISMA-ScR.

Methods

Online databases were used to search for English literature published 2014-2024. This review focuses on qualitative studies and articles obtained from PubMed, MDPI and EBSCO-HOST. Key words women, experience and maternity care and search strategies were used to identify these papers. Literature was systematically reviewed, and 1663 articles were found. 1614 articles were rejected because they did not meet the inclusion criteria, 9 were duplicates, 1 did not have full text and 39 were screened and reviewed.

Results

The results defined what maternity care services are. The experiences of women revealed five emergent themes from these studies a) attitudes by healthcare providers; b) resources; c) distracted healthcare providers; d) continuity of care and e) overall environment.

Conclusion

Maternity care services have improved greatly over the past decade, however, there is still poor implementation of quality maternity care by healthcare providers. There is a gap in provision of care especially by midwives and policy needs to be upgraded to promote respectful maternity

quality care to ensure that pregnant women give birth in a healthy and safe environment and for pregnant women to have positive childbirth experiences.

Key words: women, experience, maternity care

2.1. Introduction

The relationship between women and maternity care providers during the antenatal, delivery and postnatal periods is critically important. Gupta, Jain and Sharma (2022) indicate how a positive experience with healthcare providers is important in ensuring the universal right of maternal and child health care.

Every childbearing woman has a universal right to receive respectful maternity care. Birie and Niguse (2023) say women can feel safe and comfortable where healthcare providers treat them well and with respect during childbirth, whereas disrespect or abuse will have a negative effect on women, leaving them with long lasting damage and emotional trauma.

Beecher, Devane, White, Green and Dowling (2020) suggest how the consequences of the kind of maternity care a woman receives will affect her development as a woman and mother in the future. Specifically, that a negative experience will lead a woman to feel hurt, lonely, afraid, anxious and distrustful of any maternal services affecting future use; and a positive experience to increase self-confidence and encourage attendance of future maternity care services.

An essential component of safe motherhood is for women to experience compassion and respect during pregnancy and childbirth. Majority of women in developing countries however experience disrespect and abuse during maternity care (Mengistie, Mulatu, Alemayehu, Yadeta and Dheresa, 2022). This is not to say first world countries do not experience poor maternity care. Mistreatment during childbirth is a global issue which still occurs in countries such as Switzerland which violates a woman's fundamental human rights (Meyer, Cignacco, Monteverde, Trachsel, Raio and Oelhafen, 2022).

By measuring a woman's experiences of maternity care services they receive, we can ensure their physical, mental and emotional well-being. Redshaw, Martin, Savage-McGlynn and Harrison (2019) see the measuring of women's perspective as an effective way of monitoring the quality of care being provided in healthcare facilities.

2.2. Rational

Women give birth everyday all around the world. Modern medicine has evolved and advanced to ensure the health and safety of women during childbirth and that of her unborn child. Numerous literatures have been published addressing women`s experiences with regards to the maternity care services they receive before, during and after childbirth. This study seeks to understand why women`s experiences of maternity care services are so different despite all the improvement of maternity care services over the past decade.

2.3. Objectives

A systematic review was done on existing literature to answer what is maternity care and what are the experiences of women regarding maternity care.

2.4. Method

This review considers global published works on women`s experiences regarding maternity care services from 2014 to 2024. A web search was done on databases such as MDPI, PubMed and EBSCO-HOST using these keywords: `women`, `experience` and `maternity care`. The search was limited to journal articles and excluded book chapters, newspaper articles and conference proceedings. All articles not published in English were excluded. All articles published before 2014 were also excluded. The initial search yielded a total of 1 663 articles. Upon assessment, articles that focused on COVID19 related to issues on women`s experiences to maternity care services were removed and articles that focused on women`s experiences of maternity care services who have underlying health issues were also removed. 1 614 articles were rejected as being irrelevant to the study. 9 articles were rejected as being duplicated and 1 was rejected because full text was not accessible and eventually 39 articles were used for full text review.

2.5. Protocol and registration

Protocol was not registered; however the researcher did not deviate from the protocol.

2.6. Eligibility criteria

Inclusion criteria:

- Full text publications written in English only.
- Studies conducted in time frame of 2014-2024.
- Studies conducted across the globe.

- Studies that were focused on the experiences of maternity care services which pregnant women received before, during and after childbirth.

In this study, the exclusion criteria are:

- Publications not written in English.
- Studies that were conducted outside of the given time frame (2014-2014).
- Studies that focused on pregnant women who have underlying or chronic health issues.

2.7. Search strategy

In this study the words `experience`, `women` and `maternity care` were used to search for articles on MPDI, EBSCO-HOST and PubMed.

2.8. Selection of sources of evidence

A total of 1663 journal articles were found. Of which 1614 were rejected as irrelevant for the study, 9 articles were found to be duplicates, 1 had no full text. The title, abstract and full texts were reviewed on 39 articles.

2.9. Data charting process

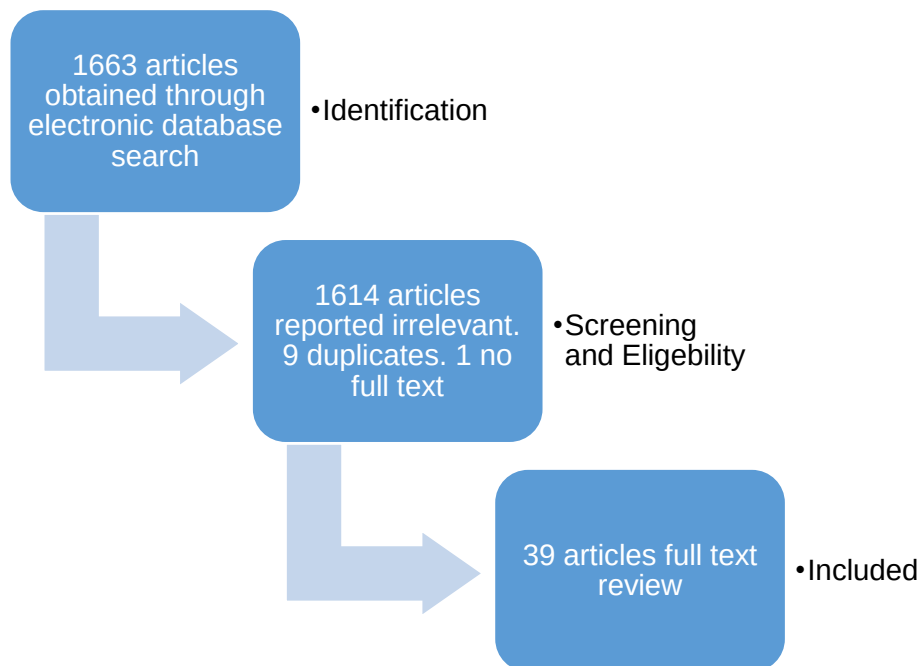


Figure 1. Flow chart of literature that was included and excluded.

2.10. Results

2.10.1. What are maternity care services?

Beecher et al. (2020) have defined maternity care services to be provision of medicine, food, electricity, trained and qualified staff, short waiting time, privacy, and continuity of care. Maternity care is not only limited to the organization of care but also includes emotional support, being treated with dignity and respect, information sharing by hospital staff with their patients, pain management, informed choices, and consent to all procedures that may be done on patients.

A study conducted in Ethiopia by Birie and Niguse (2023) shows how maternity care services were addressed as introduction of maternal waiting homes in health facilities where women could have access to free transportation and services, shorter waiting time periods, media promotion and women's conferences in the hopes of avoiding neonatal and maternity mortality.

Ahmed, Mahimbo and Dawson (2023) defined maternity care as providing women with dignified care and respect, maintaining communication and meaningful engagement between healthcare provider and pregnant woman throughout childbirth, continuity of care and pain management.

Maternity care as defined by Kawish, Umer, Arshed, Khan, Hafeez and Waqar (2023) refers to improving physical environment and resources by maintaining safety and ease through ongoing technological monitoring, maintenance, medicine and prompt expert assistance when problems emerge. In order for healthcare providers to be able to provide patients with such care there has to be respect, community knowledge and skill aimed at addressing every pregnant woman's individual needs.

Based on women's experiences Ronnerhag, Severinsson, Haruna and Berggren (2018) state that maternity care services are the steps and measures taken to ensure safe childbirth. These include involvement of women in decision making towards her own health, transparency and sharing of information by healthcare providers with women to ensure that all information regarding their health is shared and received to establish trustworthiness. Women should not be isolated and left alone to ensure a positive childbirth experience.

2.10.2. What are women`s experiences regarding maternity care services?

a) Attitudes provided by healthcare providers

Based on a study conducted on low- and middle-income countries in Sub-Saharan Africa, Ahmed, Mahimbo and Dawson (2023) women demanded to be treated with respect in a non-judgmental manner from their healthcare providers, the positive attitudes toward them by nurses, doctors, cleaners, and security guards made them feel respected. However, instances of verbal and physical abuse from healthcare providers did occur where some women reported being yelled at and being slapped during childbirth. In a survey conducted in California by Edmond, Declercq and Sakala (2021) women expressed how the positive attitudes and behaviour of healthcare providers such as doctors and nurses contributed to them having a positive birth experience. Having the healthcare practitioner`s answer their questions made them feel that their mental and emotional needs were being met.

According to Heys, Downe and Thomson (2021) women reported that healthcare providers were judgmental towards them; and that they were rude and arrogant towards them, made inappropriate and racially abusive comments.

Heideveld-Gerritsen, van Vulpen, Hollander, Oude Maatman, Ockhuijsen and van den Hoogen (2021) conducted a study where women with physical disabilities felt that healthcare providers were uncomfortable in supporting their disability related needs and were not willing to assist their needs which resulted in their partners having to help.

Emigrant Pakistani women living in Hong Kong found that they were less satisfied with the level of care being provided by healthcare providers during labour and birth. Asim, Nichini, Goggins, Dong and Yeoh (2023) observed that Pakistani women who were mostly fluent in English had poor maternal care service in Hong Kong largely due to lack of effective communication. It is not easy for healthcare providers to meet individual needs and expectations of women whose diversity is not taken into consideration.

Firdous, Darwin and Hassan (2020) share how Muslim women in the UK experienced poor maternity care due to stereotypical and discriminatory behaviour from healthcare providers.

In a study conducted in 14 countries around Europe by Fair, Raben, Watson, Vivilaki, van der Muijsenbergh and Saltani (2020) noted how migrant women are at a risk of poor pregnancy outcomes. For healthcare providers to ensure continuity of care and to provide good quality

maternal healthcare, there must be culturally competent healthcare providers who can meet the individual needs of migrant women beyond just being pregnant to ensure a positive experience.

Ethnic minority women in the UK receive poor maternity care within the public health system due to poor communication practices and discriminatory practices. Maclellan (Collins, Myatt, Pope, Knighton and Ria, 2022). Another study by Obionu, Onyedimna, Mielewczyk and Boyle (2023) conducted in the UK on the maternity care experiences of migrant and minority ethnic women reported that women had a negative experience and were not satisfied with the care they received. Women expressed how they were discriminated against, there was poor communication during childbirth between the healthcare providers and the pregnant women and no consistent continuity of care was offered post childbirth. The experience was not wholly satisfying and lacked cultural sensitivity.

