DESCRIPTIVE SURVEY OF WOMEN'S CHILDBIRTH EXPERIENCES IN TWO STATE HOSPITALS IN KWAZULU-NATAL

By

Uwonkunda Providence MUTABAZI

Dissertation submitted in partial fulfilment of the requirements for the degree of

MASTERS IN NURSING

School of Nursing and Public Health
University of KwaZulu-Natal
Howard College Campus
DURBAN

Supervisor: Professor Petra Brysiewicz

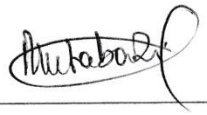
August, 2017

DECLARATION

I, Uwonkunda Providence MUTABAZI, student number 205504980, declare that:

1. This dissertation is my own work. Where use was made of the work of others, it has been duly indicated in the text and acknowledged by means of complete references.

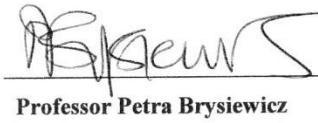
2. This dissertation has not been previously submitted for any degree or examination to the University of KwaZulu-Natal or to any other university.



21 August 2017

Uwonkunda P. MUTABAZI
Student number: 205504980

Date



21 August 2017

Professor Petra Brysiewicz
Supervisor

Date

DEDICATION

I dedicate this dissertation to Almighty God, my Creator and my Saviour, who has given me strength to carry out this study. Thank you Lord; all the Glory belongs to you.

To my husband Aimable MUTABAZI, it is because of your love, support and encouragement that I am able to achieve my dream.

To my children, Athanase Yan MUTABAZI and Izere Mary MUTABAZI, for understanding and learning to look after yourselves at an early age when mom was busy with school work. This is for you my children.

ACKNOWLEDGEMENT

I would like to express my sincere gratitude to Almighty God for the strength, wisdom, courage, protection and good health he has given to me for embarking on this study;

Special thanks also go to the following individuals who supported and contributed to the success of this study:

- Firstly, my supervisor Prof. Petra BRYSIEWICZ, for the professional guidance, your expertise, generous support, encouragement and patience in ensuring the successful completion of this dissertation. The process was challenging, but I have learnt a lot from you. Thank you so much;
- My husband Aimable MUTABAZI, I thank you for your support, encouragement and patience and for your true understanding of gender equality when you took over my duties of being a mother and a wife and looked after our children and home while I was busy with school work. May God richly bless you;
- My children Athanase Yan and Izere Mary for your understanding and the patience that you showed me. Thank you and I love you so much;
- Dr. Wilbert SIBANDA and Partson TINARWO, statisticians, for your assistance with statistics. Your caring attitude, time, effort, knowledge and love of your work are greatly appreciated.
- Management of hospital A and B for allowing me to conduct my study in these hospitals. It is much appreciated;
- My friend Consolee KANAMUGIRE for being the ear to listen to me and the shoulder to cry on when I was down, and for encouraging me so that I could make it. Thank you very much. You are a true and honest friend.
- My friend and colleague, Sister Marie Chantal NTIBASAME, your contribution, connection and facilitation in getting entry in hospital B. You are my role model and academic supporter, and I really appreciate that.
- Lastly and most importantly, my gratitude goes to the mothers who willingly participated in this study and responded to the questionnaires voluntarily. I am grateful to you as you made this study fruitful and successful. I hope that through this study, knowledge and insights will be gained which will contribute to the improvement and provision of quality care for positive childbirth experiences.

ABSTRACT

Background

Giving birth is one of the most important events in a woman's life, and is a highly individualistic and unique experience with many physical, physiological and psycho-social changes in the woman's life that requires support, help and motivation, not only from professional carers but also from family members.

Aim

The aim of this study was to survey women's childbirth experiences in two state hospitals in KwaZulu-Natal (KZN) Province in South Africa, in an attempt to identify women's experiences of labour and birth.

Method

A non-experimental, quantitative survey was conducted in two state hospitals in the eThekwini District of KZN. Population included all post-partum patients in urban KZN hospitals where the research was conducted. Purposive sampling was used. Two hundred and one low risk mothers; 119 (59%) from hospital A and 82 (41%) from hospital B responded to the Childbirth Experience Questionnaire (CEQ). Data were analysed using descriptive and inferential statistics.

Results

Results denoted both positive and negative childbirth experiences with positive childbirth experiences being dominant on almost all domains of the Childbirth Experience Questionnaire. A high level of women's experienced capacity and experienced good professional care and support as well as professional skills were found to be associated with a positive childbirth experience.

Negative childbirth experiences were reported mostly in additional comments by few respondents. These negative experiences were found to be linked to women's poor relationships with staff, a lack of information, neglect and abandonment and not receiving pain relief. Problems such as the shortage of staff and an unfriendly environment were identified to affect childbirth support, leading to a negative experience. Uncleanliness and lack of privacy contributed to feeling unsafe, and fear, anxiety and a lack of support influenced the experience of pain.

