THE EXPERIENCE OF WOMEN REGARDING THE CARE THEY RECEIVED IN MATERNITY CARE - BOTSWANA

by

MPOLOKENG TUKUNI TSHIRELETSO

Mini dissertation submitted in partial fulfilment of the requirements for the degree

MAGISTER CURATIONIS

in

MIDWIFERY AND NEONATAL NURSING

in the

FACULTY OF EDUCATION AND NURSING

at

RAND AFRIKAANS UNIVERSITY

Study leader: Professor A.G.W. Nolte

Johannesburg: November 1997

ACKNOWLEDGEMENT

It is most pleasant to have a family as understanding and supporting as mine. Their endless support and encouragement cannot be counted, especially my children who put up with staying without a mum around the house for two years. The same goes to all my friends.

I am greatful to the Nursing Superintendent (Scottish Livingstone Hospital, Botswana) and her colleagues for allowing me to sit with them and discuss this problem area of research.

The women who agreed to participate in the researched are thanked so much because without the information they provided, this would not have been possible.

I am totally indebted to my study leader, Professor A.G.W. Nolte, for her kindness, patience and ability to keep me working even in times when I was stressful. Mooi bly.

Above all, I give my thanks and appreciation to my sponsors, World Health Organization, who made it possible for me to complete the study by providing financial support.

Lastly, I wish to thank Botswana Government for granting me study leave.

MAY GOD BLESS US ALL.

Mpolokeng Tukuni Tshireletso

SUMMARY

The study aims to explore and describe what experiences women had regarding the care they received in the maternity ward in Botswana. The women are looked at in the context of Nursing for the Whole Person Theory to ensure a holistic perspective.

This is an explorative and descriptive qualitative study in which phenomenological interviews were conducted with a sample population of ten women *post partum*. Methods of data analysis according to Collaizi (1978) and Tesch (1990) were employed. In order to ensure trustworthiness, Guba and Lincoln's style was adopted.

Literature control was undertaken to establish the comparativeness of the conclusions of this study to previous studies. Women had a mixture of experiences but it can generally be regarded that they received good care.

The conclusions which were reached led to notation of limitations as well as recommendations geared at improving nursing practice, education and research.

OPSOMMING

Hierdie studie is gerig op die verkenning en beskrywing van vroue se ervarings met betrekking tot die verpleegsorg wat hulle in die kraamsaal in Botswana ontvang het. Die vroue word benader in die konteks van die Verpleegteorie vir Mensheelheid.

'n Verkennende, beskrywende en kwalitatiewe studie is onderneem waartydens fenomenologiese onderhode met tien vroue *post partum* gevoer is. Metodes van data-analise soos deur Collaizi (1978) en Tesch (1990) beskryf, is gevolg, terwyl vertrouenswaardigheid verseker is deur Guba en Lincoln se styl te gebruik.

Literatuurkontrole is onderneem om die vergelykbaarheid van die gevolgtrekkings van hierdie studie met vorige studies te bepaal. Vroue het 'n verskeidenheid ondervindings gehad, maar oor die algemeen kan gesê word dat hulle goeie versorging ontvang het.

Die gevolgtrekkings waartoe gekom is, is dat daar sekere beperkings is. Aanbevelings spruit ook daaruit voort met die oog daarop om verpleegkundige praktyk, onderwys en navorsing te bevorder.

CONTENTS

CHAPTER 1

INTRODUCTION AND RATIONALE

1.1 INTRODUCTION

"Of all the phenomena that humans experience, birth is perhaps the most emotional, dramatic and awe-inspiring. All that a person becomes is dependent on many factors - heritage, prenatal environment, the care at birth and the care thereafter." (Reeder, Martin & Koniak 1992:4).

Maternity care, because of its focus on the recipient of care rather than the provider, implies a broader meaning of the care of the mother and her baby. It also emphasizes the importance of interpersonal relationships that are significant in the family and takes into consideration all the factors that are crucial in promoting the general health and wellbeing of the family.

Reeder, Martin and Koniak (1992:9-13) further assets that maternity nursing involves direct personal care to the child-bearing woman and her infant, as well as the related activities of teaching, counselling and supervising during various phases of the child-bearing experience. The significant aspect of this care involves purposeful, sustained interaction during which the nurse assesses of the client's problems and resources and hence acts appropriately and skilfully in the nursing process.

The child-bearing experience is strongly influenced by the culture of a given society, the changing economy, liability to legal suits, all based on the type of care the women and/or their families receive. In a study by Simpkin (1992), it is showed that women do not forget. They remember events of their birth and their feelings for at least twenty years. They remember specific words and actions by the professionals in attendance and may express deep appreciation for kind action, or they may express anger, hostility and hurt as a result of thoughtless or cruel things that were done to them.

When entering the hospital in labour, the women are probably anxious and frightened by the strange environment; they may be stressed by things totally irrelevant to the circumstances surrounding birth or even about who will take care of the family while they are admitted. Meanwhile, contrary to the woman's preoccupation, the midwife may have totally different priorities in which the woman is not even involved. Owing to the fact that the midwife will look after so many women at a time, providing appropriate care is a daunting task.

In a report on intrapartum care in 1984 (Chalmers, Enkin and Keirse (eds.), 1993), the majority of the 51 women who were interviewed stated that they felt welcome, whereas a few did not really feel welcome. In their conclusions, they stated that midwives should take it upon themselves to improve admission interactions with women, provide opportunity for discussion of women's requests, plans and worries about labour and delivery, as well as to provide information about what is going on - procedures and various examinations - in order to reassure. It is also important to address them respectively by names rather than by their problems, for example, the previous C/S, Multipara *et cetera*.

Garcia and Garforth (in Chalmers, Enkin and Keirse, 1993), in their review of hospital admission practices, concluded that *"the midwife admitting a woman to the labour ward is aced with a challenging task as she seeks to give appropriate and individual care and to balance the clinical and personal aspects of care. The effects of what she says and does to a woman at such a crucial time may be far-reaching and remembered."*

It becomes apparent from literature that consumer dissatisfaction with maternity services is not a new thing (Thompson & Williamson, 1996:198). It thus becomes important to carry out such a study in perseverance of appropriate and satisfying maternity care. Unless there is mutual understanding between women and the professional staff, complaints are bound to continue. Ultimately, the woman-care giver relationship may be enhanced and this will lead to respect for each other and involvement of each party in the delivery of a sound maternity service. It is also one of the objectives of the World Health

Organization (WHO), of which the researcher is a fellow, that the concept of safe motherhood was adopted especially in developing countries like Botswana - the aim being to replace the neglected 'M' in Maternal and Child Health (MCH) and reduce maternal mortality by 50% by the year 2000.

Several complaints have been lodged either formally or informally in various settings around Botswana, about the attitudes of midwives and unsatisfying standards of care mothers received while in maternity wards. The researcher has had personal contact with women who would take advantage of her friendship with them and talk about the negligent behaviour of midwives. They would emphasize that they were not saying the researcher should question their concern as they knew that she was also a midwife. They were just making the researcher aware of what was going on. The researcher has also had personal experience of 'ill-treatment' by her colleagues because she suggested some actions to be taken and, in another instance with PROM, was questioning the care given by the midwife. Another colleague ended with an emergent Caesarean section because of cord prolapse. She had been admitted with ruptured membranes, no labour pains and was told by the midwife to walk to a distant ward and, when asking for a bedpan, because she knew the dangers of PROM, she was told that she would simply have to go to the toilet. It was in the toilet where she diagnosed herself with a cord prolapse.

People have been talking and are still talking about the care they receive, for example, in the *Botswana Daily News* No. 17 of 1997, some residents complained to their Member of Parliament about treatment by some nurses. "Residents said some nurses are rude when they talk to people and do not even take emergency cases seriously because instead they would talk over the telephone for a long time" (*Daily News*, 1997:2). In this regard, the nurses referred to both general nurses and registered midwives, while the emergency case could be a child-bearing woman.