However, a study was conducted in the UK by Higginbottom, Evans, Morgan, Bharj, Eldridge and Hussain (2019) where migrant women shared both positive maternal care experiences. Women shared how healthcare providers were caring, confidential and showed open communication with them. They expressed how this level of care made them feel that their medical, emotional, and social needs were met.

In Nigeria, disrespect and abuse is a common practice by healthcare providers towards women. Orpin, Puthussery, Davidson and Burden (2018) shared how women received poor maternity care, they were shouted at with derogatory language meted against them. Women felt hopeless and felt like they had no other choice but to accept abuse from healthcare providers because they need the maternity services. Other woman found childbirth to be a dehumanizing process.

A study in Tshwane, South Africa by Malatji and Madiba (2020) shows how midwives were rude and disrespectful towards pregnant women during their childbirth. Women narrated how they experienced verbal abuse in the form of being shouted at, rude language being used and judgmental comments when they could not understand what the nurses wanted or expected from them. Other women reported being left alone for long periods while in pain and would not receive any help even though they called out in pain for the nurses to come and assist them. Another study conducted in Tshwane by Zitha and Mokgatle (2020) also showed how women found their experiences of maternity care very hostile. Healthcare providers were abusive and used derogatory language towards them, the whole experience was negative and made their childbirth a stressful process.

Young women in Queensland reported poor quality interpersonal care with healthcare providers during labor, they were not treated with respect or kindness. Redshaw, Hennegan and Miller (2014).

Conversely, a study conducted in China by Liu, Li, Guo, Jiang, Li, Xu, et al. (2021) shares how women experienced a positive childbirth experience in midwife led centers due to the fact that there was counselling from midwives before and post birth, guidance and advice was given for the care of their newborns, a doula and family member was allowed in the room during the birthing process. Women said their experience was positive and they were satisfied with the maternal care they received.

b) Lack of resources

Heideveld-Gerritsen, et al. (2021) state that a barrier exists in providing adequate care for pregnant women with physical disabilities due to a lack of equipment, accessible care facilities and disability specific training. Another aspect that was raised from this study is that women were not allowed to have their husband's present with them in the delivery room, this was to ensure the privacy of other women as they shared labour rooms.

Magagulu, Temane and Nolte (2022) conducted a study in Eswatini on the experiences of women with mobility disability and their experience was of poor quality. Women shared that midwives were not supportive and very judgmental towards them probably due to midwives not being properly trained on how to deal with patients who are pregnant and have a mobility disability. The facilities do not have any protocol or guidelines regarding how to care for pregnant women with mobility disabilities during pregnancy, labor or post-partum. The infrastructure of the healthcare centers also does not cater for the needs of a woman with mobility disability.

Malatji and Madiba (2020) narrated how women from Tshwane expressed being denied an ambulance by midwives and told that ambulances only come for serious emergencies and that women in labour should catch a taxi and go to the hospital. Other women shared how they were refused a bed and had to sit on a bench for 6 hours while in labour. Pain relief medication was not given to women and due to overcrowding, there is no privacy in the wards and women reported having vaginal examinations in none-private setting.

In a study conducted of Sub-Saharan African women who had experienced giving birth in Sub-Saharan Africa and Australia by Mohale, Sweet and Graham (2017) women shared how in Sub-Saharan Africa health facilities were far and had been not fully equipped but in Australia health

facilities have materials and equipment available for patients to utilize. Women shared how pain relief medication was not available in Africa but in Australia pain management is available to assist childbirth.

Nagesh, Li, Fan, Chai, Fan, et al. (2024) report how migrant South Asian women struggle with cultural and language barriers which limits their access to available maternity care facilities and services in their destination country. Women have low income and are unaware of the maternity services being offered around them and as such receive inadequate prenatal and maternity care services.

A study by Tsorng-Yeh, Kurtz Landy, Wahoush, Khanlou, Yin-Chun and Chia-Chi (2014) conducted in Canada gave Chinese women's perspective on maternity healthcare in Canada. Chinese women stated how healthcare providers were not culturally and linguistically competent towards their individual needs and there is no alternative support to a more cultural method of childbirth available for them to access.

In a comparative study conducted in five countries between immigrant women and non-immigrant women, Small, Roth, Raval, Shafiei, Korfer, Heaman, et al. (2014) illustrate how immigrant women experienced poor maternal care. Immigrant women expressed how there were communication barriers with healthcare providers, they were unfamiliar with the health care system and unaware of the services being provided. Higginbottom, Hadziabdic, Yohani and Paton also conducted a study about immigrant women's experiences of maternity care services in Canada. Women expressed how barriers such as organizational environment, poor communication with healthcare providers, and their lack of knowledge about the maternity care services available to them made for a poor experience. This was also supported by Higginbottom, Morgan, Alexandre, Yvonne, Forgeron, Kocay, et al. (2015) who shared how immigrant women in Canada still have barriers in lack of information about the maternity care services available, women are not aware of the services available for them. Women also expressed how they had to contend with lack of social support structure available for them.

According to Rajbangshi, Srivastava and Nambiar (2022) women in India who utilised public health maternal care expressed poor service. Women reported lack of cleanliness, inadequate infrastructure and not having access to medicine during childbirth. A great concern was how there is no transportation such as ambulances in remote areas to transport them to hospital. There is no access to transport for referrals in remote areas as well. Women also shared how there weren't

enough healthcare providers in the wards, they were left alone unattended for long periods of time during labour, there was no prompt care available which made for a hostile environment.

c) Distracted healthcare providers

Lack of support from distracted healthcare providers is also widely reported. Ahmed, Mahimbo and Dawson (2023) noted how women reported how they felt when the baby was coming and would call out for help in vain since the nurse would think she is pretending and continue talking on the phone or writing in charts saying they are still busy and not attend to their patients. In Tasmania, Hargreaves, Young, Prior and Ayton (2022) women shared how they felt ignored by the nurses and not a lot of attention was being given to them. Some reported not getting breakfast as nurses were too busy to pay attention to their needs.

Women expressed how they felt ignored and alone throughout the care of their labour process. Koster, Romijin, Sakko, Stam, Steenhuis, Vries, et al. (2020) state how women felt on issues like lack of information and consent being shared by healthcare providers. Women also felt excluded, and that decision making was one-sided by the healthcare providers who were solely focused on their job and not on the pregnant women's needs.

d) Continuity of care

Hargreaves, et al. (2022) contend that women expressed how the lack of continuity of care affected their childbirth experience negatively. There were many nurses that attended to them, and it was difficult to build a relationship or form connections with each nurse. Most women would have preferred to have gotten one midwife.

Jenkins, Ford, Morris and Roberts (2014) spoke with women in New South Wales who felt that it was important to have women focused care where health practitioners communicate what is happening with their care, allowing women to be part of decision making; this makes women feel like they are being valued and listened to which makes for a positive experience as opposed to being spoken at with no regard of their feelings, emotions or input about the care they are being given.

Allkins (2024) study shows how continuity of care is beneficial and has positive effect on women's mental health and antenatal experiences. Midwives who were able to provide care and issue information during post-natal and antenatal care made women feel well informed and better taken care of by have one midwife attend to them throughout their childbirth process and after delivery.

Asylum seeking women in high income countries have very poor maternal care services. Frank, Fox, Njue and Dawson (2021) illustrate how the needs of women who seek maternal care in high income countries felt alone and ignored. The constant relocation meant that care could not be provided for continuously or by the same healthcare providers, these women did not feel acknowledged or heard nor did they feel like anyone cared for them.

In a study conducted in Tshwane by Oosthuizen, Bergh, Grimbeek and Pattinson (2020) CLEVER maternity care system was implemented to see how women's perception of their maternity care was. All women reported a positive experience in that they were treated within 15 minutes of arrival, they were asked for permission before an examination was done, and healthcare providers expressed respectful and good communication with women. The level of care and kindness showed good, continued care and made the experience a pleasant one for the women.

e) Overall environment

In a study conducted in Bangladesh by Kabir and Chan (2023) women who can afford healthcare opt to use private hospitals to give birth in. Women expressed how they have very low expectations of public healthcare services due to the overall environment. The hospitals are not clean or hygienic, there are long queue and laborious waiting periods to be attended to by a healthcare provider. Women also expressed how there is a lack of privacy due to the overcrowding.

According to McKinnon, Prosser and Miller (2014) women in Queensland expressed how they were dissatisfied with how overcrowded postnatal facilities were. Women expressed how they had to share a room with 3 or 4 other women who had just given birth. During the visit, the rooms were overly loud and crowded because there were 4 patients in one room, which made it very stressful for everyone to hear each other. Another woman shared how she had to wait in a room with other couples for over 6 hours before going to have her caesarean section operation done.

2.11. Discussions

From the results of the literature that was reviewed, the following five themes emerged. Attitudes provided by healthcare providers; resources; distracted healthcare providers; continuity of care and overall environment.

2.11.1. Attitudes provided by healthcare providers

In almost all the reviewed literature, healthcare providers (midwives) are abusive, rude and use discriminatory or derogatory language towards women during childbirth. Women reported to experiencing poor maternity services due to the attitudes they were receiving from midwives especially during the labor process. In most African countries (Nigeria and Ethiopia) women expect to receive physical abuse such as being pinched or slapped during labor as this has become the norm.

Immigrant women and women in minority ethnic groups also receive poor maternity services from healthcare providers in their destination countries. Healthcare providers do not show any culturally sensitive behaviour towards their individual needs.

Globally, there is still a huge gap as pregnant women still receive disrespect and abuse from midwives who provide maternity care services for them during childbirth.

2.11.2. Lack of resources

Lack of resources continues to be a barrier in health facilities being able to provide good quality maternity care. In India, hospitals are overcrowded and there aren't enough doctors and midwives to attend to everyone; this also results in patients waiting for a long period of time before being attended to. There is a shortage of water, there is no equipment's readily available for patient use during childbirth and there is a lack of medicine especially for pain management.

In rural areas such as Emaswatini the infrastructure is not adequately equipped to house patients, especially those with physical mobility disability. Health facilities are unable to cater for people who have physical disabilities within the maternity wards.

Health facilities are also far for people to access maternity services, referral transportation such as ambulances are not easy to access.

For immigrant women in their destination countries such as Canada women struggled with gaining access to maternity services due to lack of information as to the kind of care available to them and there is a lack of awareness that there are maternity care services available to them.

2.11.3. Distracted healthcare providers

Healthcare providers seem to be too busy or distracted when women are in labour. In Tasmania women complained how they felt ignored and some midwives would chart their work or attend to admin duties instead of attend to them while they are in labour.

2.11.4. Continuity of care

For maternity care services to be satisfactory and of good quality it must be continuous throughout antenatal, childbirth and postnatal process. Some women prefer to have one midwife attend to them throughout their birthing process so they can establish a relationship with each other.

Other women prefer to be well informed about their health status. Have midwives seek permission first before conducting any examinations and to explain why such examinations are being done. Care needs to be informative and inclusive so that women can have a positive experience.

2.11.5. Overall environment

The overall environment plays a significant role in women feeling that they have had a positive experience. Women in Bangladesh complained how the health facilities were not clean and unhygienic. The hospitals experience a shortage of water which doesn't make the place seem sanitary. Another problem is the overcrowding in the wards, this leads to no privacy as well and results in a negative childbirth experience.