Conclusion

No birth story is exactly the same, and the study results showed that negative and positive experiences coexisted; however positive and satisfying childbirth experiences were dominant amongst the majority of the respondents in the current study. How mothers feel about their labour and birth, whether positive or negative, was found to depend on their individual labour process and outcome. Thus, from the women's perspective, the study described childbirth experience as a multi-dimensional experience.

ABBREVIATIONS

ANC	=	Ante-Natal Classes
CEQ	=	Childbirth Experience Questionnaire
IOL	=	Induction of Labour
IUD	=	Intra-Uterine Death
IUGR	=	Intra-Uterine Growth Restriction
KZN	=	KwaZulu-Natal
NICU	=	Neonatal Intensive Care Unit
NVD	=	Normal Vaginal Delivery
SPSS	=	Software Package for Social Science
VAS	=	Visual Analogue Scale
WHO	=	World Health Organization

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

Page

CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1. INTRODUCTION AND BACKGROUND TO THE STUDY

The health care issues around childbirth have recently been concentrating on the risks and complications related to neonatal and maternal morbidity and mortality outcomes, while the experiences encountered by women during delivery and postpartum have been given less attention (Nilsson, Thorsell, Wahn and Ekstrom, 2013). Rudman (2007), states that giving birth is one of the most important events in a woman's life. It is a highly individualistic and unique experience with many physical, physiological and psycho-social changes in the woman's life requiring support and care, not only from professional carers but also from their family members. This is true and very important, especially for first time mothers, as the support, help and motivation assist them to develop good self-esteem, have positive feelings for the baby, and enable an easier adjustment to the motherhood role and future pregnancies (Nilsson et al., 2013). According to Waldenstrom and Schytt (2009), memories of giving birth are remembered for a lifetime. Certain happenings might fade but others might be remembered forever, notably positive memories of their labour and their delivery experience. Some women, however, do not have such positive remembrances of their deliveries and describe them as dreadful. A negative childbirth experience may have short or long term impact on the woman's health, her baby and on their immediate family (Mohammad, Alafi, Mohammad, Gamble and Creddy, 2014; Sengane, 2013), and furthermore, there is an increased risk of depression in the postpartum period or the time of the next pregnancy (Rijnders, Baston, Schonbeck, VanDer Pal, Pins, Green and Buitendijk, 2008). Karlstrom, Nystedt and Hildingsson (2015) affirm that the childbirth experience has long-term implications on a woman's health and wellbeing.

Nilsson et al. (2013) identified a number of factors influencing women's experiences of childbirth namely; attendance of antenatal classes, level of labour pain, support received from partners and professionals (midwives), perceived safety, a sense of being in control and women's capacity as well as involvement and participation in decision making. Similarly, Dencker, Taft, Bergqvist, Lilja, and Berg (2010), in their study done in Sweden involving discussion with experienced midwives and interviews with first-time mothers, found that a sense of security, perceived control, level of labour pain, professional support, midwifery care, analgesia given, the women's involvements in decision making and the information

given to them contributed to how women experience childbirth. Furthermore, they state that negative experiences increase the risk for maternal postpartum depression, and negatively affect the attitude for future pregnancies, as well as the choice on the mode of delivery.

Prenatal classes may affect a woman's experience of labour and delivery because they give mothers a better understanding of what to expect during their pregnancy and childbirth. Artieta-Pinedo, Paz-Pascual, Grandes, Remiro-Fernandezdegamboa, Odriozola-Hermosilla, Bacigalupe and Payo (2010) reported that studies have advocated a psychological benefit of childbirth education in that women show a more positive attitude towards the birth experience and seem more in control and involved in the process. Furthermore, Melender (2006) states that education contributes to women's self-efficacy and sense of control during childbirth (Dencker et al., 2010). Personal control and self-efficacy are amongst factors indicating women's own capacity and relate to childbirth satisfaction. Women need to realise that having self-control during labour boosts their capacity, even if situational control is beyond them (Karlstrom et al., 2015). The experience of personal control has an effect on labour pain management (Christiaens and Bracke, 2007).

Level of professional care and support given to women during labour and birth by midwives and the opportunity to be involved, participate in care and decision making empowers the women, promotes a trusting relationship with the midwives, makes them feel safe and increases the possibility of a positive birth experience (Hodnett, Gates, Hofmeyr and Sakala, 2011). Sengane (2013) adds that women also feel valued and safe when provided with midwives' care and support during labour and birth. Midwives play a central role in caring and supporting women and ensuring that women have a positive and safe childbirth experience. Midwives, as well as other health care professionals, are expected to provide psychological support, but without neglecting medical safety (Sydsjo, Blomberg, Palmquist, Angerbjorn, Bladh and Josefsson, 2015).

Satisfaction with care and a positive childbirth experience for a woman are associated with having her expectations fulfilled, state Karlstrom et al. (2015), however, the health care system in South Africa is struggling to meet the standards of health for all (Du Preez, 2010). As such, women's views on their birth experiences are important indicators of the quality of childbirth care in the country. Quality care incorporates a number of dimensions including safety, effectiveness and patient centeredness; and a range of perspectives are relevant,

including those of the patients, the health care providers and the nursing managers (Raven, van den Broek, Tao, Kun, and Tolhurst, 2015).