Studies revealed the importance of the attitudes of care-giving staff and the degree of emotional support they provide in order to preserve, protect and ensure the safety of mother and fetus (Simpkin, 1996).

In his study in Masunga, Botswana, Chipfakocha (1994) did a survey on attitudes of women towards traditional midwives. He noted in his study that *"there are environmental stressors that make the hospital experiences unpleasant and these include lack of communication, biomedical routines and technical interventions, specific hospital customs and expected patient behaviour, isolation from family and friends, and conflict of attitude and beliefs between health workers and parturients".*

Professor Makhokha (a WHO/UNICEF consultant on safe motherhood), in his study in Botswana in 1994 to find out why women delivered at home, concluded that *"staff attitude and performance and lack of support services and treatment similar to those provided at home are deterrent to women utilising health facility-based maternity services".*

The care givers were given an opportunity to determine whether they were providing the best possible care and 68,75% considered that they were doing their best (Omondi & Kobue, 1993:27).

It is thus based on these grounds that the researcher intends to find out from parous women who have already delivered in a maternity ward, their experiences with regard to the care they received.

1.2 PROBLEM STATEMENT

The question therefore arises: How do women experience the care that they receive in the maternity ward?

1.3 OBJECTIVES OF THE STUDY

- To explore and describe in the women's terms their experiences with regard to the care they received in the maternity ward.

- To make recommendations or suggestions geared towards improving maternity care in Botswana.

1.4 PARADIGM

The paradigm will be based on Nursing for the Whole Person Theory (Rand Afrikaans University, 1992:), the philosophy of Judeo-Christian and principles and biblical values. The theory, adopted from Oral Roberts University: Anna Vaughn School of Nursing (1990:136-142) reflects the focus on the whole being - the body, mind and spirit. The theory also focuses on the parameters of nursing service, which are individual, family and community as well as beliefs about man, health, nursing and environment.

1.4.1 Metatheoretical assumptions

- **Person**

According to NWPT (Rand Afrikaans University, 1992:), a person is a spiritual being who functions in an integrated biopsychosocial manner to achieve his quest for wholeness. A person is in constant interaction with both internal and external environments. A person in this study is the parous woman who delivered in a maternity ward.

- **Health**

Used synonymously with 'wholeness', health is a state of spiritual, mental and physical wholeness. A person's health is determined by patterns of interaction with internal and external environment. Illness potential exists in those who are healthy. The woman who is seeking assistance in a maternity ward should be able to interact holistically with both the internal and external environment in order to achieve wholeness (Rand Afrikaans University, 1992:).

- **Nursing/Midwifery**

A goal-directed service to assist individual, family and community to promote, maintain and restore health. Here, nursing refers to midwifery which is a specialised field and an integral part of nursing (Sengane, 1995).

- Maintenance of health refers to nursing activities which are directed at continuing and preserving the health status of individuals, families and community.

- Promotion of health refers to nursing activities contributing to a greater degree of wholeness for the individual, family and/or community.

- Restoration of health refers to those nursing activities which facilitate the return to the previously experienced levels of health of individuals, families or community.

- **Environment**

The concept refers to both internal environment, the nature of which is body, mind and spirit, and the external environment, which is physical, social and spiritual in nature. In this regard, the internal environment would refer to all those processes that take place within the woman's body, mind and spirit, and the external environment to all that takes place around her (physically, socially and spiritually).

1.4.2 Theoretical assumptions

Based on Nursing for the Whole Person Theory, from where theoretical assumptions are derived, the central statements here are:

- The individual is a holistic being who functions in an integrated biopsychosocial manner in his/her quest for wholeness.

- The midwife, through the health delivery system, facilitates promotion, maintenance and restoration of individual wholeness.

1.4.3 Methodological assumptions

The purpose of this research is to explore the experiences of the parous women during their encounter with the professional staff in a maternity ward. The researcher's view holds that good research yields action-orientated prescriptions for the improvement of practice. For this reason, the functional approach as described by Botes (1991) will be utilised. It emphasizes the usefulness and application of knowledge for the improvement of practice as an objective. Its usefulness in improving practice will also serve as criteria for validity. A model of nursing research (Botes 1995) will be used to guide the research processes.

1.5. THEORETICAL DEFINITION

Definitions are important because meanings of concepts are specified. *"Where the connotative meaning of a concept (the general intention or idea that it incorporates) is more closely specified, is referred to as theoretical definition."* (Mouton & Marais, 1994:131).

- **Experience**

"It is directly related to a person's internalisation of an event, which has been personally lived through. Factors may include emotions, thoughts, preferences, values, perceptions, et cetera" (Ceronio, 1992:7 in Sengane, 1995:8).

- **Parous woman**

This refers to a female within the child-bearing age (15 - 49 years) who has previously

given birth or delivered a baby.

- **Care**

The process of looking after somebody or the provision of what somebody needs for their health or protection (*Oxford Advanced Learners Dictionary*, 1995:168).

- **Midwife**

An individual who has successfully completed a prescribed midwifery programme, is registered with the local nursing council and duly provides a service which facilitates the safe and satisfying transition of woman to motherhood by supporting, caring, guiding, monitoring and educating (Royal College of Midwives, 1992:3).

- **Caregiver**

This shall refer to all those persons involved in the care of the mother, including midwives, doctors and other auxiliary personnel.

1.6 RESEARCH METHODOLOGY

- **Design**

The design of the study is an explorative, descriptive and qualitative. It is explorative because it involves listening to women as they reiterate their experiences and analyse the statements they make. It is descriptive because it will describe the experience they have had in the maternity ward.

- **Method**

A phenomenological study in which semi-structured interviews will be carried. It

becomes phenoemnological because it strives to describe the experiences as lived by the women themselves.

- **Data gathering**

Data will be gathered first by undertaking a pilot study of two women who will be asked the question: "Can you please share with me the experience regarding the care you received while admitted for delivery in the maternity ward?" The same question will be asked to a total number of ten (10) women. The criteria for choice of women would be a parous woman who has delivered in hospital before; she must speak English or Setswana. Again, she must have consented both verbally and in writing that she agrees to participate in the study.

- **Ethical considerations**

Ethical considerations by SANA (1991:1-5) will be enforced to emphasize privacy, anonymity, the right to participate or refuse, and termination if the participation so wishes.

- **Data analysis**

Data will be analysed concurrently with data gathering. Important themes will be noted as the interview progresses. The methods of analysis by collaizi (1978 in Holloway & Wheeler, 1996:125) will be used, together with Tesch (1990 in Cresswell, 1994:153-155).

- **Validity and reliability**

Methods by Guba and Lincoln (1985:290-320) for ensuring trustworthiness and the strategies of credibility, transferability, dependability and confirmability will be used. It is explained further in chapter two.

1.7 ARRANGEMENT OF CHAPTERS

The content of this mini-dissertation will be presented as follows:

CHAPTER 1: INTRODUCTION AND RATIONALE.
CHAPTER 2: RESEARCH DESIGN AND METHODS.
CHAPTER 3: DATA ANALYSIS.
CHAPTER 4: LITERATURE CONTROL.
CHAPTER 5: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS.

1.8 SUMMARY

This chapter describedthe conceptualisation of the research idea. It was aimed at describing all the processes that will take place in the process of this research. Being an orientation chapter it also attempts to ensure logic and justifiability of the research (Botes, 1994:41-42). The chapter notably discussed the following:

- Introduction
- Problem statement
- Objectives of the study
- Paradigm
- Theoretical definitions
- Methodology
- Arrangement of chapters.

CHAPTER 2

RESEARCH DESIGN AND METHODS

2.1. RESEARCH DESIGN

This involves the arrangement of conditions for the collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure (Selltiz *et al.*, 1965:50 in Mouton & Marais, 1994:32).