In Queensland, women complained about having to share one room post childbirth. It gets very loud and noisy especially during visiting hours because 4 women share one room and everyone gets visitors, it does not make for a peaceful environment. Another lady also complained how she had to wait 6 hours in a room with another couple before going to get cesarean section done.

2.12. Limitations

The study is solely limited to the experiences of women about the maternity care services which they received before, during and after childbirth. Studies about women's experiences regarding maternity care services, who have any underlying or pre-existing health issues were not included in this review. This review only focused on literature that was published in English. There may be other studies published in other languages that may impact the review.

2.13. Summary of this chapter

Maternity care services need to address a pregnant woman's individual needs while seeking to cater for her physical, emotional, social and cultural needs. Culturally appropriate maternity care needs to be workshopped so that healthcare providers can care to individual needs of pregnant women despite their ethnicity or race. Where women can feel that they are being listened to and their needs and opinions matter. We need to implement policies that promote respectful and non-abusive care during childbirth.

Healthcare facilities need to improve their surroundings so that the infrastructure is clean, safe and hygienic. Equipment need to be sourced so that patients can access them. This is to ensure a safe and positive experience for women before, during and after childbirth.

CHAPTER 3: RESEARCH METHODOLOGY

3.1. Introduction

Research methodology refers to the process and techniques that the researcher will use to conduct their study (Maree, 2016). The focus of this chapter is to describe the research approach and design, sampling method, population and study setting. It also describes how measures of trustworthiness and ethical considerations were observed.

3.2. Study approach and design

A qualitative method of research was used to explore in depth information about women's experiences regarding the maternity care services they received before, during and after childbirth. A qualitative approach allows the researcher to gather information from the participants without any limitation due to its nature of asking open ended questions (Maree, 2016), women were able to express themselves freely about the maternity care services which they received.

A phenomenology research design was used as this is the best way to study human experiences that they have lived through in certain environments (Brink et al., 2018). Making use of this design was the best approach to explore and describe the experiences of women regarding maternity care services which they received in selected hospitals of Vhembe District, Limpopo Province.

3.3. Setting of the study

The study setting refers to the location where the research will be conducted (Cresswell, 2018). The study was conducted at Vhembe District in the Limpopo Province of South Africa. The Limpopo Province has a total of five districts, namely: Capricorn District, Mopani District, Vhembe District, Waterberg District and Sekhukhune District (Department of Cooperative Governance & Traditional affairs, 2020)

Vhembe has an estimated population of about 1 402 779 people, with 46, 7% being male and 53% female. The languages spoken in the district are Tshivenda 69%, Xitsonga 27%, Sepedi 2%, Afrikaans 1%, Sesotho 1%, and other languages 1%. Approximately 90% of the population resides in rural areas (Department of Statistics, 2022). Vhembe District has 1 Regional hospital (Tshilidzini), 6 district hospitals (Donald Fraser, Siloam, Musina, Elim, Louis Trichardt and Malamulele), 8 community health centers, 22 mobile services, 1 specialized psychiatric hospital (Hayani) and 115 clinics. Approximately 93.6% of the population is uninsured and relies on public health care services (Department of Cooperative Governance & Traditional Affairs, 2020).

This study was conducted at Tshildzini Hospital. Tshildzini Hospital is a regional hospital located along the Punda Maria main road, Shayandima. A regional hospital is a second level health care which receives referrals from and provides specialist support to district hospitals. Tshildzini hospital offers clinical services such as surgery, obstetrics and gynecology, out-patients department, medicine, pediatrics, mental health, geriatrics, casualty, and clinical forensic medical services. (KZN Department of Health, 2023)

Below is a map of Vhembe District

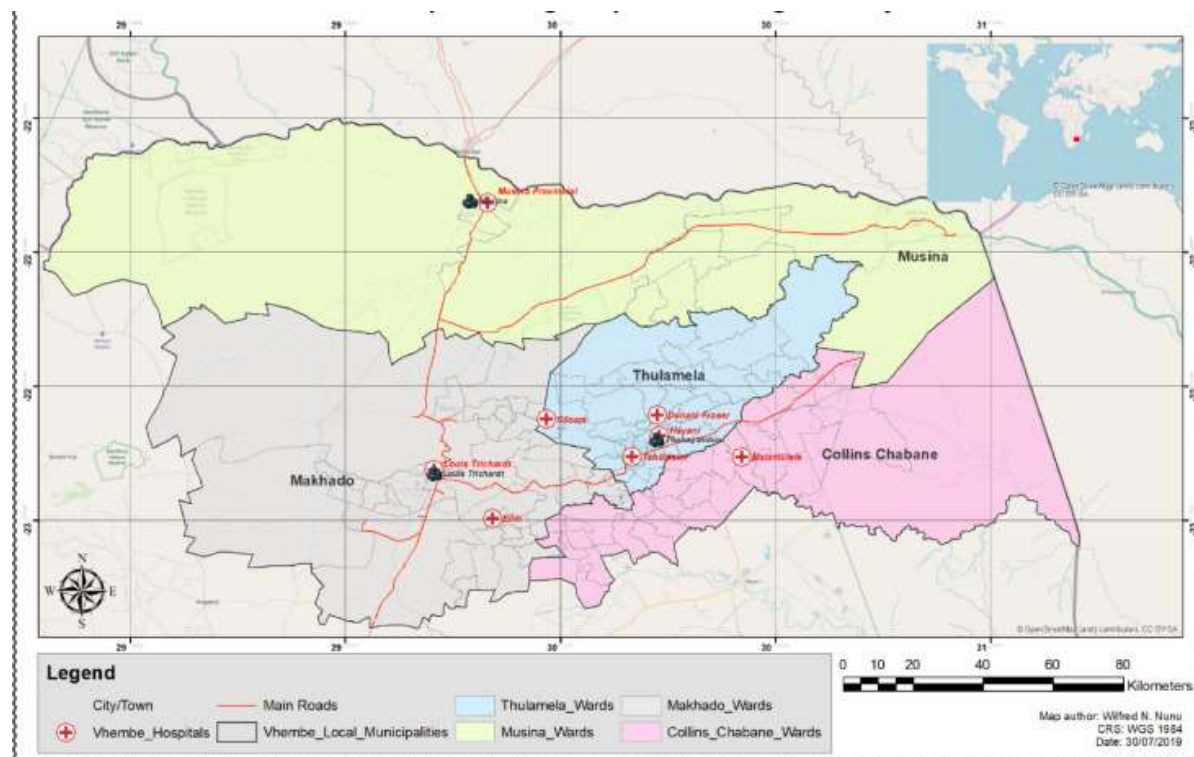


Figure 1. Vhembe District Map (Research gate, 2020)

3.4. Study population and sampling

This section provides information about the study population, sample and sampling, and inclusion and exclusion criteria.

3.4.1. Study population

Study population refers to all the participants who were involved in conducting the study who meet the criteria of the study (Kumar, 2019). The study population were all pregnant women at

Tshilidzini maternity ward. The target population were pregnant woman who were admitted in the maternity ward and gave birth at Tshilidzini Hospital and were being discharged at the time of the study when data was collected.

3.4.2. Sample and sampling

Sampling refers to choosing the elements which are the basic units from data and information to be gathered which will represent the entire population (Cresswell, 2018). Non-probability purposive sampling was used by the researcher in selecting which hospital to select. According to Brink, et al. (2018) purposive sampling will allow the researcher to be able to select a hospital that will give more information about the topic. Tshilidzini hospital has the highest intake of pregnant woman as it is a regional referral hospital and emergency cases are referred there.

Non-probability purposive sampling has been used to target participants. Brink, et al. (2018) refer to purposive sampling as a researcher using their judgement to decide which participants have the most suitable characteristics and knowledge about the research topic. Participants who have been discharged from maternity ward will have the most in-depth knowledge of the type of maternity care that they have just received before, during and after childbirth from the hospital.

With regards to the sample size, data saturation was the determining factor. Data saturated at participant number fourteen, but the researcher continued to conduct the research until participant number eighteen.

3.4.3. Inclusion and exclusion of criteria

Inclusion criteria refer to characteristics that participants possess that make them eligible to be included as part of the study (Kumar, 2019).

- Participants are woman who have been admitted at the maternity ward in Tshilidzini hospital to give birth.
- Must have already given birth and are being discharged.

Exclusion criteria refer to characteristics that participant possess that make them not to be included as part of the study (Kumar, 2019)

- Women who were admitted at any other ward in the hospital.

3.5. Data collection tool

In qualitative research, the researcher acted as a data collection instrument (Brink et al., 2018). The researcher conducted the interview using an interview guide (**Appendix E**). An interview guide is a tool used for in-depth interviews to gather rich information about a detailed concept using open ended questions. The questions in the receiver's interview guide were not controlled or tried to make them inflexible; it will only be used to guide the interview. This tool was chosen because it allows the researcher to ask more questions which are not on the interview for clarity and more evidence and that can be referred to as follow up questions and probing questions.

According to De Vos, et al. (2013), the questions in an interview guide are projected to answer the research objectives. The first division of an interview guide entails the research topic and aim of the study as well as demographic information of the participant, code, period of the interview and venue of the interview. Furthermore, the following section includes the central question "***May you please share your experience about the maternity care you have received since you arrived at the hospital until now***"

3.6. Pre-testing

Brink, et al. (2018) refer to this stage as testing how feasible the research instrument will be. This process provides the researcher with the opportunity to rectify any adjustments or improvements to their research instrument. The researcher interviewed two participants from Tshilidzini Hospital to serve as pre-test of the appropriateness of the research tool and the central question. The data collected during pre-test was not destroyed, the researcher used it to modify their interview skill and the central question.

3.7. Data collection

This is the process wherein information related to the topic is collected from samples for the purpose and objectives of the study to be reached (Brink et al., 2018).

The researcher visited Tshilidzini Hospital with the permission letter from district and regional level to seek permission to conduct interviews for the purpose of the research. Arrangements with the hospital manager were made that the researcher would come during the week for as long as data is needed to be collected so that the researcher may be able to collect data from the maternity ward.

The researcher visited the maternity ward and approached women who had given birth and were being discharged. The researcher was the main instrument for collecting data. The researcher

informed the potential participants that participation in the study was voluntary and can be terminated at any time should they wish, anonymity would be maintained in that no one's names would be used, the interviews would be private and that the interview is recorded strictly to retain useful information.

The interviews were conducted face-to-face on a one-on-one basis in a private cubicle in the post-natal ward at Tshilidzini Hospital. An unstructured interview guide was used with one central question which allowed participants to give more detailed information and for the researcher to probe more information from the participants. The interview guide consisted of demographic information of the participants which included their age, mode of delivery and how many times they have been admitted to Tshilidzini maternity ward. Field notes were taken, and the interviews were recorded on a tape recorder and the recording were transcribed verbatim. Each interview lasted roughly 30 to 45 minutes and interviews were conducted on different days of the week.

3.8. Data analysis

Brink, et al. (2018) defined data analysis as the process of systematically applying logical techniques to describe, illustrate, recap, and evaluate data. This is where a researcher reads through data to find a pattern or similar theme. The main reason for data analysis is to organize data in a way that themes and sub-themes that emerge from data can address the research problem. Interpretative phenomenological design was applied for the study.