A recent main focus of maternity care has been also to identify the prevalence and contributing factors of negative birth experiences, in order to improve the quality of the services (Karlstrom et al., 2015). Shortages of nurses and midwives and an unfriendly environment are amongst the challenges faced by the health care system in South Africa, which may impact on the job satisfaction of the midwives as well as on the patients' satisfaction. The HIV/AIDS epidemic, together with the economic constraints experienced in low and middle income countries further places great demands on providing cost effective, safe, quality childbirth care that meets the needs and expectations of women (Du Preez, 2010). In addition, women's expectations are affected by the context of the much medicalised birth environment, including unplanned medical and obstetrical emergency interventions such as augmentation and induction of labour, operative deliveries, intrapartum complications and the need for resuscitation, which mostly contribute to a negative experience.

Literature shows that a number of studies in the field of maternal and child health have been conducted around the world, however they mostly assessed isolated aspects of childbirth and focused on the risks and complications of childbirth outcomes (Dencker et al., 2010; Nilsson et al., 2013). Experiences encountered by women during childbirth have been given little attention, especially in low and middle income countries where greater priority has been assigned to preventing pregnancy related deaths (Fisher, Mello, Patel, Rahman, Tran, Holton and Holmes, 2012; Nilsson et al., 2013). Knowledge of women's birth experiences and satisfaction is thus very important in order to improve childbirth care (Dencker et al., 2010).

1.2.PROBLEM STATEMENT

The health care provided during childbirth has primarily focused on neonatal and maternal morbidity and mortality outcomes, rather than on women's childbirth experiences (Nilsson et al., 2013). Research on childbirth experience in women originates mainly from high income countries and results have been conflicting, and the majority of these studies assessed only isolated aspects of childbirth (Dencker et al., 2010). There is limited data available describing the birth experiences of women in low and middle income countries, including South Africa, as the main focus has been placed on the prevention of pregnancy related deaths (Fisher et al., 2012; Nilsson et al., 2013).

The factors that influence positive and negative childbirth experiences by women remain complex, however, the type of childbirth experience plays a major role in whether mothers will develop positive feelings towards their infants, adjust easily to motherhood, and influences their attitude towards future pregnancies and childbirth. The type of experience may influence the relationship between the mother and her child, the relationship between the mother and her partner as well as her relationship with her family at large. Negative birth experiences may also increase the risk of depression after delivery or during a future pregnancy (Dencker et al., 2010; Mohammad et al., 2014).

Studies are therefore needed to investigate and describe childbirth as a multi-dimensional experience and from the women's perspective. In addition, these studies are needed in order to identify mothers in need of support and counselling, and knowledge about the women's experiences of childbirth is important in order to improve the childbirth care (Dencker et al., 2010). This is crucial for maintaining and monitoring the quality of maternity care, informing service development and delivery, as well as minimising complications. All pregnant women deserve competent and continuous care during childbirth, and a woman's right to health includes her right to have a healthy baby. Pregnancy and childbirth should not be a source of fear or apprehension for women, but rather a good experience and a celebration of life (Mathebula, 2013).

1.3. AIM OF THE STUDY

The aim of this study was to survey women's childbirth experiences in two state hospitals in the KwaZulu-Natal (KZN) Province in South Africa, in an attempt to identify women's experiences of labour and birth.

1.4. OBJECTIVE OF THE STUDY

- To identify women's experiences of childbirth/labour in two state hospitals in KZN.

1.5. RESEARCH QUESTIONS

- What is the level of capacity experienced by women during childbirth?
- What is the level of professional care and support experienced by women during childbirth?
- What is the level of safety experienced by women during childbirth?
- What degree of control, involvement and participation in the labour and birth management process is experienced by women?

1.6. SIGNIFICANCE OF THE STUDY

Childbirth experience is identified as an individual life event, including an interrelated subjective psychological and physiological process which is influenced by social, environmental, organisational and policy context (Larkin, Begley and Davane, 2009). Identifying and incorporating women's views on their childbirth experiences is essential to improve the health outcomes for mothers and babies and to inform nursing practice. Knowledge on how women experience labour and birth is also important in order to improve the quality of childbirth care (Dencker et al., 2010), therefore, the following agents which have been identified to play a major role in improving the childbirth experiences and care may benefit from this study:

1.6.1. Nursing education

Childbirth is a holistic experience which thus requires a holistic and multi-dimensional approach to care. This means a deeper reflection and more earnest consideration, not only of the physiological aspects of care but also of the psychological aspects. Therefore, the findings of this study may assist with education and further training which honours this holistic approach, with a view to a more integrated approach to midwifery care that prepares midwives to deal with the psychological as well as the physiological dimensions. Furthermore, the findings of the study may assist to identify weak areas in the midwifery training curriculum which need to be reviewed.