The design, according to Lobiondowood and Haber (1990:194) is to aid in the solution of research questions and to maintain control. The design of this research is explorative, descriptive and qualitative. It is explorative because it aims to explore the relatively unknown experiences of women. It will lead to insight and comprehension as it involves people who have had practical experience of the problem studied. It is descriptive because, as indepth interviews are carried out, more information will be collected about the women's experiences as they naturally occurred. In descriptive studies protection against bias is achieved through (i) sample selection and size; (ii) valid and reliable instrument; and (iii) data collection procedures that achieve some environmental control (Burns & Grove, 1993:293).

2.2 METHOD

A phenomenological study, in which indepth individual interviews are carried out to study the experiences of women who have delivered in a maternity ward, will be undertaken. Phenomenology being both a philosophy and research method, strives to describe the experiences as they are lived to capture the 'lived experiences' of study participants. It is believed that the person is integrated with the environment; the world is shaped by the self and also shapes itself. It is further believed (Holloway & Wheeler, 1996) that there is no single reality, each individual has its own reality. That is why individuals will be asked to reiterate their experiences as seen in their own reality.

2.3 DATA COLLECTION

- A pilot study in to ascertain the relevance and simplicity of the question asked was done with two women, who met the same criteria as the study population. The semi-structured phenomenological interview was conducted and data was analysed according to Collaizi (1978 in Holloway & Wheeler, 1996:128) as well as Tesch (1990 in Cresswell, 1994:135-155). The pilot study revealed and determined the feasibility of the study because women answered relevantly.

  The participants did not really complain about the care except certain aspects which demoralised them to some extent. They were provided with information even though often inadequate. They expressed that their feelings were hurt due to the fact that some services are not made available to participants, the strain caused to parents, the expenses incurred and the long waiting periods. Communication was good.

- Data will be collected in a hospital where suitable candidates will be identified. The interviews will be recorded on a tape recorder.

- Participants will receive a follow-up visit at their residences within ten (10) days of parturition, where the recorded interviews will be re-played for them to ascertain that that was what they had said. They are thus given a chance to change or delete.

- The purpose of the study will be explained and a tape recorder will be used to ensure a relaxed atmosphere.

- The use of ethical considerations (SANA, 1991:1-5) will be emphasized to ensure privacy, anonymity, the right to agree to, or refuse participation, termination if so desired.

- Verbal and then written consent will be obtained (see Annexure for sample consent form).

- The participant will be made to feel as comfortable as possible so that she can share as much as she can remember.

- The question that will be asked is: "Can you please share with me your experience regarding the care you received while you were admitted for delivery in the maternity ward."

- Techniques such as probing, reflection, eye contact will be used to entertain communication.

- At the end of the discussion of the main question, the women will be asked what, in their opinion, can be done to improve the situation.

- Even though the interview will be recorded on a tape recorder, notes will also be taken to ensure credibility. Whole sentences may not be taken down, but important themes and points will be identified and noted.

- Women will be visited at their homes within ten days post partum in order to exhaust all available information and to ensure consistency of information provided.

2.4 TARGET POPULATION

2.4.1 Sampling population

Population is an aggregate of elements sharing some common set of criteria and hence target population refers to the population that the researcher wishes to study or about which the researcher wishes to make generalisations. In this study, the target population

will include Botswana women who have previously delivered in a hospital and who have just had another delivery (Woods & Catanzaro, 1988).

2.4.2 Sampling

This is the process of selecting a subject from a population regarding a phenomenon in a way that represents the entire population (Woods & Catanzaro, 1988:97). The names of the participants will be selected from a maternity register of one hospital in Botswana which is conveniently selected. A total of ten (10) women will be selected purposively from the village/town being served by the hospital. The researcher confined herself to a single village in Botswana. A purposive sample is used because the potential participants have to meet the selection criterion, namely being parous women who have delivered in a maternity ward and are within three days postpartum. This particular characteristic is considered since the researcher believes that these women may have special information about their experiences. In addition:

- there will be an age limit; all women in the child-bearing age will be considered;
- selection will be done irrespective of matrimonial or socio-economic status or educational preparation;
- selection will be done at the hospital after the woman has delivered and the interview conducted after the second day post partum when the woman has rested for a while and before they went home; and
- the woman must speak English or Setswana.

2.5 DATA ANALYSIS

It is noted by Holloway and Wheeler (1996:118) that in data analysis for phenomenological enquiry, the researcher aims to uncover and produce a description of the lived experiences. Ray (in Holloway and Wheeler, 1996:124) further points out that data analysis in descriptive phenomenology requires the researcher to make full use of bracketing (that is to suspend his/her past experience, knowledge or prediction of

phenomena). Intuition and reflection are also important to help open up the meaning of experience both as discourse and as text. Analysis of qualitative data involves organising the data into patterns and cross-validating the information for interpretation. This, according to Catanzaro and Woods (1988:439f) includes reduction of data, display of data and making and verifying conclusions.

Holloway and Wheeler (1996:125) identify seven stages of analysis that was developed by Colaizzi (1978:59-61), including:

1. Reading the narratives to acquire a feeling for their ideas in order to understand them.

2. Extracting words and sentences related to the phenomenon being studied. Colaizzi calls this stage 'extracting significant statements'.

3. The researcher 'formulates meanings' for each significant statement.

4. The researcher repeats this process for each description by the participants and arranges these formulated ideas into clusters of themes:

    a) The researcher returns to the original description to validate themes.
    b) She resists the temptation to ignore data or themes which do not fit.

5. The researcher integrates all the resulting ideas into an 'exhaustive description' of the phenomenon being studied.

6. The exhaustive description of the phenomenon is reduced to an essential structure. This stage is described as an unequivocal statement identifying the fundamental structure of the phenomenon.

7. The researcher returns to the participants in the research for further interviews to

elicit and validate their views on the findings.

Colaizzi encourages flexible use of these stages. Colaizzi's method matches the eight steps by Tesch (in Creswell, 1994:153-155) very will. Both will be utilised in analysing data. Data analysis will therefore run concurrently with data collection.

- The interviews recorded on tape will be transcribed by the researcher and a coder (nurse researcher) who knows the language used in the interview.

- The steps will be used and thus the descriptions of the women will be abstracted in a more defined vocabulary and hence the phenomenon would be formulated.

2.6 VALIDITY AND RELIABILITY

2.6.1 Validity

This refers to the extent to which the instrument actually reflects the abstract construct being examined. Validity has to do with truth, strength and value; it is like integrity, character or quality to be assessed relative to purposes and circumstances (Burns & Grove, 1993:342).

2.6.2 Reliability

This concerns how consistent the measurement technique is in measuring the concept of interest. It is also concerned with characteristics such as dependability, consistency, accuracy and comparability (Burns & Grove, 1993:339).

Measures of ensuring trustworthiness as termed by Lincoln and Guba (1985:290) will be employed. Trustworthiness can be operationalised as dealing with credibility, transferability, dependability and confirmability. The four criteria for trustworthiness are truth value, applicability, consistency and neutrality. Truth value will be ensured by using

strategies of credibility and applicability by using strategies of transferability. Consistency will be ensured by using strategies of dependability, while neutrality will be ensured by using strategies of confirmability. The following will consequently be done to ensure trustworthiness:

- **Credibility**

There are certain ways in which credibility can be ensured.

1. *Prolonged engagement*

   The researcher has spent enough time in the research setting to understand the context in which the observations were made. The researcher was placed in a maternity ward and later as a senior nurse, a supervisor of the maternity ward and again as a mother who has been admitted to a maternity ward. She has experience of prolonged involvement in the subject matter. Searching and reading through previous studies and other relevant material also exposed the researcher to the problem under research. Personal contact with female friends also provided some insight into this matter.