Once data had been collected from participants, the researcher transcribed the interview notes and arranged them into different sections where the researcher read and re-read what the participants were saying to get a better understanding of the information. Data was then categorized using codes under different sections where themes and sub-themes emerged based on the information given by the participants. These themes and their sub-themes were then tabulated, and the researcher can explain the findings and interpret the data.

3.9. Measures to ensure trustworthiness

Trustworthiness measures the degree which the research procedures were employed to ensure the accuracy of the findings (Fouche, Strydom and Roestenburg, 2021). Various ways are used to achieve trustworthiness in research, the following standards were used to ensure trustworthiness:

- **Credibility**

This is establishing confidence in the truth (Brink et al., 2018) and will be done through prolonged engagement in the field with the participants, this will build trust between the researcher and the participants. The hospital was visited first and prior arrangements were made before the data was collected. The researcher gained in-depth understanding of the information from participants through probing and assessing participant's emotions and listening for responses. The researcher also continued collecting data until the eighteenth participant to ensure the information was accurate, regardless of data saturation being reached at participant number fourteen

- **Dependability**

This refers to how stable the data is if repeated in similar situation over time (Brink et al., 2018). The researcher checked and rechecked data to ensure that the findings are giving the participants lived experiences and that their mental and physical state is being addressed as well.

- **Confirmability**

This refers to the procedures used in the research to be free from bias (Roestenburg, 2021). The researcher must not reflect his own opinions and views, the data collected should reflect the voice of the participants. Only the information collected from the voice recordings and transcript have been used as data in the research.

- **Transferability**

This refers to being able to apply the findings of your data into another context (Brink et al., 2018). The researcher conducted interviews with participants until data saturation was reached.

3.10. Ethical considerations

Every research needs to ensure that it has high ethical standards and measures that give the direction in which the research will take. This also ensures the protection of human subjects through the application of appropriate ethical principles (Roestenburg et al., 2021).

These are the guidelines that the researcher followed: obtaining ethical clearance, permission to conduct the research, informed consent, anonymity, and non-discrimination.

3.10.1. Obtaining ethical clearance

The researcher submitted the research proposal to the Department of Public Health, Faculty of Health Sciences, and the University of Venda's Higher degrees committee for quality assurance before data was collected. An application for ethical clearance from the University's research ethics committee was made and approved with clearance number FHS/23/PH/26/0602.

3.10.2. Permission to conduct research.

The researcher requested permission at national and district level of the Department of Health to conduct research at Tshilidzini Hospital and obtained permission (**Appendix H and Appendix I**)

3.10.3. Informed consent

Informed consent refers to providing participants of the study with information about what the research is about and what the purpose of the research is (Cresswell, 2018). The researcher explained to the participants what the research is about and if they would like to be part of the study. After explanation a consent form to verify their willingness to participate in the study was given to them to sign (**Appendix B**). Participation in the study is voluntary and that participants could withdraw at any time without any penalty.

3.10.4. Confidentiality and Anonymity

Brink (2020) states that confidentiality is an essential aspect of research ethics that ensures that the privacy of participants and information they give is protected.

The researcher did not include the participants' names, addresses or phone numbers in the study to maintain everyone's privacy and keep them anonymous.

3.10.5. Non-discrimination

Roestenburg (2021) states that a researcher should not discriminate against participants. The researcher did not discriminate against participants based on ethnicity, religion, or race.

3.11. Plan for dissemination and implementations of results

Copies of the outcome of this study will be submitted to the Faculty of Health Sciences, University of Venda library and the Department of Health. The findings of this study will be published in peer reviewed journals. The findings of this study will also be presented in academic conferences as a way of disseminating information.

3.12. Summary of this chapter

The method in which data was collected and analyzed is detailed in this chapter. This chapter also covers and describes the study approach and design, study setting, population and sampling methods, trustworthiness, ethical considerations and the plan for data dissemination.

CHAPTER 4: PRESENTATION AND DISCUSSION OF RESULTS

4.1. Introduction

This section discusses research findings which resulted from face- to – face interviews which were conducted with 18 participants. The interviews were conducted at Tshilidzini Hospital post-natal ward and analyzed using interpretive phenomenological analysis. The duration of each interview lasted about 30 – 45 minutes. The demographic information of participants was illustrated. Findings were set out as emergent themes and sub-themes backed by verbatim quotations from the participants.

4.2. Objective of the study

The main aim/purpose was to explore and describe women`s experiences regarding the maternity care services which they received before, during and after childbirth.

4.3. Demographic information

This section presents the demographic profile of 18 participants who were purposively sampled and interviewed using an unstructured interview guide. **Table 1.1** below illustrates the demographic profiles of all 18 participants.

Table 1.1 Demographic profiles of participants

Participant	Age in years	Mode of delivery method	Number of times being admitted at Tshilidzini maternity ward
Participant A	27	Natural vaginal birth (NVD)	1
Participant B	34	NVD	3
Participant C	27	Caesarian section (C-section)	2
Participant D	38	NVD	4
Participant E	36	NVD	4
Participant F	24	NVD	1
Participant G	36	C section	2
Participant H	32	C- section	2

Participant I	25	NVD	2
Participant J	22	NVD	1
Participant K	21	NVD	1
Participant L	21	NVD	1
Participant M	29	NVD	2
Participant N	19	NVD	1
Participant O	37	NVD	3
Participant P	36	NVD	2
Participant Q	31	C- section	2
Participant R	22	C- section	2

Table 1.1 revealed that most of the participants (10) were between the ages of 22-35. Followed by 3 who were under 21 and 5 who were 36 and above. The table further reveals that 5 of the participants gave birth via C-section, and that only 6 participants had one child. Furthermore, the table also reveals that 12 of the participants have been admitted to Tshilidzini hospital's maternity ward more than once.

4.4. Study findings

Data was collected through face-to-face interviews with all the participants. Participants communicated their experiences in their own mother tongue and the voice recordings were translated verbatim into English. Interpretative phenomenological analysis was used to analyse the data which was collected. Four themes emerged during data analysis, (1) Women's experiences in provision of maternal health care; (2) Environmental factors affecting the provision of maternal health care; (3) Lack of resources and (4) Attitudes of nurses towards patients.

The study findings are presented in the form of themes and sub themes which are supported by verbatim quotations from participants.

Table 1.2 Below illustrates the themes and sub themes.

Table 1.2 themes and sub-themes

Themes	Sub-themes
4.4.1. Women's experiences in provision of maternal health care	• Pre-natal care • Care during active labour • Post-natal care
4.4.2. Environmental factors affecting maternal health services	• Hygiene • Animals in the ward • Infrastructure and surrounding
4.3.3. Lack of resources	• Materials • Water shortage
4.4.4. Attitudes of nurses towards patients	• Physical and verbal abuse • Unfair discrimination and ill-treatment • Lack of transparency

4.4.1. Women's experiences in provision of maternal health care

The standard of care that participants experienced was not the same. Almost all the participants indicated that the care they received after childbirth was better than the care, they received during the delivery process. Most of the participants explained that nurses were checking to see how many centimeters along their dilation was, blood pressure and baby's heartbeat was monitored regardless of the nurse being friendly or rude.

The Maternal child and women's health draft policy document 655 of 2012 ensures to safeguard and protect the interests, safety and health status of pregnant women and their newborn during primary, secondary and tertiary care. The level of care should be of high quality throughout delivery and post childbirth.

4.4.1.1 Pre-natal care

In this section, participants shared how doctors and nurses checked and assessed their health and that of their unborn baby.

With regards to having vitals checked and tests being done regularly, nurses seem to be able to attend to their patients, **Participant R (22 years):** *"I was admitted because I had to have a C-*

section because this was my second baby. I only ended up getting the C-section done 3 days later because there were other emergencies ahead of me. The doctor explained to me how my water hadn't broken yet and that the reason for the delay was that other patients had to be rushed to the theatre due to life threatening emergencies. The nurses checked my BP, urine, and blood daily and were very friendly towards me. I had such a nice stay here; everyone made me feel comfortable." This participant shared how her experience was a very pleasant one due to the good care she received. This statement was also backed by the experiences that was shared by **Participant A (27 years)**: *"The nurses checked my BP and told me to come to her every 2 hours so she can check for the baby's heartbeat. And that if I start feeling a lot of pain or if I think I want to go to the toilet I should call her she will come."*

Not every participant had the same positive feedback with regards to being assessed by nurses, **Participant I (25 years)**: *"When I arrived no one attended to me or checked me for over 2 hours. When a nurse eventually came, I told her I felt like I needed to go to the toilet, and she told me to lie down its not time. I didn't know what to do, it was an older nurse, so I was too scared to answer back or say anything."*

4.4.1.2. Care during active labor

Upon interviewing the participants, it seems a lot of the issues and problems that arise between nurses and patients is when the pregnant mother must deliver the baby. Most of the participants shared how the delivery process was very hard and even more unbearable because of how nurses treated and responded to them at that time.

It seems that nurses are very rude and don't seem helpful or supportive to patients when it's time for them to deliver their babies, **Participant E (36 years)**: *"When it was time for the baby to come the nurse told me to get on the bed, I was in a lot of pain, and I had forgotten I had my phone in my hand. The nurse then said I must get off the bed and go put my phone in the drawer because I want to record her. I asked the nurse to put it away for me and she refused and insisted that I get off the bed and do it myself, which I refused because I could feel the baby's head was coming out and I didn't want my baby to fall on the floor. The nurse said she wouldn't help me because I am being cheeky so I started shouting at her saying she must help me, and I threw my phone at her legs. Only then did she assist in delivering my baby."*

The poor treatment from nurses during labour is also supported by statements from **Participant O (37 years)**: *"The nurse was very rude, she accused me of wetting myself when my water broke. Yooh! It was so bad. That nurse didn't even tell me to get on the bed and she could see I was in*

a lot of pain, she just kept shouting at me, I just wanted to cry. When the baby came out, she said to me look its boy I'm sure you will keep coming back here because you are looking for a girl. It was so painful. I felt so down and lonely."

The poor service being provided by nurses during labour is also shown in the following statement

Participant I (25 years): *"When it was time to push, I was so scared, the nurse kept shouting at me so loudly I don't even know what she was saying because I was so scared and confused and just did not know what to do. After the baby came out, I had to get stitches and I was crying because it was so painful, but the nurse kept yelling for me to keep quiet I'm making noise."*

4.4.1.3. Post-natal care

Participants shared how they felt that nurses are mainly nice and friendly only after they have given birth. None of the participants expressed any bad behaviour or ill-treatment once in the post-natal ward.

Participants seem to have felt well taken care of and nurses showed interest and concern about the well-being of themselves, and their baby as reported by **Participant P (36 years):** *"I am honestly relieved to have given birth. The nurse checks on me and the baby. She also showed me how to hold the baby so that she can breastfeed well. It's surprising how nice the nurses are this side."*

Nurses were not only helpful but, also gave helpful advice to participants about how to care for their baby's, **Participant L (21 years):** *"I had dozed off and the baby woke up, that nurse told me to wash my hands first so I can pick up the baby. She advised me that I must wash my hands often before picking up the baby so that she does not get germs or get sick. She even showed me how to hold the baby's head properly see just look."*

4.4.2. Environmental Factors affecting maternal health services

When asking participants about what they thought about the overall environment of the hospital many of them expressed their disappointment about the hospital. The building itself looks very old and bushy, there are stains in the bathrooms and how the hospital looks like one is living in the bush. There are animals that roam in the wards, and it doesn't seem like a clean place where sick people should be in. These were just some of the things participants felt was lacking with regards to the overall environment of the hospital

4.4.2.1. Hygiene

The hospital does not appear to be clean to most of the participants and they have expressed how not much is being done to maintain a clean environment where patients can live once they have been admitted into the wards. There is a huge problem with regards to the level of hygiene being maintained

Participant N (19 years): *“Since I arrived yesterday until now, I have not seen anyone cleaning here. This place is very dirty.”* This participant expressed how the ward looked very dirty and that since she was admitted a day before she had not seen anyone come and sweep or mop the place, she was extremely unhappy about the place being dirty.