1.6.2. Nursing administration

A good quality, safe and competent health care service is a strong determining factor of overall satisfying care and healthy birth outcomes (Lewallen, 2011; Nyango, Mutihir, Laabes, Kigbu and Buba, 2010). The findings of the study may assist nursing management in

identifying areas of maternity care that require improvement in order to facilitate a positive and satisfying childbirth experience.

1.6.3. Nursing practice

The results of this study may aid in identifying postnatal mothers in need of support and counselling. Since midwives play a significant role in supporting women during childbirth in hospitals, knowledge of factors affecting maternal birth experiences may influence clinical practice.

1.6.4. Nursing research

The findings of this study might add to the limited body of knowledge in KZN regarding this area of research and may motivate other researchers to explore further on the topic, thus further contributing towards an increased body of knowledge in this area.

1.7. DEFINITIONS OF TERMS

The following terms used in this study are defined:

1.7.1. Childbirth

The process of giving birth to a baby, involving labour and birth (Hornby, 2005). In this study, it involves giving birth to a live infant through normal vaginal delivery (NVD).

1.7.2. Experience

This is an event or series of events and activities that are lived through and affect a person in some way (Hornby, 2005). This study involves the experience of childbirth.

1.7.3. Woman

In this study, woman refers to an adult female human who has recently given birth to a live baby and the woman is 18 years or older.

1.8. CONCLUSION

This chapter introduced the concept of childbirth experience. It presented the background to the study and the problem statement. The aim and objective were determined, and the research questions and the significance of the study were stated. Finally, the key terms related to the childbirth experience were identified and defined.

CHAPTER TWO: LITERATURE REVIEW

2.1. INTRODUCTION TO THE LITERATURE SEARCH

A literature search for the available knowledge pertinent to women's experiences of childbirth was performed. Keywords identified were based on the research topic and the research questionnaire and included; *childbirth, own capacity, childbirth professional support, and childbirth perceived safety, women childbirth participation and involvement, induction and augmentation of labour and labour duration, experiences and perceptions.*

The following electronic databases were used: EBSCO HOST, Medline, Academic Premier Research and Science direct. Additional articles and theses were accessed electronically through the search engines: Google and Google Scholar.

2.2. LITERATURE SOURCED

A broad range of studies exist on issues concerning childbirth. The literature review in this study was intended to present what has been identified in previous studies on childbirth experiences and the gaps within this wealth of literature.

2.2.1. Overview of childbirth experiences

The experience of childbirth is multidimensional, complex and subjective and it is one of the most important experiences in a woman's life. Women have different views of what they consider to be a positive and satisfying birth experience, depending on both the outcome and the process of labour and birth experienced by them as individuals (Shahoei, Khosravy, Zaheri, Hasheminasab, Ranaei, Hesame and Shahoei, 2014). This was confirmed by Lundgren, Karlsdottir and Bondas (2009), who state that women's childbirth experiences are influenced by the overall outcomes of labour. Although childbirth is considered to be an individualistic experience; Callister, Getmanenko, Garvrish, Eugenevna, Vladimirova, Lassetter and Turkina (2007), in their study *"Giving birth: the voices of Russian women"*, affirm that the birth experience is universal for all women, that there are some similarities in their birthing and that the significance of the physical, emotional and spiritual dimensions of giving birth is universal.

Many studies have shown that women tend to remember their experiences of labour and birth for the rest of their lives, as giving birth is one of the most important life events that the

women will ever experience (Bryanton, Gagnon, Johnston and Hatem, 2008). Waldenstrom and Schytt (2009) also state that the memories of giving birth are remembered for a lifetime. Certain happenings might fade but others might be remembered forever, especially positive memories of their labour and delivery experiences. Lundgren (2004), in the thesis submitted at Uppsala University in Sweden, reports that some women spoken to during the study relayed harmony and happiness and that their experiences of childbirth were positive. Giving birth empowered and strengthened them. Some women, however, do not have such positive remembrances of their deliveries and describe them as dreadful. A negative childbirth experience may have a short or long term impact on the woman's health, that of the baby and on their immediate family (Sengane, 2013; Mohammad et al., 2014). Furthermore, there is an increased risk of postpartum depression and depression during the next pregnancy (Rijnders et al., 2008); and Karlstrom et al. (2015) affirm that the childbirth experience has long-term implications on women's health and wellbeing. Lundgren (2004) reports encountering women who asserted that giving birth was their worst experience in life, in that they had a terrifying experience and feared death; an experience which they hoped never to encounter again.

Given that childbirth is a multi-dimensional experience with different aspects, its experience may be perceived positively or negatively as women may experience both positive and negative experiences. According to Larkin et al. (2009), a positive birth experience is one of satisfaction and has both short and long-term benefits in terms of the maternal emotional connection and relationship with the baby. Positive birth experiences contribute to the ability of the mother to cope with motherhood and increase self-esteem, as well as the wellbeing of both the mother and the baby. Contrary to this, negative childbirth experiences negatively affect the health of the mother and lead to psychological consequences such as maternal depression, anxiety and post-traumatic stress disorders, state Soet, Brack, and Dilorio (2003); Goodman (2004) and Larkin et al. (2009). These interfere with the mother-baby relationship and the family is affected at large. These different experiences lead to the idea that childbirth is a complex multi-dimensional event and may be understood basically as a subjective experience for childbearing women which is influenced by different external factors (Lundgren, 2004; Dencker et al., 2010).