2. *Triangulation*

   Another way of ensuring credibility is through triangulation. Different methods of recording the interviews will be followed concurrently, that is tape recording as well as taking notes:

   - Literature reviews adds to triangulation of sources, together with interviews with the ten women who are expected to provide information relevant to the study.
   - The use of both Colaizzi and Tesch's methods of analysing qualitative data. the transcription of the recorded interviews will be compared with

the notes written down during the interviews.

3. *Member checking*

During data collection the tape will be played back to the interviewees so that they can confirm their utterances. As the interview progresses, the opportunity for member checking occurs as the researcher rephrases and reflects on the comments made by the informants so that the informants can verify the accuracy of the researcher's interpretation.

4. *Peer examinations*

The involvement of the researcher's colleagues right from the conception of the idea of the research study and throughout the research process is important. It is hoped that the peers will, disinterested as they are, be able to probe the researcher's biases, meanings explored and clarification done regarding methodological or ethical matters.

- **Transferability**

Through explanation of the study processes so as to enable anyone interested to transfer the study to another context. Even though the sample size and context are confined to one village, the results can be generalised to a certain extent to embrace a larger area.

- **Dependability**

Even though credibility influences dependability, there is a need to deal with dependability directly. Having a study leader throughout this project will satisfy the enquiry audit technique which ensures dependability. The study leader examines the processes of the enquiry and in determining their acceptability, will attest to dependability of the enquiry (Guba & Lincoln, 1985).

- **Confirmability**

Triangulation, as already discussed under methods to ensure credibility, also ensures confirmability. The use of a reflexive journal (or diary) in which daily schedules will be recorded, reflecting one's values and interests as well as methodological decisions and associated rationale.

3. SUMMARY

This chapter outlined the methodology of the research and it included the design and methods undertaken. Being a phenomenological qualitative study, the methods of data collection, sampling and target population, and data analysis were selected to suit this type of study. The methods to ensure trustworthiness were also identified and outlined.

CHAPTER 3

DATA ANALYSIS

3.1 INTRODUCTION

"The act of recognition and willingness to enter relationship might be initiated by asking. What is this experience like for you? Tell me about it. With these words and the talk that they bring, both care giver and woman may find better and more humane ways of understanding the experiences of motherhood in any form in which it occurs in women's lives." (Marck, Field & Bergun, 1994:296)

The methods of data analysis were already described in chapter two and as discussed, seven stages developed by Colaizzi (in Holloway & Wheeler, 1996) were followed. These were merged with methods of analysis proposed by Catanzaro and Woods (1988: 439f).

3.2 DATA ANALYSIS

Data was collected by interviewing ten (10) women. They were identified at the hospital, both verbal and written consent was obtained, the use of a tape recorder was explained and anonymity of information shared was assured. A private room was requested for use during the interview. After ensuring that rapport has been estabished, the women were put at ease as much as possible and the question was asked: "How did you experience the care that you received while admitted to the maternity ward?" At the end of the discussion, the women were asked what they thought should be done to improve the situation. By listening intensely and noting identified themes, the researcher started to analyse data throughout the data-collection process.

The data on tape was transcribed verbatim and translated into English with the assistance of a Motswana English teacher. Within ten (10) days of delivery, the women were visited

at their homes to ascertain whether the information shared by them at the hospital was still as recorded. The women stood by what they had said and, after listening to the tapes, emphasized what they communicated before.

The participants will be given codes P1, P2, P3 to P10 for easy reference and excerpts and/or quotations. One great thinker was quoted as saying "You cannot create experience, you undergo it" (unidentified reference - ND).

It became apparent that each woman, in her own way, had varied experiences. These experiences are described in different ways, though often with the same meaning. Now, having explored the experiences of ten women by means of interviews, the data is arranged into meaningful statements so as to bear testimony of the true experiences the women had when they gave birth at the hospital. The following experiences were identified:

- **Good care**

The women felt that they received good care. This was reiterated by statements such as:

"They looked after us." (P1, P6, P9)
"Care was good." (P6, P3, P8)
"Care is alright...indeed has improved." (P2, P7, P6, P5, P9)
"You are examined every now and then." (P2, P4, P5)
"Great care given by nurses." (P4)
"Handled me well." (P3)
"They are OK." (P7, P2)
"Looked after me well." (P1, P6, P9, P4)
"I see it alright for me" (P10, P7, P2)
"They help you." (P5, P9, P7, P6, P8)

It was discovered that nine respondents (n=9) stated that they received satisfactory care.

This further illustrates the compliments that were due to the midwifery care givers.

- **Neglect**

According to the *Oxford Dictionary* (1995:778), neglect is "to give no or not enough care or attention to somebody or something". It is deduced that two out of ten women felt that they were not given proper care. This was supported by the following statements:

> *"It does not resemble what used to be done."* (P10)
> *"No one checks us this side."* (P10)
> *"Now you stay the whole day with a dirty child with no one to help you."* (P4)
> *"Care does not resemble what used to be done."* (P10)
> *"We are neglected - no one will say anything to you."* (P10)

The element of neglect also came up when some women said that they felt it was necessary to transport them back home.

> *"The only problem is the way they neglect us regarding transport when discharged."* (P1)
> *"It is like you are lost."* (P1)
> *"You stand there."* (P1)

- **Financial problems**

It became apparent that some of the women's experiences were aggravated by their problem of a shortage of money, for example:

> *"It is your own responsibility to go home even if you don't have money."* (P1)

- **Unhappiness**

The element of unhappiness was deduced from statements such as:

"Care was alright during the past years." (P10)

This referred to the fact that the woman was unhappy about the care that is currently given. For example, one woman stated that the babies used to be bathed, especially if it was a first baby as it was difficult when one has never done it before. Other statements which indicated that the women were unhappy were:

"I saw something that did not make me happy." (P2)
"Superintendent did not think fairly." (P4)

This referred to transport problem, since they believed that they were not involved in the decision to cease transport.

When people become scared, they are bound to feel unhappy.

"You would be so scared, thinking of death, operations." (P6)

The women also exhibited unhappiness about the issue of cleanliness as indicated by the following statements:

"The sugar...put in an improper bottle." (P2)
"Throwing pads inside the toilet." (P6)
"Do not clean thoroughly...once said we sweep ourselves." (P10)

- **Help**

As regards help, the majority of women stated that they were helped, whereas only a

minority thought that help was not enough.

"They help you." (P4, P6, P5, P9, P8, P7)

"I was unable to wash my baby...they took my baby and washed it." (P9)

"Able to help me." (P6)

"Gave me treatment." (P8)

"Helping me take out that blood." (P8)

"Really trying their utmost." (P6)

"When you call a nurse they come." (P7)

Have a way to help." (P5)

Sixty per cent (N=10) of the total sample stated that they were helped whereas only twenty per cent stated that they were not helped at one point. The statements below show that the women felt that they were not helped.

"No one to help you." (P4, P1)

"Used to assist us especially with first baby." (P4, P10)

"Refuse to come and collect us at night." (P4)

"Sick and alone...no one checking you." (P10)

- **Improvements**

There were statements by women which showed that with regard to previous experiences, they felt that there were improvements in the care. The following statements are indicative of care having improved.

"On the side of nurses, there is more care than in the past - it has improved a great deal." (P4, P2, P6, P5)

"It is better these days, unlike last time." (P10)

"The care that I was given in the hospital is alright and indeed has improved." (p6)

"Health, as I see it, has improved." (P6)

"I realise ti is already better." (P2)

"There is a difference towards improvement." (P5)

- **Privacy**

As one of the basic rights of every person, privacy is very important. Some of the women consequently felt that they should be given privacy during childbirth. The following statement clearly indicate the need for privacy.

"We would be placed in the vicinity of everyone and when you deliver you would be just watching others because you have problems." (P5)

- **Fear**

Three women (N=3) said that the thought of going to the hospital often scares them.