The bathrooms had stains in the bathtubs and in the toilets, it was very uncomfortable for patients to use these facilities and patients felt it was too unhygienic for a place where newborn babies had to be in, as said by **Participant M (29 years):** *“It’s not clean here at all, quite dirty. Even the stains in the bathrooms are so bad I don’t even want to sit on the toilet. This is not a clean place for a baby to be in”.*

4.4.2.2. Animals in the ward

Every participant spoke about how monkeys and cat’ roam freely within the ward at any time of the day. No one chases them away. And if one is not careful and leaves food unattended the monkeys can take your food, or you find cats eating your food.

One participant explained how she had left her food unattended for less than 5 minutes and when she came back her plate had been taken by a monkey, **Participant B (36 years):** *“There are cats and monkeys that get in the ward, and no one is chasing them away. I left my food on this table, and I went to the toilet, when I came back my food was gone. A lady next to my bed showed me a monkey outside that was eating and said it came in and took my food and it’s eating it.”*

The animals in the ward seem to be a problem for patients, especially those who do not like cats. This participant felt it was not safe at all to have animals in the ward or that patients are expected to sleep on the beds where cats or monkeys had been sleeping or sitting on, this was said by **Participant F (24 years old):** *“I don’t like cats at all and there are so many here. You will find a cat sleeping on the bed and the nurses will say go sleep on it without even changing the linen. It’s very bad.”*

Participant J (22 years): *“There are a lot of cats everywhere.”* This supports the fact that there are animals that roam freely within the wards.

Another participant told how she was so disgusted by seeing cats eating food that had been prepared for patients within the ward and for those reasons had refrained from eating any food served by the hospital and relied on food brought from home. **Participant O (37 years) said:** *“There was food in that tray which had been left by the entrance and a cat was busy licking that food. When the lady came back, she just hit the cat with a book and it ran away, but she proceeded to hand out the same food to patients in the ward. That is why I have not been eating the food here.”*

4.4.2.3. Infrastructure and surrounding

Participants were not impressed with the overall environment of the hospital. The hospital has been described as old and falling apart, it has not been well maintained

Participant J (22 years): *“This building looks like it can fall any time, just look at that ceiling coming off. This place is old.”* This participant showed how parts of the ceiling in the ward had come off and that the structure of the entire hospital building looks too old in such a way that it might collapse with people in it.

There are huge trees and thick high bushes that surround the hospital and within the hospital grounds the grass is very high. The area is very dense and bushy, and this has a participant worried about safety with regards to animals such a snake`s being a common thing in such a bushy environment as said by **Participant H (32 years):** *“This hospital is too bushy, it’s almost as if it’s a forest. What if there are snakes here and come into the ward and bite us?”*

Participants are expecting a certain level of cleanliness in a hospital and when one sees’ cleaner come and mop, but the area is still untidy it becomes very confusing and unsettling for patients. This was said by **Participant A (27 years):** *“I don’t understand why this place looks so untidy, I have seen cleaners come in and mop, but it still looks dirty.”*

4.4.3. Lack of resources

There are resources that the hospital seems to be lacking, things such as pads, blankets and there being water shortages are some of the resources that participants complained about. Interview also revealed that patients had to take turns to bath because sometimes water gets finished, and one would have to wait until there`s water to bath. This also affects the functionality of flushing the toilets

4.4.3.1. Materials

Participants shared how they were not given enough pads after giving birth and how there was one thin blanket on each bed and the ward was very cold. It was also stated that the newborn babies were not given warm blankets to be wrapped in.

Participants expected to have a bed with a warm blanket for them to sleep in, but the hospital only provides for one very thin blanket, this is shown by Participant **J (22 years)**: *“There are no blankets in this hospital, they gave us thin ones and it gets very cold at night.”* This sentiment was also shared by **Participant A (27 years)** who said: *“These beds don’t have proper blankets it gets very cold at night.”*

Some participants expected the hospital to offer them pads after they have given birth. They were offered pads but when more were needed the participants were told that there weren’t enough pads anymore so they couldn’t be given any more. **Participant F (24 years)** said: *“After I gave birth they gave me a pad, but I was bleeding a lot, so I asked the nurse for another pad, and she told me there aren’t enough pads to be given more. Just imagine Yooh!”*

4.4.3.2. Shortage of water

The hospital does not have water running all day. There are times where water is finished, and this means that patients cannot bath and that toilets are not flushing. This becomes a huge health concern and culminates into a dirty and smelly ward.

Participant D (38 years) said: *“There is only cold water to bath in. in the morning I had just gotten in the shower then the water was finished before I could finish bathing. When I told the nurse about the water not coming out, she said it’s just finished I must wait maybe an hour then I can go bath to bath. The toilets weren’t flushing either, so it was so smelly and dirty until the water came back.”* The issue with no water compromises the level of care and hygiene with regards to how patients will be able to keep themselves clean or not after giving birth and just how the ward will smell should toilets be defective.

Patients should be able to have access to clean water when they have been admitted in the ward, instead of having to ration how and when water can be used. This is supported by what was said by **Participant B (34 years)**: *“The nurse told us that we had to wait and take turns to bath because water won’t be enough for everyone, and it gets finished.”*

4.4.4. Attitudes of nurses towards patients

This section revealed that patients are not receiving the best quality care in the maternity ward. Participants shared how they were verbally and physically abused by nurses. That nurses

attended to them while portraying bad attitudes. Preferential treatment was given to Indians while Zimbabweans were ill-treated. Information regarding the health status of a patient is not always communicated or shared with patients, though some patients were well informed about what was happening and why it had to be done that way.

4.4.1.1. Physical and verbal abuse

The findings revealed that majority of the participants reported as to having poor experiences by receiving bad attitudes from nurses, some reported having been too terrified to ask for help or assistance due to the attitude and behavior of the nurses towards them and other patients who were in the ward. Participants said nurses were rude, abusive, and ill-treated them. In this study, this statement was supported by **Participant C (27 years)**: *'I was feeling so much pain and could feel the baby was coming, then I called out to the nurse to come and help me because the baby was near. The nurse then started shouting at me saying I am making noise how do I know the baby is here because they have already checked me. I just didn't know what else to do because the pain was just too much painful.'*

Nurses are expressing verbal and physical abusive behaviour towards their patients; this was also supported by what was said by **Participant F (24 years)**: *"I was screaming because of the pain. The nurse came and checked me and told me the baby was still far. The pain just kept coming and I was calling out to the nurse, when she came back, she was slapping my back very hard saying I should stop making noise she wasn't there when I made the baby and she left. I was walking around in the ward making a lot of noise because of the pain then I got on the bed because I could not walk anymore, then I called for the nurse, and no one came. I started to feel this big pressure and pain and I was screaming even more loudly, and the baby came out right there on the bed. I was so scared because I was alone. The nurses ran to me and were shouting at me saying what did I do? Who told me to push the baby? They were very angry at me."*

The abusive behaviour that nurses portray is very intimidating towards other patients and makes it very difficult for patients to willingly go seek help from the nurses even though they are in pain and do need medical assistance, this is supported by statements made by **Participant K (21 years)**: *"After I got my file, I arrived at that ANC ward and I found a nurse shouting at this other lady, I got so scared, so I just sat on the bench by the entrance. Maybe an hour went by, and no one came to me, and I knew the nurses saw me, so I went over to them. The nurses asked me why I just came and sat by the door without saying anything. I hesitated and said I was scared*

because you were shouting at that girl over there. They just laughed and said “is this how I behave at home? Just enter a house without greeting naa?” I gave them my file and one of the nurses showed me to a bed and she checked me. They were nice to me shem. Maybe it’s because I was following the instructions they were giving. They didn’t give me any attitude at all.”

One participant did however show that she was treated well by a nurse **Participant M (29 years):** *“The nurse helped to get on the bed because I was not feeling well, my stomach was very painful, but she told me that I should try lie down since I’m only 2cm and to call for her if the pains get worse. She was so nice to me.”*

4.4.1.2. Unfair discrimination and ill-treatment

A few participants indicated that nurses treated people differently if one is from Zimbabwe or is Indian. It seems that patients felt they were not all treated equally or the same and this seemed very unfair. **Participant G (36 years):** *“The nurses must treat us all the same, there’s no need to make Indians feel better than us. We all the same here.”*

The unfair treatment seemed to be based of discrimination, one Indian patient in the ward seemed to have been given special treatment over everyone else, this is based on what was said by **Participant H:** *“These nurses are somehow. They tell us visiting hours is only at 12 but that Indian over there had visitors come in when it was 3 and they were many people almost 10 busy crowding the ward and making noise, but the nurses didn’t say anything. When we get visitors, they will say we can only allow 2 people inside then they tell them to leave at 1. It’s not nice when they do these sorts of things.”*

A participant alluded to the fact that she was treated poorly because she is a Zimbabwean. **Participants C:** *“When my water broke, I was standing by a bed, and it made a big mess. The nurse was so angry busy shouting at me saying you Zimbabweans like coming here to give birth, look at the mess you have made tomorrow you want to go on radio saying we are bad but here you are busy making all these mess. You people must go home and start giving birth there. I felt like crying. Another nurse came and checked me then she said it doesn’t look like there is a way for the baby I will have to go for C-section, this was so scary for me.”*

4.4.1.3. Lack of transparency

Interviews revealed that participants all wish to know what is happening when doctors and nurses come and attend to them. They prefer to have full information concerning their health and the

health of their baby. Some participants were never told why certain procedures were being done or what the purpose of such procedures is.

Participant J (22 years): *“The nurse was rude. I didn’t even know how many centimeters I was every time she would check me. When I asked her how long she thought it would take for the baby to come she didn’t answer. Even when she was taking my blood, she didn’t say what the bloods tests were for. Yoooh! Ha ah, these people are somehow.”* This indicates how nurses are not being transparent about the procedures being done on their patients, no care is given towards giving patients full information about what is being done or why the procedure is being done.

Conversely another participant expressed how she had felt relieved during her C- section when doctors paid attention to what she was saying, and they made sure she was well medicated throughout the procedure. **Participant Q (31 years):** *“I was admitted because it was an emergency and the doctor told me I was going to get a C-section because the baby’s heartbeat was very low, but not to worry too much. When I was inside the theatre, they started to cut me and I told the doctor that I can feel what they are doing, he then told me that they are going to increase the dose so that I won’t feel anything. After a little while he asked me if I could still feel anything, and I said no. Shooo! It was such a relief. Afterwards when I woke up, they brought my baby and told me that the operation was a success. I was very happy.”*

4.5. Summary of this chapter

The results revealed that there are poor maternity care services being provided to women at Tshilidzini Hospital. The quality of the maternity care service is extremely low and qualified trained nurses are mistreating women who are in labour, there is a lot of verbal and physical abuse happening within the maternity wards. Threats and ill-treatment seem to stem mostly from nurses who attend to women during the childbirth process.