2.2.2. Factors influencing childbirth experiences

Studies done in the field of pregnancy and childbirth have identified that factors such as complications, expectations, pain, care, support received from relatives, midwives and the medical team, as well as the organisation of the institution, all have an influence on how women experience the process of childbirth. Nilsson et al. (2013) argues that women's experiences of childbirth is influenced by the attendance of antenatal classes, intensity of the labour pain, support received from a partner and professionals (midwives), perceived safety, sense of being in control and participation in the decision making process. Similarly, Dencker et al. (2010), in a Swedish study targeting experienced midwives and first-time mothers found that a sense of security, perceived control, the level of labour pain, personal support, midwifery care, analgesia given, the women's engagement in decision making and the information given contribute to how women experience childbirth.

Antenatal classes may affect a woman's experience of her labour and delivery because they give a better understanding of what to expect during pregnancy and childbirth. Artieta-Pinedo et al. (2010) report on studies that advocate the psychological benefit of childbirth education, stating that women show a more positive attitude towards the birth experience and seem more in control of the process. Furthermore, Melender (2006) states that antenatal education contributes to a woman's self-efficacy and sense of control during childbirth, and a woman's perceived control during birth is significant (Dencker et al., 2010). Personal control and self-efficacy are thus amongst factors that relate to childbirth satisfaction, and women need to realise that they can have some degree of control over their labour in terms of their choices, even if situational control is beyond them (Karlstrom et al., 2015). Added to this is benefit that the experience of personal control and self-efficacy has on the management of labour pain (Christiaens and Bracke, 2007).

Childbirth is also affected by the amount of support given to the mother during labour and birth. Support given by a midwife to a woman during labour and delivery and an opportunity to participate in their care and the decision making process empowers women, promotes a trusting relationship with the midwives and increases the possibility of a positive birth experience (Hodnett et al., 2011). Women also feel valued when provided with midwives' support during labour and birth (Sengane, 2013). Midwives play a central role in supporting women and ensuring that women have positive and safe childbirth experience. Midwives as

well as other health care providers are expected to provide psychological support, but without neglecting medical safety (Sydsjo et al., 2015).

Findings from a study done in northern Sweden show that a positive and satisfying childbirth experience for a mother is associated with having the mother's expectations fulfilled (Karlstrom et al., 2015). Yet, according to Du Preez (2010), the health care system in South Africa is struggling to provide a suitable quality service to meet the standards of health for all; thus the assessment of women's views on their birth experiences provides important insight into the quality of the childbirth care. Quality health care incorporates a number of dimensions, including the safety of practices, the effectiveness of the care and a patient centred approach. A range of perspectives is also relevant to accurately assess the quality of the care, including those of the patients, the health care providers and the health care managers (Raven et al., 2015).

More recently, research has focussed on the prevalence of negative birth experiences, with the aim of improving the quality of care (Karlstrom et al., 2015), and a shortage of nurses and midwives and an unfriendly environment are amongst the challenges faced by the health care system in South Africa, which may impact on the job satisfaction of the midwives, as well as on women's satisfaction with their labour and birth experiences.

The HIV/AIDS epidemic, together with economic constraints experienced in low and middle income countries, further place great demands on providing cost effective, safe, quality childbirth care that meets the needs and expectations of women (Du Preez, 2010). In addition, women's expectations are affected by the more medicalised birth environment, and unplanned medical and obstetrical emergency interventions such as augmentation, the induction of labour and caesarean deliveries, intrapartum complications and the need for resuscitation, all of which generally contribute to a negative birth experience. Overgaard, Fenger-gron and Sandall (2012) Danish study concurs with this, stating that the environment and context, birthplace and care providers all influence the childbirth experience and the medical paradigm of childbirth is said to dominate the experience in most high and middle income countries. They added that the overall birth experience is an important outcome of birth, and studies of the psycho-social birth outcomes and women's perspectives of the care received are increasingly being conducted to evaluate and develop maternity care services and birth experiences. The perceived level of care is found to be influenced by specific

elements of patient-centred care, such as support, participation in decision-making, attentiveness to the patients' psychological needs and wishes for type of birth, information, and being listened to (Overgaard, Fenger-gron and Sandall, 2012).

2.2.3. Women's level of control and capacity during labour and birth

Capacity refers to the level of personal control, labour expectations and emotions such as feeling strong, happy and the ability to handle the whole childbirth situation very well. In other words exhibited levels of self-efficacy. The ability to fulfil childbirth expectations, coping with labour pain and self-efficacy determines the level of capacity, postpartum experience and the evaluation of the birth (Christiaens and Bracke, 2007).