"When you come to the hospital, you would be scared, thinking of death, operations."(P6)

"When you come, you are sort of unsure, you don't know whether you'll be cared for." (P6)

- **Dependency**

This is a state of relying on somebody or something for something (*Oxford Dictionary*). It became apparent that some women felt that other women who came to deliver were rather dependent on the nurses, even for some activities that they capable of performing themselves. Statements such as the following indicates that one often find the patient's conduct unbecoming because she believes that everything should be done for her.

"We so much rely on nurses to clean all our mess." (P6)

"She was saying it was the nurse's duty." (P6)

"We cannot just rely on nurses, we are human beings as well." (P6)

- **Knowledge**

Knowledge is one of the attributes that empower human beings in their daily lives. It is through knowledge that proper decisions can be made. The following statements clearly indicate that there was no preparation for such tasks during the ante-natal period.

"When it is your first baby, it is so difficult, you don't know what to do." (P10)

It also becomes apparent that some women do not seem so liberated as to question some of their observations, for example they did not ask about the transport that was stopped, neither were they informed why it had stopped. This results in women drawing their own conclusions since they had not been informed. At the same time, some women claimed that they were provided with information about their condition. for example, the explanation given to a woman who was bleeding. It was apparently explained to her , therefore she was able to relate it.

"They said I had little blood in my body." (P8)

"I had bled a lot from my uterus." (P8)

- **Washing babies**

This can be classified under the care previously discussed, but since it was felt that two participants felt strongly about the matter, it needed to be addressed separately. The following statements indicate the discontent regarding the washing of babies.

"Care was alright during the past years when babies were bathed." (P10)

"when it is your first baby, it is difficult, you don't know what to

do." (P10, P4)

"Comparing with when I delivered in 1991, when you had just delivered, we were assisted by nurses and the ladies who work to wash your baby and bring it clean to you. Now you stay the whole day with a dirty child with no one to help you." (P4)

The statements above show that something is amiss in the caring of newborn babies - the initial baths. Another woman who was assisted with bathing her baby because she was not well and her hands were painful. This would indicate that there was some form of assistance.

- **Assessment**

There was a higher percentage of women who felt that they were checked appropriately and timeously. In fact, there were some who felt that they have never been checked, as the following statements suggest:

"No one will say anything to you...No one checks us." (P10)

"If you are sick and you are alone there will be no one to check on you." (P10)

"They would be seeing everything but won't come and do anything." (P10)

Even though this participant felt that there were no adequate checking, the rest of the participants were content with this aspect.

- **Respect for culture**

It should be noted that in the Setswana culture, a newly delivered mother is regarded as still weak and needs total support from those caring for her. Therefore, if women are asked to make their beds and even sweep floors, the participant wondered what their

work was. It is also the responsibility of the care giver to bath the baby just until the mother has been taught to master the skill. If that assistance is not given at the hospital, it impinges on the way of life of the people.

In conclusion, the care that the women experienced was described as rather satisfactory by a majority of women. There often lingers memories of experiences that have disturbed them, but which they were able to overcome at the time of the interview. They were provided with good care, they were assisted, they appreciated some improvements that were made, they were provided with some form of information albeit not enough. There were several ill experienced which were reiterated and which included feelings of neglect, the financial problems created by transport problems, elements depicting unhappiness, privacy, lack of respect for culture. It should also be mentioned that women often felt dependent on nurses as well as scared.

While the interviews were conducted, the question was put to the women how they thought improvements could be made. Six out of ten women (N=6) seemed to have been caught off guard. They had either not really thought of anything to do, or they had no idea at all what might be done to improve the situation. Some felt that there was no need for improvement as the care has already improved. The remaining four (N=4) had some thoughts about what could be done.

- **Reinstate former transport**

The participants suggested that the old system where newly delivered mothers were sent home for a fee should be reinstated. They said they were willing to pay even more. The worry was that it was very likely that one's condition could change on the way home but if they were in an ambulance they could be rushed back to the hospital.

> *"We need to be assisted with transport."* (P1, P4)
> *"You don't know what might happen to change your condition on the way home and you are alone."* (P4)

"They should send you home and you pay them." (P4, P1)

The above statements were made by the women who hoped that transport would be reinstated.

- **Bathing babies**

This was one of the things that women felt they should be assisted with, especially in the case of first-born babies.

> *"I think we can be helped with bathing babies, just like it used to be done. It was much better, let them help you to bathe the baby."* (P4)

- **Monitoring**

The women felt that care givers should always strive to do their utmost - to do what they are expected to do because, according to one participant (P10), they were taught during their training and were employed to apply their knowledge.

- **Dependency**

Some women felt that the patients should not entirely rely on nurses for everything. Patients should be taught that there are some things they could do on their own.

- **Cleanliness**

Some women talked about cleanliness both on the part of fellow patients and the hospital workers.

> *"Women must be encouraged to keep their surroundings clean."* (P6)

"Wipe clean to help others and not entirely depend on them."

The above statements imply that women should also assist in cleanliness. As far as workers are concerned, the following suggestion was made:

"They strive to do the best in everything they do." (P10)

The question of "what are they hired for" was asked especially when at one time they were asked to sweep the floor.

"Be kind and respectful. Although much of a midwife's job is to meet the health needs of women, she also must be aware that women have human needs too. sometimes the most important thing you can do for someone's health is to listen to them, try to understand them and let them know you care about them. This is especially true in pregnancy and birth. Often a kind word, a gentle touch, a massage or a respectful talk will do more than medicine. When you show a woman care and respect, you help her to respect and care for herself." (Klein, 1996:6)

3.3 SUMMARY

In this chapter, several themes that describe experiences of women have been identified. In general, it was discovered that women received satisfactory care; there were elements of neglect; they reiterated problems with finances and thus a need to be assisted with transport. Unhappiness was also disclosed by some women because of incidents that occurred. The majority of women felt that they were helped, whereas a minority disputed this. The women felt that even though they had observed some improvements, there is room for more, for example the need for privacy seemed to have been addressed. It was good to realise that even though there might be doubts in women's thoughts, even to the extent of being scared when they came to the hospital, it turned out to be alright after all. This proves that some women were humane in realising the need to participate in the care they were given, for example, taking part in the cleanliness of their surroundings,

assisting with washing their babies, being checked regularly; they needed knowledge in order to make informed decisions and be respected for what they are.

Women's experiences can be shared and understood so that care givers can better assist and work with women as they go through the mothering experience. Each woman's experience is unique - even though there are commonalities; it is clear that each woman's experience is unique and true for her and that the task of the care giver and other people involved is to be attuned to the meaning that she individually brings to the situation (field & Marck, 1994).

CHAPTER 4

LITERATURE CONTROL

4.1 INTRODUCTION

"A review of relevant literature is conducted to generate a picture of what is known and not known about a particular situation. Relevant literature refers to those sources that are important in providing the indepth knowledge needed to make changes in practice or to study a selected problem." (Batey, 1977 in Burns & Grove). This chapter is, therefore, geared towards making comparisons between studies that have been undertaken in the past and the results of this study.

The studies of experiences in Botswana were not identified and only those which reflected the attitudes of women will be considered to facilitate the control. In addition, studies done internationally will also be utilised. This will be discussed in relation to the identified experiences in order to make the comparison much clearer.

4.1 GOOD CARE

As much as the majority of women experienced good care, which is comparative with the other studies where it was found that women also had good care.

Field and Marck (1994:222) noted that studies on women's satisfaction with their childbirth experience and their perceptions of personal impact of childbirth, show that satisfaction is associated more with emotional care received during labour than with the physical process.