It is also revealed that the infrastructure of the hospital is in a poor state. Hygiene being one of the major issues. Water is scarce, the building is not being repaired or maintained; the area around the hospital is bushy and does not look clean. There are animals inside the hospital wards where patients are. There is a high risk of infections being spread easily due to unhygienic behavior and the number of animals that patients are exposed to. For Tshilidzini Hospital to be able to improve its standard of care there are many things that need to be changed not just regarding the building structure or practices of cleanliness but also workshopping their staff and improving patient care principles.

CHAPTER 5: DISCUSSION OF FINDINGS

5.1. Introduction

The previous chapter focused on the results, demographic information of participants and themes which emerged from data. This chapter focuses on the main findings of themes and links them with reviewed literature.

5.2. Objectives of the study

The main aim/purpose was to explore and describe women`s experiences regarding the maternity care services which they received before, during and after childbirth.

5.3. Women`s experiences in the provision of maternal health care

The findings of the study revealed that most of the women are receiving good quality pre-natal care. Continuous assessment of vitals is done by nurses on their patients. According to Cardona-Morell, Prgomet, Lake, Nicholson, Harrison, Long, Weatbrook, Braithwaite and Hilman (2016) the continuous assessment of vital signs on patients by nurses guarantees that the patients will have a more clear and detailed medical history and early detection of potential health risks.

Good pre-natal care assists nurses being able to foresee any possible complications that may arise with their patients, and it also affords their patients peace of mind that their health needs are being met. Liu, Chen, Chan and Chen (2025) have illustrated that good prenatal care not only benefits the infant but the mother as well. Especially women who had vaginal deliveries. Having experienced good prenatal care also reduces the chances of post-partum maternal hospitalization. This creates a positive impact on infant and maternal health.

The major problem seems to arise during active labour stage, all participants expressed how nurses were rude, abusive, used derogatory language and made their childbirth process very stressful and unbearable. Zitha and Mokgatle (2020) show how midwives` attitudes and behaviour were abusive and left women fearful and anxious, this also made some women push the baby before it was time to get attention and care from the midwives. The childbirth process felt very strenuous and hostile to the pregnant women.

During the post-natal stage this study revealed how women had a positive experience and that nurses were helpful and kind towards them and their infants. There was continuous assessment of both infants and the moms; and that women felt that their needs are being met.

5.4. Environmental factors affecting maternal health services

This study has revealed that for patients to receive good quality maternal care the environment of the hospital and its surroundings play a huge important role in providing such quality care. Tshilidzini Hospital looks dirty, patients reported how dirty the bathrooms and full of dirty stains. Another patient reported how since she was admitted she had not seen any cleaners come in and clean the ward she was in. The hygiene level is very poor and unsanitary, especially for a ward where newborn babies are in. There is a high chance of bacteria and/or infection spreading due to the uncleanliness of the wards. Bouzid, Cumming and Hunter (2018) states that one of the main cornerstones of a safe environment is cleanliness and the maintenance of hygiene. Health facilities need to be able to offer their patients a clean hygienic environment to reduce the spread of viruses and to guarantee the health and safety of its patients.

The study showed how animals were a big problem at Tshilidzini Hospital. Monkeys and cats roam freely and unsupervised through the wards. No one restricts or chases these animals away. Cats sleeping on patient beds which is very unsanitary, and linen never gets changed once a cat or monkey sleeps on it. Patients are expected to sleep on the bed even though they see that a cat was sleeping on the same bed being offered to them. Food is left unattended, and cats and monkeys eat or lick the food, the same food is then still offered to patients to eat. This is unhygienic and not safe. Pathogens can be transmitted from the cats or monkeys to patients who might end up falling ill. The presence of these animals in the ward greatly increases the risk of diseases spreading. Murthy, Bearman, Brown, Bryant, Chinn, Hewlett, George, et al. (2015) conducted research stating how animals may be present in healthcare facilities for various reasons, however, to try reducing the cross transmission of pathogens from animals to human beings there must be little to no animals within health facilities. This is to ensure safety and well-being of individuals within the health facilities.

Another environmental issue that was revealed by the study is how the infrastructure is in a poor state. The hospital building structure is not being well maintained. The hospital looks old and worn out, parts of the ceiling are falling off in the ward and the hospital ground is bushy with grass at high levels. Patients expressed how the area does not feel safe with the possibilities of snakes being on the hospital premises. Bouzid, Cumming and Hunter (2018) state how women in developing countries expressed how good quality maternal health care service also included a good physical environment of the health facility. This contributed to a positive experience.

5.5. Lack of resources

For a health facility to be able to offer good quality services resources need to be available for patients to use. Muema (2016) shows that there is a relationship that exists between the resources available and good quality service in a hospital. For a hospital and hospital staff to deliver good maternal services there must be availability of staff and resources to care for patients. Patients expressed how one thin blanket was being offered to them and it was very cold at night they were not warm enough. Things such as pads were lacking, and patients could not be offered more than one pad after giving birth.

A serious issue was the shortage of water being experienced at Tshilidzini Hospital. Patients had to take turns to bathe due to water shortage, sometimes patients had to wait for water to be available before they could bathe. This made toilets smelly and unclean because patients could not flush the toilets due to the water shortage. Bouzid, Cumming and Hunter (2018) showed how women in Bangladesh, India, Thailand and Gambia rated good quality maternal services due to them services such as availability of water, clean drinking water and clean toilets.

5.6. Attitudes of nurses towards patients

The study revealed how nurses are providing poor and low standard of maternal care towards patients. WHO (2022) has set out guidelines that ensure the health and safety of pregnant women and their newborn which healthcare providers must follow to have a positive and supportive environment for pregnant women.

Women expressed how the nurses were not friendly or kind towards them. They were shouted at while in labour, nurses were rude and abusive and used offensive and derogatory language towards their patients. In a study conducted by Heys, Downe and Thomson (2021) women reported that healthcare providers who offered them care during their childbirth expressed judgmental towards them; and that these healthcare providers were rude and arrogant, made inappropriate and racially abusive comments towards them. Verbal abuse Zitha and Mokgatle (2020) found that some women experienced midwives shouting at them, and rude remarks being made, these left the pregnant women feeling fearful, anxious and very nervous to be in the hospital, the hostile environment left the pregnant women feeling unsafe and very scared of the midwives.

Participants gave the impression how a Zimbabwean patient was not treated well, yet an Indian get special treatment. Visiting hours were not shared at equal allocated times. An Indian lady

could have almost 10 visitors at the same time and their visitors would stay past the allocated visiting time. There was unfair discrimination being practised amongst the patients, nurses were not treating everyone the same way due to ethnicity. Higginbottom, Evans, Morgan, Bharj, and Hussain (2019) conducted a study in the UK about the immigrant women's experiences of their access to maternal healthcare. Women reported having had a negative experience in that they found the health professionals rude, discriminatory, and very insensitive towards their cultural and social needs. This led to women losing interest in utilising the maternity care services which were being provided. Small, Roth, Raval, Shafiei, Korfker, Heaman et al. (2014) also conducted a study which supports how immigrant women had a negative experience in that there was poor communication with the healthcare providers, the immigrant women perceived their caregivers to be unkind, discriminatory, and not respectful.

Lastly, the study also revealed how there is no transparency with regards to sharing information by nurses. Nurses were conducting physical examinations such as drawing blood, or checking how many centimeters a patient was and not disclosing to the patients because the procedure is being done or seeking consent. These left patients feeling very nervous and anxious because they did not know if everything was ok or not. Jenkins, Ford, Morris and Roberts (2014) state that for healthcare providers to ensure a positive experience for pregnant women there needs to be open communication between the caregiver and their patients. Women seem calmer and happier when they are continually informed about the care and procedures that they receive from their healthcare providers.

5.7. Summary of this chapter

The study described women's experiences of maternity care services which they received before, during and after labour. According to the responses given by these participants the quality of maternity care service being provided at Tshilidzini Hospital is very poor. Participants have shown how they had a negative experience of the kind of maternity care which they received at Tshilidzini Hospital. These negative experiences were largely due to the bad attitudes and poor treatment that they received from nurses, the lack of resources at Tshilidzini Hospital and the uninhabitable environment surrounding the area of the hospital.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1. Introduction

The previous chapter discussed the presentation and findings of data collected from participants. This chapter will focus on the conclusion and the recommendations of the study.

6.2. Summary of the study

The study purpose was to explore lived experiences of women regarding the maternity care services in selected hospitals in Vhembe District, Limpopo Province. The central question was: ***“May you please share your experience about the care you have received since you arrived at the hospital until now.”***

A qualitative study approach was adopted. A phenomenological design was used to target women in the maternity ward who received maternity care services before, during and after childbirth. Participants were sampled purposively until data saturation was attained at 14 participants, but the researcher continued to collect data to ensure that no new information emerged until participant 18. The data was analysed through an interpretative phenomenological analysis and all precautions to ensure trustworthiness of the research findings were adhered to. Based on these findings’ recommendations were made.

6.3. Study limitations

The study was conducted at Tshilidzini Hospital only and the results cannot be generalized to all hospitals in the Limpopo province.

Some participants refused to be recorded despite the researcher having informed them of anonymity and confidentiality, so the results cannot be generalized to all hospitals in the Vhembe District.

6.4. Study recommendations

Based on the findings of the study, the following recommendations were made:

6.4.1. Recommendations for the Department of Health

The findings of this study will provide vital insight on the quality of maternal care currently being provided at Tshilidzini Hospital. This will assist the Department to assess if the care being provided is in line with the principles of maternal care provided and stipulated in the maternity

care guidelines. This will afford the Department to bridge the gap being provided and to provide good quality maternity care services

With the information that the study has made, respect and humanity will be able to be achieved for women with regards to how pregnant women would love to be treated when they give birth.

The findings of the study may also shed light on how to reduce any childbirth complications that may arise during childbirth and postpartum.

6.4.2. Recommendations for future researchers

Future researchers may seek to find out if good quality maternity care is being provided in hospitals.

Future researchers may also seek to enquire how good quality maternity services is important in ensuring good physical and mental health for women who have given birth.

6.5. Conclusion

Maternity care services are the cornerstone of ensuring the health and safety of pregnant women and their newborn. It is the responsibility of healthcare facilities and all healthcare providers to ensure that the maternity services being provided to pregnant women are of good quality.

The provision of good quality maternity care services improves woman`s prospects on future pregnancies. Good quality maternity care services also provide women with a sense of security and safety during childbirth. It also reduces childbirth complications and injuries and post-partum health complications.

In conclusion, this study has shown that healthcare providers at Tshilidzini Hospital are providing poor maternity care services to pregnant women during childbirth process. There is still a gap between the care that is being provided and quality maternal healthcare guidelines that have been set out. For maternity care services to be of good quality, it not only depends on the services being provided by healthcare providers, but it also depends on a clean and safe environment.