Literature has shown that perceived control is a strong predictor of childbirth satisfaction. A sense of being in control during labour and birth is seen as an important predictor of positive childbirth outcomes, broadly defined as satisfaction (Stevens, 2011). Different authors indicate that perception of control during birth is an essential way of feeling satisfied and empowered, and is associated with capacity and self-efficacy (Christiaens and Bracke, 2007). Although pain management is the best short-term solution to help women cope with childbirth, personal control provides a long-term benefit. This is supported again by Christiaens and Bracke (2007), who affirm that the experience of personal control and self-efficacy has an effect on labour pain management. Haines, Robertson, Pallant and Hildngsson (2012) agrees that when women are able to participate in decisions related to their labour, their ability to control pain and to control their emotions and behaviours can be achieved.

When women participate actively, they are empowered by the experience of control. This empowerment experience increases self-efficacy and self-efficacy refers to us as the ability to cope with any stressful situation which in this study leads to a positive childbirth experience. Childbirth confidence is also an important marker of women's coping abilities during labour and birth (Schwart, Toohill, Creedy, Baird, Gamble and Fenwick (2015). Christiaens and Bracke (2007) assert that women's self-efficacy is the ability to cope with the labour process and it is associated with more satisfaction, especially when there is support from the midwife and the physician. In addition, findings from a study done on Belgian and Dutch women to assess the influence of their expectations about childbirth, labour pain, personal control and self-efficacy showed that personal control consistently improves satisfaction and lowers the impact of labour pain (Christiaens and Bracke, 2007).

The feelings and attitudes of women, their ability to build trust, their preparation for childbirth and the provision of appropriate information to deal with labour pain increases their self-esteem and sense of control and contributes to positive birth experiences. Antenatal education contributes to woman's self-efficacy and sense of control during childbirth (Melender, 2006) and Dencker et al. (2010) also asserts that a woman's perceived control during birth is significant to the overall experience.

As personal control and self-efficacy are amongst factors that relate to childbirth satisfaction, women need to realise that they can have self-control during labour, even if situational control is beyond them (Karlstrom et al., 2015). Hence, women need to be informed and given health education by the health care workers involved in their maternity care on how they can increase their personal control during childbirth.

2.2.4. Professional care and support during childbirth

Historically and across different cultures women have delivered at home and been helped and supported by other women during their labour and delivery (Leap and Hunter, 2016). They learnt about childbirth from their mothers, grandmothers and sisters and gave birth, constantly cared, supported and comforted by other women who were family members or members of the community (Green, Amis and Hotelling, 2007). Nowadays, women around the world give birth in hospitals, where labour and birth seem to be much more medicalised. As a result, providing continuous care and support to the woman is not easy to achieve (Hodnett, Gates, Hofmeyr and Sakala, 2013). They no longer receive the same care, support and encouragement from the women from their homes and community and although nurses give care and support in hospitals, they are often looking after several women in labour at the same time and have many other responsibilities assigned to them. It thus becomes difficult for them to stay with only one woman for the duration of that woman's labour.

Midwives provide the majority of the maternity care in South Africa without adequate support and facilities, with no relief system and with increasing demands for health care (Du Preez, 2010). Mothers assume that a nurse, midwife and a doctor will stay with them throughout their labour (Green et al., 2007), thus developing expectations regarding the midwives' level of care during their labour and when these are not met, the mothers become dissatisfied and eventually experience negative feelings of their labour. From the mothers'

viewpoint, the main contributing factor to a pleasant childbirth experience is the full support provided by midwives (Sengane, 2013).

Literature cites a number of factors that may affect childbirth care and support. Among them, a shortage of staff in hospitals and economic constraints are the most predominant. Shortages of nurses and midwives and an unfriendly environment are amongst the challenges faced by the health care system in South Africa and elsewhere around the world which may impact on the job satisfaction of midwives as well as on the patient's satisfaction with their labour and birth experiences (Karlstrom et al., 2015). A shortage of maternity staff (nurses/midwives, doctors and obstetricians) contributes to inadequate childbirth professional care and support. There is a relationship between staffing shortages and the quality of patient care, and little published research in Sub-Saharan Africa exists on the effects of staff shortages on the quality of care, more particularly relating to maternity care (Gerein, Green and Pearson, 2006). A study by Shimpuku, Patil, Norr and Hill (2013) reported that in Tanzania, the shortage of health care providers, mostly in rural areas, makes it challenging to provide mothers with the support they need in hospitals. This study then described women's perceptions of childbirth support at a hospital in rural Tanzania. Most women who participated in the study valued having family members present to provide care and affection. It was identified that women's needs were difficult to fulfil at this busy facility. The study suggested that increasing women-centred childbirth care and support and recognising family as important contributors may provide a strategy to meet the needs of both women, as well as health care providers.