In the study by Simpkin (1996:252) titled "The experience of maternity in a woman's life", it was found that when expectations are met and are associated with feelings of accomplishment in being in control and of enhanced self-esteem, then satisfaction is

ensured. Satisfaction is also associated with positive feelings about the care giver's words and actions, for example, the women stated:

> *"You are examined every now and then... Great care is given by the nurses."* (P4, P5)

Good care was noted in the study done by Chipfakacha in Botswana in 1994, titled "Attitudes of women towards traditional midwives". It was found that women preferred to be assisted by the traditional midwife, the reason being that they were much more caring. This leads us to think that the women expect the individualised care they receive at home, to resemble the care at the hospital. It is also interesting to note that in another study in Botswana, under the leadership of Professor Makhokha (a WHO/UMCEF consultant on safe motherhood initiative), which assessed and evaluated the utilisation of health facility-based maternity services, the women were satisfied with the services they received during home deliveries. The reasons were associated with availability and accessibility of the service as well as the support provided by those who attended them. They received good care at home and thus did not worry about transport or money to receive satisfactory care. If they were given the right environment in addition, the majority of women would prefer to deliver at a health facility (Makhokha, 1994:4). This study also tends to support other experiences by women who preferred to be offered privacy, respect for culture, who needed to be helped and listened to by the care givers.

4.3 FINANCIAL PROBLEMS

It has been shown in some studies that women do experience financial problems which hamper their health-seeking behaviour. It was discovered by Makhokha in 1994 that women predominantly recognise and prefer health workers and health facilities for all aspects of maternity care, despite all the socio-economics factors, such as transport.

Personal control depends upon resources and options that allow choice, being adequately informed about the available choices, being involved in decision making and being able

to implement those decisions once they are made (Walker, Hall & Thomas, 1995:128). Hallgren *et al.* also observe that feelings of resourcefulness, acceptance of a rewarding problem to be solved with one's own resources and anticipation of a challenging and exciting joint effort influences childbirth experiences.

4.4 NEGLECT AND UNHAPPINESS

This may not, perhaps, be described as neglect as such, it rather implies care which is not satisfactory.

Hodnett (1996:257), whose research article "Nursing support of the labouring woman", purports that labour support is a repertoire of techniques which the nurse can use to help women during one of the most memorable and personally challenging experiences of their lives. It was found that there were two obstacles in providing support, namely lack of time and lack of educational preparation in the matter of labour support. Hodnett (1996:213) further states that mothers whose experiences were worse than they had expected, are at risk of experiencing feelings of failure and inadequacy that remain with them for years. It may thus mean that women who were not totally satisfied with the care they received, may have been influenced by previous encounters with maternity staff.

Feelings of helplessness and loss of control have been identified as contributing to a distressing and unpleasant labour experience. In contrast, a satisfying childbirth experience has been associated with women's participation in decision making during labour. It became apparent in this study that women felt neglected and unhappy mainly because they did not understand why things were the way they were.

4.5 KNOWLEDGE AND DEPENDENCY

It was indicated that women in this study received little or no information regarding the care they were going to receive. This could be attributed to the fact that women are so dependent on health personnel for their care. It is noted by Simpkin (1996:) that

childbirth is a means to the end of parenthood, and how it is done does not seem all that important to most pregnant women today. She also observes that fewer women are learning about pregnancy and childbirth from traditional sources, for example the mother, female relatives, *et cetera*, because of changes in family and societal patterns of living. Simpkin (1996:249) therefore observes that the growing complexity of childbirth management means that women's knowledge gained through personal experience and passed on to others, is less applicable to the newer approaches. The net effect is greater reliance on experts in the mechanics of childbirth to establish a new set of rules, educate women about the reproductive process and to replace old tales with latest scientific knowledge. This shows that women are in need of information and they are also reliant on the health workers.

A hospital can be regarded as a place where the fragility as well as the urgency of life can be keenly felt. Simic, Bennet and Garrod (1995:40) found in their study "women's experiences of maternity care" that there is a need for more information about options for maternity care. This information would be discussed as part of a continuing relationship between the woman and the carer. It is believed that, if information is shared, women will feel liberated to ask any question about what they need to know.

Nyaphisi *et al.* (ND:45-99) conducted a research which demonstrated that education is a key factor in a woman's life with respect to her health. This will have a significant impact on the health-seeking behaviour of women and will improve their capacity to appropriate health -care measures for safe living. It supports the experiences described by women that they often felt hesitant to speak their minds because they were probably ignorant about their rights and options.

Another study by Sengane (1995:87) in which she explored and described the experiences of black fathers concerning support during labour, found that lack of information and support from professional people contributes to their expression of mixed feelings, for example anxiety, fear, difficulty and excitement. This study also supports the experiences of being scared, unhappy and even excitement on account of

good care.

4.6 RESPECT FOR CULTURE

Simpkin (1996:252) feels that personal experience of childbirth will, as always, in some way reflect the cultural values of each woman and her family. This also carries a great potential for her development as a woman and mother, and for the future of the children she brings into the world. It needs to be recognised that a woman has her unique way of living and needs the respect of care givers.

Yet another study by Berg *et al.* (1996:12-13) which describes women's experiences of the encounter with the midwife during childbirth, revealed the following:

- Women emphasized the need to be seen as individuals.
- Women wanted midwives to be friendly and gentle or rather to have a trusting relationship.
- Women wanted support and encouragement. The midwife was needed for guidance but on the woman's own terms.

It was also found that it is not only what is done during labour and delivery or how it is done, but simply the calm presence of the midwife which seems to constitute the essential value. Caregiver behaviour that is warm and nurturing produce feelings of comfort, strength and relaxation for the women.

Quite a number of participants in the study made it clear that the nurses were there for them; that the care was alright and that they were helped. This is supported by the above-mentioned study.

It may be noted that experiences narrated by women are interrelated in a way because they were able to account for each other, for example, good care can be explained alongside help.

4.7 SUMMARY

In this chapter previous related studies were looked at. The childbirth experiences reflect commonalities in most studies reviewed, which also tend to support this study.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter, conclusions, limitations of the study and recommendations will be presented. Conclusions, according to the *Oxford Dictionary* (1995) is "a belief or an opinion that is the result of reasoning". These will be derived from the previous two chapters and correlated with the objectives of the study. It is here that the limitations of the study will be identified and mentioned. Recommendations will be made pertaining to the conclusions made.

5.2 CONCLUSIONS

Objective 1

To explore and describe in the women's terms what experiences they had regarding the care they received in the maternity ward.

A pilot study was conducted with two women who were interviewed at their homes, using a tape recorder. It proved that the women understood the question they were asked. The data was transcribed and translated, followed by a trial of the proposed data-analysis method. Having ascertained the usefulness of the pilot study, the researcher then continued with the actual study.

Interviews were conducted in a private room in the maternity ward of a hospital. This was followed ten days *post partum* by visits to the women's homes to verify the information they share during the interview and to add or delete where they deemed it necessary.

It was found that the women were initially uncertain during the interview, but rapport

was established very soon, as was observed in the relaxed and open attitudes of the participants.

Emanating from data analysis as well as literature review, the following conclusions can therefore be made about the experiences of women in the maternity ward.

- The women received satisfactory care despite certain aspects that caused unhappiness, anger, uncertainty, anxiety and even disappointment. They nevertheless accepted and appreciated the care they were given. Literature has also shown that women experience so much of a crisis as she undergoes the most intense physical sensations and emotional stressors. Authors of literature reviewed are also of opinion that midwives and other care givers are responsible for enhancing women's experiences of childbirth.

- Women were left out of decisions that affected them. The decision to stop transport, for example, was seen as not in the best interests of the women. Thus it is the issue of involving the consumers of care in what affects them. Some studies have proved that, although women recognise and prefer health workers and facilities despite socio-economic factors, they tended to utilise traditional birth attendants because they were satisfied with their services.

- Women are not given adequate information to familiarise themselves fully with the expectations and processes of childbirth. In previous studies the need for women to be educated in all aspects of maternity care so that they can make informed choices, has also been noted. Field and Marck (1994:295) observe that participation by both care givers and women in understanding and responding authentically to one another, appears to involve personal knowledge, objectivity and risk. Their study concludes that communication is not of an expected standard.