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APPENDICES:

APPENDIX A: INFORMED CONSENT

RESEARCH ETHICS COMMITTEE

UNIVEN Informed Consent

LETTER OF INFORMATION

Title of the Research Study : Women`s experiences regarding poor maternity care in the selected hospitals of Vhembe District, Limpopo Province

Principal Investigator/s/ researcher : (*Tshiembe Masibigiri BSW*)

Co-Investigator/s/supervisor/s : (*Dr. A.G. Mudau, PHDPH*)

Brief Introduction and Purpose of the Study: The study is about women`s experiences regarding poor maternity care in the selected hospitals of Vhembe District, Limpopo Province. The purpose of the study is to explore the experiences of women regarding the maternity care services in selected hospitals in Vhembe District, Limpopo province.

Outline of the Procedures : The participant will sat down with the researcher for an interview wherein the participant shared their experience of the care they have received in

the hospital. The interview was recorded, and the researcher took down notes as the interview was being conducted. No personal details of the participant was shared or included in the study. The interview was conducted on the hospital premises. The participants were free to end the interview at any time they wished to do so. Only women who gave birth and were being discharged at the time of data collection were included as participants in the study. No form of medication or treatment was given to the participants during the interview. The only expectation was for the participant who willingly preferred to give honest information about their experience of the care that they have received since they arrived at the hospital.

Risks or Discomforts to the Participant: There are no risks or discomfort anticipated that you may get by participating in this study.

Benefits : There are no financial benefits or reimbursements for participating in this study.

Reason/s why the Participant May Be Withdrawn from the Study: Should the participant fall ill or choose to withdraw consent; they are free to do so and there is no penalty or consequences for withdrawing consent

Remuneration : There was no remuneration given to the participants

Costs of the Study : Participants were not expected to pay any form of money to participate in this study.

Confidentiality : Confidentiality was maintained throughout the entire process of the study. No names, personal information of any identification were required from the participants and were not included in the study.

Research-related Injury : Should the participant suffer any injuries during the interview, the researcher would not be held liable. No compensation would be afforded by the researcher.

Persons to Contact in the Event of Any Problems or Queries:

(Dr A.G. Mudau tell: 015 962 8601) Please contact the researcher (Tshiembe Masibigiri cell: 073 036 4799.), my supervisor (tel no: 015 962 8601). University Research Ethics Committee Secretariat on 015 962 9058 / Vanecia.Khoza@univen.ac.za

Complaints can be reported to the University Research Ethics Committee Secretariat on 015 962 9058 / Vanecia.Khoza@univen.ac.za or Whistle blowing Ethics Hotline Tollfree Telephone number: 0800212755 Email.univenhotline@tipoffs.com

General:

Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population.

CONSENT FORM

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, **(Tshiembe Masibigiri)**, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: **FHS/23/PH/26/0602**
- I have also received, read, and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.

- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant

Date

Time

Signature

I, ...

(Name of researcher) herewith confirm that the above participant has been fully

Informed about the nature, conduct and risks of the above study.

Full Name of Researcher

.....

Date.....

Signature.....

Full Name of Witness (If applicable)

.....

Date

Signature.....

Full Name of Legal Guardian (If applicable)

.....

Date.....

Signature.....

Please note the following:

Research details must be provided in a clear, simple and culturally appropriate manner and prospective participants should be helped to arrive at an informed decision by use of appropriate language (grade 10 level- use Flesch Reading Ease Scores on Microsoft Word), selecting of a non-threatening environment for interaction and the availability of peer counseling (Department of Health, 2004)

If the potential participant is unable to read/illiterate, then a right thumb print is required and an impartial witness, who is literate and knows the participant e.g. parent, sibling, friend, pastor, etc. should verify in writing, duly signed that informed verbal consent was obtained (Department of Health, 2004).

If anyone makes a mistake completing this document e.g. a wrong date or spelling mistake, a new document must be completed. The incomplete original document has to be kept in the participant's file and not thrown away, and copies thereof must be issued to the participant.

References:

Department of Health: 2004. *Ethics in Health Research: Principles, Structures and Processes*

<http://www.doh.gov.za/docs/factsheets/guidelines/ethnics/>

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http://www.nhrec.org.za/?page_id=14

APPEMDIX B: LETTER OF PERMISSION (PROVINCIAL DEPARTMENT OF HEALTH)

P.O Box 81
Thohoyandou
0950

Enquiries: Masibigiri T
Cell: 073 036 4799
E-mail: 11629526@mvula.univen.ac.za

Requisition for permission to conduct research: Limpopo Province Department of Health Ethical Committee

I MASIBIGIRI TSHIEMBE a master's student at the University of Venda request permission to conduct research at the district hospitals in Limpopo Province. The title of the study is **“Women`s experiences regarding poor maternity care in the selected hospitals of Vhembe District, Limpopo Province.”**

The purpose of the study

The study aims to explore the experiences of women regarding the maternity care services in selected hospitals in Vhembe District, Limpopo province.

The significance of the study

- The findings of the study might benefit the Department of Health in shedding light on why child mortality and maternal death cases still occur.
- The findings of the study might help the Department of Health gain insight on how to bridge the gap between poor health care services and the implementation of maternity guidelines by healthcare providers.

If you have any queries on the matter which is not reflected in this correspondence, the contact details are as follows:

Researcher : Masibigiri T
Cell number : 073 036 4799
E-mail : 11629526@mvula.univen.ac.za
Thank you in anticipation

APPENDIX C: LETTER OF PERMISSION (VHEMBE DISTRICT DEPARTMENT OF HEALTH)

P.O Box 81
Thohoyandou
0950

Enquiries: Masibigiri T
Cell: 073 036 4799
E-mail: 11629526@mvula.univen.ac.za

Requisition for permission to conduct research: Limpopo Province Department of Health Ethical Committee

I MASIBIGIRI TSHIEMBE a master's student at the University of Venda request permission to conduct research at the district hospitals in Limpopo Province. The title of the study is **“Women's experiences regarding poor maternity care in the selected hospitals of Vhembe District, Limpopo Province.”**

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- The findings of the study might help the Department of Health gain insight on how to bridge the gap between poor health care services and the implementation of maternity guidelines by healthcare providers.

If you have any queries on the matter which is not reflected in this correspondence, the contact details are as follows:

Researcher : Masibigiri T
Cell number : 073 036 4799
E-mail : 11629526@mvula.univen.ac.za
Thank you in anticipation

APPENDIX D: LETTER OF PERMISSION (TSHILIDZINI HOSPITAL)

P.O Box 81
Thohoyandou
0950

THE MANAGER
Tshilidzini Hospital
Private bag x 919,
0945

Enquiries: Masibigiri T
Cell: 073 036 4799
E-mail: 11629526@mvula.univen.ac.za

Requisition for permission to conduct research: Limpopo Province Department of Health Ethical Committee

I MASIBIGIRI TSHIEMBE a master's student at the University of Venda request permission to conduct research at the district hospitals in Limpopo Province. The title of the study is **“Women`s experiences regarding poor maternity care in the selected hospitals of Vhembe District, Limpopo Province.”**

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- The findings of the study might help the Department of Health gain insight on how to bridge the gap between poor health care services and the implementation of maternity guidelines by healthcare providers.

If you have any queries on the matter which is not reflected in this correspondence, the contact details are as follows:

Researcher : Masibigiri T

Cell number : 073 036 4799

E-mail : 11629526@mvula.univen.ac.za

Thank you in anticipation.

APPENDIX E: INTERVIEW GUIDE

INTERVIEW GUIDE ON WOMEN`S EXPERIENCES REGARDING POOR MATERNITY CARE IN THE SELECTED HOSPITALS OF VHEMBE DISTRICT, LIMPOPO PROVINCE

Age

Race.....

Name of hospital

When did you give birth?

Is this your first time being admitted at this hospital?

(a) May you please share your experience about the care you have received since you arrived at the hospital until now?

APPENDIX F: DEMOGRAPHIC INFORMATION

Date: 22 April 2024

Venue: Post-natal ward Tshilidzini Hospital

Time: 09:30-09:55

Participant code: Participant B

Age of participant: 34 years

Name of interviewer: Tshiembe Masibigiri

My name is Tshiembe Masibigiri. I would like for us to set some rules for the interview before we begin. Thank you so much for agreeing to partake in this interview. The interview will last roughly 20 – 30 minutes. During the interview I will jot down some notes and also record our interview. If you would not like the interview to be recorded please let me know. If at any point during our interview you feel uncomfortable about any questions please feel free not to answer them. You are free to answer or refuse to answer anything I will ask you. You are also free to stop participating in the interview should you feel you are uncomfortable or you no longer wish to partake in the interview. Although the interview will be recorded I will not share any personal information such as your name. It is important that you share your feelings and emotions freely, there are no right or wrong answers.

I am conducting research on Women`s experiences regarding poor maternity care in the selected hospitals of Vhembe District, Limpopo Province. It includes any care received before, during and after childbirth.

I would like you to provide permission and consent for us to continue with the interview by signing below:

Interviewer's Signature: _____ date: _____

Central Question

May you kindly share your experiences about the care you have received from nurses and doctors since you have arrived.

Close the Interview

Thank you for your time and ideas. This has been extremely helpful

APPENDIX G: TRANSCRIPT

Date: 22 April 2024

Venue: Post-natal ward Tshilidzini Hospital

Time: 09:30- 09:55

Interviewer: Hello, my name is Tshiembe Masibigiri and I am a student at University of Venda currently studying for my master`s in public health. I am conducting a research study on **Women`s experiences regarding poor maternity care in the selected hospitals of Vhembe District, Limpopo Province.**

Interviewer: Would you be comfortable to partake in an interview of sharing your experiences which would be used for research purposes of my research project?

Participant B: Yes

Interviewer: You will have to sign a written consent form that you agree to participate in the interview, is that okay with you?

Participant B: Yes, it fine

Interviewer: Are you comfortable with me recording our interview?

Participant B: why does it need to be recorded?

Interviewer: So that I do not miss any important information that you will share with me, I will not share the recording with anyone or publicize them. It`s solely for gathering information accurately for this research project. Is that okay with you?

Participant B: ow okay, its fine if you record

Interviewer: Thank you

Interviewer: I am going to ask you some questions just so I can gain a better understanding of who you are and the method of childbirth, you do not have to answer any questions you are uncomfortable with.

Interviewer: How old are you?

Participant B: 34 years

Interviewer: How many times have you been admitted at Tshilidzini maternity ward?

Participant B: This is my third time

Interviewer: Did you have a caesarian section or vaginal birth?

Participant B: I had a vaginal birth

Interviewer: Ok thank you. May you please kindly share with me your experience about the care you have received since you have arrived at the hospital until now?

Participant B: Yooh. It has been good and bad.

Interviewer: follow up, May you please tell me more about what you mean by good and bad.

Participant B: I arrived here yesterday because I was in labor, I went and got my file and the nurse told me to go to the ward.... (Looks around nervously)

Interviewer: Please tell me more about what happened

Participant B: Well, I got to the ward and there were other women there. This is not the first time I have given birth, so I know the ward very well. I was in a lot of pain, and I gave the nurse my file and she showed me which bed to use. The nurse told me to get on the bed she is coming back

Interviewer: Did the nurse come back?

Participant B: Yes, she did. When she was examining me there was another lady in the ward who was screaming and in a lot of pain, she was making me very nervous. Just as she finished with my examination the nurse told me that the baby is still far and to call her if I feel anything changing. Then another nurse walked in and started shouting at the girl who was screaming.

Interviewer: What happened next?