Shortages of staff were identified in all hospitals in Malawi. Labouring women in these hospitals have little contact with the midwives as midwives have to attend to many women in labour at the same time, consequently failing to provide continuous and adequate care and support needed by a woman as an individual during labour and birth (Kungwimba, Maluwa and Chirwa, 2013). A study conducted by Banda, Kafulafula, Nyirenda, Taulo and Kalirani (2010) in Malawi found that relatives such as mothers, mothers-in-law, grandmothers, sisters and friends are used as birth companions. Although companionship during labour and delivery was found to provide physical and psychological support to the women and reduce the workload of the health care workers in this study, these companions are not professionally prepared for this role, as is the case in well developed countries where these companions are chosen and prepared in advance. The women essentially just choose any woman who is

available to accompany them to the hospital when they are in labour, and these companions are not able to provide complete care and support to them (Kungwimba, Maluwa and Chirwa, 2013).

The shortage of maternity staff does not only have negative implications for the patients; health care providers are affected as well. A review of safe staffing levels for nursing care revealed that shortage contributes to staff stress, personal injury, illness, frequent errors and delays in carrying out emergency tasks (Gerein et al., 2006).

Childbirth care and support provides numerous benefits and contributes positively to the childbirth process and outcomes. Support given to the labouring woman by a midwife and the opportunity to participate in their care and the decision making empowers women, builds a trusting relationship with the nursing staff and increases the possibility of a positive birth experience (Hodnett et al., 2013). Women feel valued when they are given care and support by midwives during labour and birth (Sengane, 2013), and midwives thus play a central role in supporting women and ensuring that women have a positive and safe childbirth experience.

Findings from a study conducted in Iran at the educational hospital, the Arak University of Medical Science, indicated that midwifery supports and improves coping strategies to deal with childbirth stress, therefore enabling mothers to experience a more comfortable labour with less anxiety. This study's results confirm that the relationship between a midwife and a woman during labour and delivery is essential to facilitate childbirth (Kordi, Bakhshi and Tara, 2014).

A study by Pascalo, Bonaro and Kroger (2004) showed that caring and supporting the mother during childbirth reduces the intensity of labour pain, facilitates childbirth, shortens the duration of labour and contributes to the positive aspect of the experience of birth. The study reported that the need for analgesia was reduced by 28% as well. Hodnett, Gates, Hofmeyr and Sakala (2012) also affirmed in their Cochrane Review of delivery care that the continuous presence of a support person reduced the need for pain relief and operative deliveries and led to better condition of the newborn. Furthermore, studies have shown a number of psychological and physiological benefits from an efficient caring and supportive midwife interaction with mothers, which in turn leads to a reduction of the intensity of pain,

thus reducing the use of analgesia and contributing to better childbirth outcomes (Hunter, 2009).

Midwives, as well as other health care providers, are expected to provide psychological support along with ensuring medical safety (Sydsjo et al., 2015). Besides clinical care, women in labour also need attention, guidance and support, understanding, empathy, as well as encouragement (Khadivzadeh, Katebi, Sepehri Shamloo and Esmaily, 2015). Results from a review done to identify practical points for supporting women in labour found that women in labour have a strong need for companionship, empathy and help during this period. This review reported that continuous support has a great benefit and that it contributes to the women's overall satisfaction with the labour process, more so than the perceived effectiveness of pain management (Iliadou, 2012). When women are provided with continuous care and support during labour, there is more of a chance for spontaneous vaginal birth, the duration of labour becomes shorter, there is a reduction in the use of labour analgesia, fewer caesarean sections and instrumental deliveries are required and there is a less number of babies with low Apgar scores. It is also of great benefit when this labour support is provided by a professional midwife (Langer, 2007).

Larkin et al. (2009) and Hodnett et al. (2013) present the types of support and intrapartum care needed by a woman in labour: emotional support is the first one and it consists of a continuous presence, reassurance and praise, demonstration of an effective caring attitude, positive and calming verbal and non-verbal expressions, distractions and the use of humour. In the study by Nikula, Laukkala and Polkki (2015) which was aimed at describing mothers' perceptions of labour support during childbirth at the Finnish University Hospital in Finland; mothers perceived emotional assistance as the most important type of assistance. They mentioned the giving of praise, treating the women on an individual basis, answering the women's question and understanding.

Another type of support presented by Larkin et al. (2009) and Hodnett et al. (2013) is physical support. It includes comfort measures such as touch and massage, offering warm baths, insuring adequate fluid intake and output, and helping the woman to express her wishes and choices. Encouraging and allowing different positions and mobilisation, the application of hot and cold packs, hygiene and nourishment are also cited as important physical support measures. Providing information and advice is seen as an important

supportive measure as well to the labouring woman and it consists of listening to the woman's views, providing information about the labour progress and providing advice on coping mechanisms for pain such as instruction on breathing and relaxation, as well as providing information on routines and procedures.

Midwives also play a role of advocacy and this support involves protecting the client (in this study the client refers to the woman in labour), assisting the client to make informed choices and decision making, being the client's voice when necessary and conflict management. Labour care and labour support are powerful nursing functions and it is the responsibility of health care facilities to provide an environment that encourages a united patient-nurse relationship during childbirth (Haines et al., 2012).