- Women's cultural interests were not respected by those giving care. It became

apparent when they felt offended by being expected to clean their rooms, which is contrary to Setswana culture where the woman is expected to rest fully until her back is strong enough to perform such a task.

- The midwives endeavoured to perform their utmost irrespective of certain shortcomings mentioned by the women. It was ascertained by women being appreciative of the care even though the emotional aspect seemed to be lagging. According to Murphy-Black (1995:283) women (midwives) have betrayed women (mothers), not by physical harm, but perhaps in a way that leaves just as lasting psychological scars. The really sad aspect is that it is often done in the name of 'being good', that is, blindly following the rules designed for the smooth running of an institution rather than the needs of the individual. The same author also asserts that a full range of midwifery care was provided by midwives prior to hospital care, but as midwives moved to hospitals, this resulted in fragmentation of care, where care was provided by a variety of midwives and numerous other staff.

- Women were not content with the way their environment was kept. This is consistent with other findings where women placed emphasis on the need for privacy as well as the cleanliness of their surroundings.

5.3 LIMITATIONS

Limitations are bound to occur in any study and this study is no exception.

Since the interview question was how women felt, it initially made them feel hesitant to open up. The researcher assisted the conversation by probing, paraphrasing and using non-verbal cues in order to collect as much information as possible. Therefore, it is likely that not all information was shared.

The small sample of ten women is unlikely to be generalised for a larger population of

women.

The use of a tape recorder and signing of consent forms were also likely to influence the women in sharing their experiences truthfully, especially since they were interviewed in the hospital.

5.4 RECOMMENDATIONS

In order to achieve the objective to make recommendations or suggestions geared towards improving maternity care in Botswana, the following recommendations are presented which will address nursing practice, nursing education and nursing research.

5.4.1 Nursing practice

- The hospital environment seems to be in control of the caretakers because they decide how it appears. It is imperative that women are granted an opportunity to make choices.

- There is a need for respect for culture by those giving care. The way we are born and the way we give birth are both very much part of our culture. By alienating women from it, their whole culture is affected. Therefore, the gap that exists between the modern and the traditional midwife must be closed. They should be seen to work together so that ideas are shared.

- Reaching out to the community in regard to midwifery education and research in order to facilitate the community's quest for wholeness. A feeling of involvement will enhance the realisation of joint decision making.

- The birth attendant or care provider needs to assist the woman in accomplishing the inseparable goal of a safe and satisfying birth. The woman should at least feel that her needs and her person are respected and that she receives adequate

attention. A satisfactory birth can be achieved only if both care giver and the parturient work together towards that end (Robert & Wooley, 1996).

- Midwives may claim to be acting in the woman's best interest, namely paternalism. Clarke (1995:271) describes paternalism as the belief that it can be right to order the lives of others for their own good, irrespective of their own wishes or judgements. This does not take into account the emotional, cultural and social needs as being equally important. It must be realised that maximising the wellbeing of women involves consideration of all aspects of health and not just the physical component.

- Childbirth is an emotional experience. The woman experiences one of the most profound, if not thé most profound, life changes she will ever undergo. She experiences pain, exertion, fatigue, fear, anxiety, doubt, vulnerability, strange surroundings, unfamiliar people, nakedness. The quality of emotional support from those attending these women, including the presence or lack of kindness, respect and thoughtfulness during the emotional crisis of birth, therefore influences the woman's ability to use her coping skills and can influence her existing self-image negatively or positively, that is improve a negative self-image or damage a positive self-image (Field & Marck, 1994).

Simpkin (1996:252) notes that "for care givers, the lesson is that much more is involved in the outcome of a healthy mother and a healthy baby than coming out of it alive with no permanent physical damage. The goal of a good memory should guide the care giver". Nurses should thus be careful how they influence the long-term impact of the childbirth experience on a woman.

- A special effort should be made to avoid stereotyping the labour experience and cultural and individual differences and preferences should be taken into consideration. It is for this reason that Rajan (1993:145) states that recognition should be given to every woman's need to maintain control over her labour, by

providing information, support and more profound understanding and acknowledgement thereof, thus enabling a relationship of trust and confidence to develop between her and her staff in attendance.

5.4.2 Nursing education

- Midwives should be upgraded in an attempt to keep up with current trends in midwifery.

- The schools of nursing must emphasize interpersonal skills training which should be included in the curriculum.

- Childbirth education classes should be established in order to prepare women physically and emotionally for childbirth. It is hoped that the women will be liberated in their thinking.

- Faculty practice for those who teach midwifery, so that they can be in touch with real patients and keep their skills up to date.

5.4.3 Nursing research

- Further research is recommended with a larger population to enable generalisation of results.

- It may be of assistance to conduct research on midwives' experiences so that comparisons can be made.

- Other midwifery research results should be considered in everyday care in the maternity ward.

5.5 SUMMARY

In this study, the researcher attempted to explore and describe the experiences of parous women in a hospital maternity ward in Botswana. It was found that in general, the women felt they were satisfied with the care they were given. Communication was not so good, hence feelings of unhappiness, anger, fear, anxiety and uncertainty on the part of the women. The recommendations were also made on aspects that are thought could improve care.

Flint (1986:225) states: "together we can make childbirth the joyous, growing, confidence-enhancing experience it can and should be. But the person it must start with, the person it all hinges on, the person on whom it all depends, is the midwife."

BIBLIOGRAPHY

BOTES, AC 1994: *A justifiable research proposal.* Johannesburg: Rand Afrikaans University.

BUE, RAND AFRIKAANS UNIVERSITY 1994:

BURNS, N & GROVE 1993: *The practice of nursing research - conduct, critique and utilisation.* W.B. Saunders Company.

BERG, M *et al.* 1996: Women's experiences of the encounter with the midwife during childbirth. Midwifery **12**:11-15.

CERONIO, CC 1992: *The experiences of parents where pregnancy ended in an unplanned Caesarean section.* M.Cur. Mini-dissertation. Johannesburg: Rand Afrikaans University.

CHIPFAKACHA, V 1994: Attitudes of women towards traditional midwives - a survey in the Kgalagadi region. South African Medical Journal **84**:30-31.

CLARKE, AR 1995: Ethics and midwifery practice. Midwives, Aug. 1995:270-291.

CRESWELL, JW 1994: *Research design - qualitative and quantitative approaches.* SAGE Publications, Inc.

DEPARTMENT OF NURSING, RAND AFRIKAANS UNIVERSITY 1993: *Nursing for the Whole Person Theory.* Johannesburg: Rand Afrikaans University.

ENKIN, M; KEIRSE, MJNC & CHALMERS, I 1990: *A guide to effective care in pregnancy and childbirth.* Oxford University Press, New York, USA.

FIELD, PA & MARCK, BP (Eds.) 1994: *Uncertain motherhood: Negotiating the risks of the childbearing years*. Sage Publications, Inc. California USA.

FLINT, C 1986: *Sensitive midwifery.* William Heinemann Medical Books. UK: London.

FLINT, C 1995: *Communicating midwifery: Twenty years of experience.* Books for Midwives Press, England.

FLOYD, L 1995: Community midwives' view and experience of home birth. Midwifery **11**:3-10.

GARCIA, J *et al.* 1990: *The politics of maternity care.* Claredon Press, Oxford.

GOVERNMENT OF BOTSWANA. *National Health Policy 1995.* Government Printers, Gaborone, Botswana.

GREEN, JM 1993: Expectations and experiences of pain in labour: Findings from a large prospective study. Birth **20**:2.

GUBA, EG & LINCOLN, YS 1985: *Naturalistic enquiry.* Sage Publications, Inc.

HALLGREN, A *et al.* 1995: Women's perceptions of childbirth and childbirth before during and after education and birth. Midwifery **11**:130-137.

HODNETT, E 1996: Nursing support of the labouring woman. JOGNN Clinical Issues **25**:3.