Participant B: I felt bad for the girl, but I did not say anything because I didn't want to upset the nurses, you see it's not my first time in this hospital so I know that it's not a good idea to upset the nurses. Plus, the pain I was feeling was getting worse so I just started walking around the ward.

Interviewer: You mentioned that it's not a good idea to upset the nurses, please tell me more.

Participant B: I have seen that when you don't follow instructions or upset the nurses with your behavior, they will shout at you or just not help you.

Interviewer: Is this something that you have experienced before from the nurses?

Participant B: No, but I have seen it happen to other women, even when I gave birth to my son in 2019 it was the same. I always listen and try not to make noise and the nurses help me.

Interviewer: Do you feel you were helped even now?

Participant B: Yes, when the baby arrived the nurse who helped me give birth was very helpful. She told me not to waste energy too much when I push so that the baby must not get tired. By the time the baby arrived I was very tired, but I was glad that it was over because the pain was just too much. (Giggles)

Interviewer: You sound very satisfied and happy right now, is that correct?

Participant B: Yes, I am happy because my baby arrived and is healthy. That's all that I wanted.

Interviewer: Congratulations on your baby, I'm glad he is healthy.

Interviewer: You mentioned earlier on that your experience was good and bad

Participant B: Ow, yes this was the good part, let me tell you what I was not happy about

Interviewer: Ok, tell me more

Participant B: After I gave birth, I was brought here with my baby. At night food was brought for us to eat, I got my plate and I put the plate on my bed because I needed to go use the toilet. When I came back from the toilet my plate was gone, I was so confused I asked the lady on the bed next to me if she had seen my food. She told me that a monkey took my plate, then showed me to a monkey outside that was eating my food. I was so shocked.

Interviewer: Are you saying the monkey came inside the ward when it took your food?

Participant B: Yes, the monkey came inside and took it. I even told the nurse that my food was taken.

Interviewer: What did the nurses say or do after you told them that your plate had been taken by a monkey?

Participant B: She told me that she will try ask the serving lady to get me more food and that I should be very careful not to leave my food lying around unattended because it might get taken again.

Interviewer: Did you manage to get food?

Participant B: Yes I did

Interviewer: Ok, that's good. Are the monkeys inside the ward or outside?

Participant B: Both, I have seen them inside the ward and when I go outside. They are everywhere. You can even find cats sleeping on the beds here inside the ward. It's very bad. The hospital needs to do something and get rid of these animals.

Interviewer: What do you think the hospital can do to improve this situation with the cats and monkeys?

Participant B: I feel like they should hire people to come and catch these animals so that they no longer disturb us in the wards.

Interviewer: Ok, thank you I will note that down.

Interviewer: Is there anything else you would like to share about your experience here at Tshilidzini?

Participant B: Yes, in the morning we had to go and bath and the nurse told us that we will have to wait and take turns when we bath because water gets finished.

Interviewer: How many people managed to bath?

Participant B: We all eventually managed to bath, but only 4 people at a time then we would wait maybe 20 or 30 minutes then another 4 would bath. And there was no hot water so we bathed in cold water.

Interviewer: Is there anything else you would like to share?

Participant B: Mmmh no, that's all.

Interviewer: Would you say that your experience of maternity care service you have received at Tshilidzini Hospital is positive or negative?

Participant B: I cannot say it's positive because of all these animals that are just running around. And they really need to solve the issue of water, especially now when it's starting to get cold. We can't bathe in cold water.

Interviewer: Thank you, we have come to the end of the interview

Participant B: Okay.

APPENDIX H: PERMISSION LETTER FROM PROVINCIAL DEPARTMENT OF HEALTH



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
HEALTH

Ref : LP_2024-02-012
Enquires : Legodi P
Tel : 015-293 6028/6410
Email : Malesela.Legodi@dhsd.limpopo.gov.za

T MASIBIGIRI

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

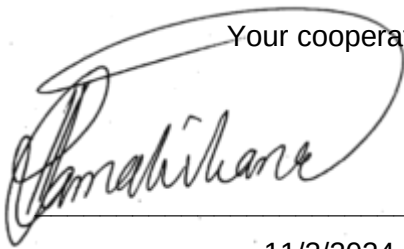
Your Study Topic as indicated below.

WOMEN'S EXPERIENCES REGARDING POOR MATERNITY CARE IN THE SELECTED HOSPITALS OF VHEMBE DISTRICT, LIMPOPO PROVINCE.

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
 - a. Present this letter of permission to the office of District Executive Director a week before the study is conducted.
 - b. This permission is **ONLY** for Tshilidzini Hospital
 - c. In the course of your study, there should be no action that disrupts the routine services or incur any cost on the Department.

- d. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
- e. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
- f. **The approval is only valid for a 1-year period.**
- g. If the proposal has been amended, a new approval should be sought from the Department of Health
- h. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.



11/3/2024

pp Head of Department

Date

Private Bag X9302, Polokwane 0700

Fidel Castro Ruz House, 18 College Street, Polokwane 0700

Tel: 015 293 6000. Fax: 015 293 6211. Website:
www.doh.limpopo.gov.za

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APPENDIX I: PERMISSION LETTER FROM VHEMBE DISTRICT

**LIMPOPO**
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

**DEPARTMENT OF
HEALTH
VHEMBE DISTRICT**

Ref: S8/4/2/3

Eng: Gertrude Baloyi

Date: 13 March 2024

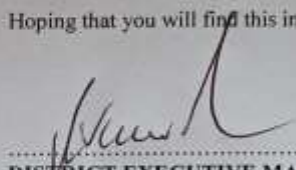
TO: T Masibigiri
University Of Venda

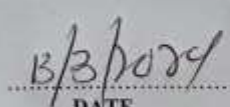
**SUBJECT: REQUEST TO CONDUCT A STUDY (RESEARCH) AT
TSHILIDZINI HOSPITAL IN VHEMBE DISTRICT**

**Your study topic: Women's experiences regarding poor maternity care in the
selected hospitals of Vhembe District, Limpopo Province**

1. The above matter has reference
2. The Department of Health has acknowledged your communiqué received on the 12 March 2024 for the above mentioned. Kindly be informed that permission has been granted to conduct a research at **Tshilidzini in Vhembe District from 18 March 2024- 11 March 2025.**
3. You are also advised to comply or adhere with the Departmental Policies, rules and regulations during your operations.

Hoping that you will find this in order.


DISTRICT EXECUTIVE MANAGER


DATE

VHEMBE DISTRICT, Private Bag X5009 THOHIVANDOU 0960
Old Parliamentary Building Tel (015) 962 1848, (015) 962 1852, (015) 962 1754, (015) 962 1001/2/3/4/5/6 Fax (015) 962 2373.

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APPENDIX J: PERMISSION LETTER FROM TSHILIDZINI HOSPITAL

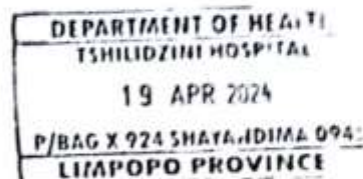


LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
HEALTH
TSHILIDZINI HOSPITAL

Ref: B/1/1
Enquires: Netshifhefhe L E
Date: 09 April 2024

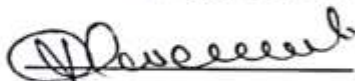
To: Masibigiri Tshiembe

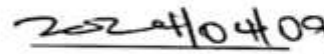


SUBJECT: WOMEN'S EXPERIENCES REGARDING POOR MATERNITY CARE IN THE SELECTED HOSPITALS OF VHEMBE DISTRICT, LIMPOPO PROVINCE.

1. The above matter refers.
2. Your letter received on the 18 March 2024 requesting for permission to conduct a study is hereby acknowledged.
3. Permission is therefore granted for the study to be conducted in Tshilidzini Hospital based on the approval letter you provided from the Head of Department Limpopo Department of Health and the Chief Director Health Services Vhembe District.

Wishing you success in your studies.


Chief Executive Officer


Date

Tshilidzini Hospital, Private Bag X924, SHAYANDIMA, 0945 Tel 015 964 4384, FAX 015 964 1492/015 964 1072
Physical Address: R524 PUNDA MARIA ROAD
An accessible, caring quality health and social development service for the people of Vhembe District.

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APPENDIX K: ETHICAL CLEARANCE

ETHICS APPROVAL CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:

Mrs T Masibigiri

STUDENT NO:

11629526

PROJECT TITLE: **Women's experiences regarding poor maternity care in the selected hospitals of Vhembe District, Limpopo Province.**

ETHICAL CLEARANCE NO: **FHS/23/PH/26/0602**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr. AG Mudau	UNIVEN, Advanced Nursing Science	Supervisor
Mr D Manyema	UNIVEN, Advanced Nursing Science	Co-Supervisor
Mrs T Masibigiri	UNIVEN, Advanced Nursing Science	Investigator – Student

Type: **Masters Research**

Risk: **Minimal risk to humans, animals, or environment (Category 2)**

Approval Period: **February 2024 – February 2025**

The Human and Clinical Trials Research Ethics Committee (HCTREC) hereby approves your project as indicated above.

General Conditions

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

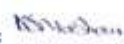
- The project leader (principal investigator) must report in the prescribed format to the REC:
 - Annually (or as otherwise requested) on the progress of the project, and upon completion of the project.
 - Within 48hrs in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
 - Annually a number of projects may be randomly selected for an external audit.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the REC. Would there be deviation from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date; a new application must be made to the REC and new approval received before or on the expiry date.
- In the interest of ethical responsibility, the REC retains the right to:
 - Request access to any information or data at any time during the course or after completion of the project.
 - To ask further questions; Seek additional information; Require further modification or monitor the conduct of your research or the informed consent process.
 - Withdraw or postpone approval if:
 - Any unethical principles or practices of the project are revealed or suspected.
 - It becomes apparent that any relevant information was withheld from the REC or that information has been false or misrepresented.
 - The required annual report and reporting of adverse events was not done timely and accurately.
 - New institutional rules, national legislation or international conventions deem it necessary.

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: **February 2024**

Name of the HCTREC Chairperson of the Committee: **Prof NS Mashau**

Signature: 



PRIVATE BAG X5050, THOHOYANONG, VHEMBE DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE: 018 354-5050 FAX: 018 354-5050
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APPENDIX L: EDITORIAL LETTER

Editorial letter

This serves to confirm that I, Dr. TE Sikitime, attached to University of Venda, Department of English Media Studies and Linguistics have proofread a proposal titled: **Women`s experiences regarding poor maternity care in the selected hospitals of Vhembe District, Limpopo Province.**

BY
TSHIEMBE MASIBIGIRI

STUDENT NUMBER (11629526)

Editorial work focused mainly on technical precision and common errors relating to syntax, diction, word order and formulation of ideas. Corrections and suggestions were made for the student to effect before submission.

Signature



Date 08/06/2024

Ext: 015 962 8262

Mobile: 0832561666

Email: Emmanuel.sikitime@univen.ac.za

BA (ed), BA (Hons) English, Univen, BA Communication Science UNISA, MA (SLS) Stellenbosch University , PhD (English) Univen

APPENDIX M: TURNIT IN REPORT

MASIBIGIRI_T_MINI-DISSERTATION_12102.docx

ORIGINALITY REPORT

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SIMILARITY INDEX

14%

INTERNET SOURCES

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STUDENT PAPERS