HOLLOWAY, I & WHEELERS 1996: *Qualitative research for nurses.* Blackwell Science Ltd., UK.

HUSS, LM 1992: *Patient experiences in critical care unit.* M.Cur.-dissertation. Johannesburg: Rand Afrikaans University.

ILLIFF, VF (ND): Maternal mortality in Zimbabwe.

KINTZ, DC 1996: Nursing support in labour. JOGNN, Mar./Apr. 1996.

LITCHY, R & HERZBERG, E 1993: *The waterbirth handbook.* Gateway Books, UK.

MORSE, JM (Ed.) 1991: Qualitative nursing research - a contemporary dialogue. SAGE Publications, Inc. California U.S.A.

MOUTON, J & MARAIS, HC 1994: *Basic concepts in the methodology of the sciences.* Human Sciences Research Council Publishers. Pretoria, SA.

MURPHY-BLACK T (Ed.) 1995: *Issues in midwifery.* Longman Group Limited.

NYAPHISI, M *et al.* (ND): *Risk factors associated with maternal mortality in Lesotho, Malawi, Uganda and Zambia.*

RAJAN, L 1993: Perceptions of pain and pain relief in labour: The gulf between experience and observations. Midwifery **9**:136-145.

REEDER, SJ, MARTIN, LL & KONIAK, D 1992: *Maternity Nursing - family, newborn and women's health care.* 17th edition. JB Lippincott Co

ROBERTS, J & WOODLEY, D 1996: A second look at the second stage of labour. JOGNN **25**:5.

RUBIN, R 1984: *Maternal identity and the maternal experience.* Springer Publishing Company, Inc. New York USA.

SENGANE, MLH 195: *The experiences of black fathers concerning support during labour*. M.Cur.-dissertation. Johannesburg: RAU.

SIMIC, P; BENNET, IJ & GARROD, D 1995: Women's experience of maternity care in an inner city - a team based qualitative study. Midwives, Feb. 1995:38-40.

SIMPKIN, P 1996: The experience of maternity in a woman's life. JOGNN; Clinical Issues **25**:3, 247-252.

SOUTH AFRICAN NURSES ASSOCIATION 1991: *Ethical standards for nurse researchers*. Pretoria: SANA.

THOMPSON, A 1996: Safe motherhood at risk. Midwifery **12**:159-164.

TLOU, S 1989: Health status of Botswana women. Women's Studies International Forum **12**:2, 167-174.

WALKER, JM; HALL, S & THOMAS, M 1995: The experience of labour: A perspective from those receiving care in a midwifery led unit. Midwifery **11**:120-129.

WILLIAMSON, S & THOMPSON, AM 1996: Women's satisfaction with ante-natal care in a changing maternity service. Midwifery **12**:198-204.

WOODS, NF & CATANZARO, M 1988: *Nursing research, theory and practice*. CV Mosby Company. Missouri, USA.

ADDENDUM A

COPY OF CONSENT TO PARTICIPATE

Rand Afrikaans University
P.O. Box 524
Auckland Park
Johannesburg 2006

Re: Consent for Participation in Research Project

Dear Madam,

I, the undersigned, gives consent for participation in the research explained to me by the researcher. This research is an undertaking as fulfilment for the master's degree programme at Rand Afrikaans University.

The research endevours to find out our experiences regarding the care we received while in the maternity ward as well as solicit from us the improvement that can be made thereafter.

It was explained to me that all information gathered would be treated confidentially and anonymously for ethical reasons. The study leader will be the only person having access to the information.

Participant's signature: ----------

Researcher's signature: ----------

Date: ----------

Place: ----------

Your aprticipation is highly appreciated and will benefit midwifery service a great deal.

ADDENDUM B

TWO TRANSCRIBED INTERVIEWS

INTERVIEW IV

R: I just want to know how you experienced the care that you were given while admitted in this hospital. Just explain it wholly and from the bottom of your heart. Please do not withhold anything, it might be very important.

P: What you are saying is I should talk from previous deliveries or just this one.

R: Even if you were to talk about them both, in fact the issue is care. That is why I am talking to people who have delivered before because they will understand what care to expect. Therefore they can explain it better than those having first babies. Let us use this thing (microphone) so that our communication is recorded.

P: That which is given by the nurses is great care really because they look after you all the time, they are able to come and assess you and help you accordingly depending on what stage they find you. Now the difference today comparing with when I delivered in 1991, when you had just delivered we were assisted by nurses and the ladies who work, to wash your baby and bring it clean to you. Now, you just stay the whole day with a dirty child with no-one to help you. On the side of the nurses, there is more care than in the past - it has improved a great deal.

R: You are saying you have observed that you are no longer assisted with bathing babies.

P: Yes, like today there is someone who is unable to help herself because of dizziness. The dizziness has unabled her to wash her baby herself. They used to assist us especially if it was the first baby like her.

R: Is there anything again you would like to talk about? I realise you are not content with staff not helping you wash babies.

P: What I am going to say now will not be under the nurses. I think it is under the direction of the superintendent. It is related to transport. Transport here, that is if you phone during the night because you do not have transport and what occurred to you was untimely during the night, they refuse to come and collect you. Another thing, when you are discharged from the hospital after delivery, it is such a problem to walk to the taxis. Now I don't know if it is the superintendent's ruling on this, he did not think constructively especially for women just delivered.

R: Would you like to suggest what you think can be done?

P: I think we need to be assisted with transport. I think we can also be helped with bathing babies just like it used to be done. It was much better, let them help you to bath baby. In this one of transport for just delivered mothers, at least when they have collected you, they should send you back home and you pay them.

R: Do you mean like it used to be?

P: Yes, in fact at times you would go and board a taxi, you don't know what might happen to change your condition on the way and you are alone. If you are taken by ambulance, they can rush you hack to the hospital safely.

R: Thank you so very much. Your suggestions are going to be represented collectively. There shall be no mention of individual participants.

P: Yes, mma.

R: O.K.

INTERVIEW X (Repeat interview erased accidentally)

R: Researcher

P: Participant

R: I would like to go back to that question. I asked you the other day. As you have been coming to deliver in this hospital, how have you experienced the care you were given? But I would like to emphasize that feel free, talk your mind. Do not talk about some things and leave the others out. Just explain as you see everything.

P: The care in fact ever since I came to the hospital looked to be alright. But it was really alright during the past years when the babies were bathed. When it is your first time to have a baby, it is so difficult, you don't know what to do. This care today does not resemble what used to be done at all. We are neglected, no-one will say anything to you. As I sleep this side (pointing to a room where prem-mothers sleep), as you know people are checked, this side no one checked us. We make our own beds. If you are sick and you are alone there no-one will check on you. When I was sick, one of my fellow patients went to tell the nurse, they said to her why don't I take myself to them? Again as I am this side, I will hear my babies crying because they slipped in between those things (referring to incubator) or maybe covered by a blanket. They would be seeing everything but they won't come and do anything. Another thing is cleanliness where we sleep. Anyway these days it is a bit better, they sweep unlike last time.

R: Do they sweep every day?

P: they sweep every day. They sweep, its just that they do not mop or move things. But it is also surprising because they say we must make our own beds and I just wonder what their work is. It was once said we must also sweep for ourselves.

R: Did you ever ask about this?

P: We often ask but they will take us to be joking or playing as we will just be laughing as we ask.

R: Now, what do you think can be done to improve the situation?

P: Inproving, I don't know. Isn't it as we are human beings, we must strive to do our best in everything we do, do what we are expected to do for others and not to be taught. Just imagine a "matsetsi" asked to sweep hospital rooms. let the nurses do as they were taught and the other staff also as they are supposed to (what they were hired for). Everyone should remember to always do what is right.

(NB: SOME PART OF THIS AUDIOTAPE NOT AUDIBLE

R: Thank you for your patience. Hope to see you again. May those kids grow bigger.