2.2.5. Women's safety during childbirth

Pregnancy, labour and birth are times when a mother wants to make sure that both herself and her baby are safe. Feeling safe is a concern for most pregnant women and it influence their behaviour and decision making. Safety incorporates the care of self and the baby, the importance of midwife skills, the availability of hospitals with the necessary facilities and resources, the environment, medical expertise and medical intervention (Howarth, Swain and Treharne, 2013). According to Jenkinson, Josey and Kruske (2013) a safe and satisfying birth experience also depends on the level of stress experienced by the birthing woman, and labouring women need to feel safe and secure. This is confirmed by a study conducted in Iran by Iravani, Janghorbani and Bahrami (2015). All women who participated in this study stated that once their own safety and that of their babies was assured, they felt more in control and empowered as the fear of childbirth and low self-confidence affects the women's ability to give birth. A fear of childbirth also increases the duration of labour (Adams, Eberhard-Gran and Eskild, 2012).

Childbirth care involves the labour and delivery care of healthy, low risk women and their babies. However, it is not always the case and sometimes levels of risks and complications are present which interfere with the normality and safety of childbirth (Chin, Warren, Komman and Cameron, 2011). Any pregnant woman could potentially experience complications during pregnancy, delivery, or after giving birth. Although access to quality health care has made the risk of maternal mortality negligible in high income countries; in lower income countries, however, that risk is still elevated because complications related to pregnancy and childbirth often prove to be fatal. Too often, maternal death and injury are

accepted as a natural and expected part of pregnancy and womanhood, rather than as a preventable loss of life and the tragic result of policy decisions that neglect and devalue women (Cook and Dickens, 2005).

Safety issues are identifiable at all levels of health care systems such as; regulations, guidelines and rules, or organisations such as the culture or work process, training of staff and communication between sectors. Safety issues also are found in immediate environments of care, for example, the condition of equipment and cleanliness. There are, in addition, interactions and procedures which directly involve staff and patients, such as their knowledge, skills, competencies and safe practice (Mgee and Askham, 2008). Inadequate funding, insufficient training of health workers, inadequate equipment at all levels of health care delivery and an unhealthy environment contribute to the failure to provide safe childbirth care in low and middle income countries, including South Africa, adds Pearson et al. (2007).

Maternity care, of course, is an area where safety and risk are a crucial concern. The priority for modern maternity services is to provide a choice of safe, high quality maternity care for all women. According to Redshaw, Rowe, Hockley and Brocklehurst (2006), how women perceive the safety of the maternity care they receive is highly individualistic and it depends on their views about childbirth, how risky they see it to be and the level of control they have over the process. Childbirth managed by a skilled midwife is the most important intervention to promote safe motherhood (Jenkinson, Josey and Kruske, 2014). A survey done in the UK by (Sandall, Mantrhorpe, Mansfield and Spencer, 2007) on support workers in maternity care expressed some anxiety related to issues of safety, where unqualified workers were involved in maternity care. A number of enquiries into maternal deaths and adverse maternity care outcomes were also reported and linked to this unsafe practice (Smith and Dixon, 2007).

All women need to feel safe during labour, assert Stenglin and Foureur (2013). During birth, feelings of safety and satisfaction are influenced by the birth environment (Newburn and Singh, 2005; Rudman, Khouri and Waldenstrom, 2007). According to Walsh (2007), the setting for birth can be the difference between a fulfilling and a traumatic childbirth experience. Environment safety is very important for both women in labour and maternity care providers, and the birth environment is the agent behind states of relaxation and wellbeing. For many women, the hospital birth environment is foreign and provokes fear and anxiety, which, in turn, results in feeling unsafe, and this can interrupt the delicate neuro-

hormonal influence that drives labour and birth, making medical intervention more likely. Intervention, in turn, is associated with a greater risk of a dissatisfying birth experience, trauma and postnatal mood disorders, with potentially life-long consequences for the wellbeing of women, their babies and their families (Jenkinson et al., 2014).

2.2.6. Women's level of involvement and participation during childbirth

Around the world, the current provision of maternity care reflects the rising importance of women's views and women being at the centre of decisions about their childbirth care. Women's ability to express their views, feelings and concerns freely, and being involved in the decision making process and in their treatment leads to better outcomes and a greater sense of satisfaction (Yeh and Nagel, 2010). If women participate actively, they are empowered by the experience of control, and women are increasingly seeking to be involved in deciding about their childbirth care. According to Harrison, Kushner, Benzies, Rempel and Kimak (2003), women have interest and feelings of responsibility for the health of their babies and themselves, and while some choose active involvement, some still choose to be more passively involved in the health care decisions. This study reports that women who want to be actively involved achieve it but they have to struggle and negotiate to be heard, and this should be encouraged. Others, however, choose a more passive involvement and then those who face a health crisis have no choice but to trust the expertise of the nurses and doctors.

Harrison et al. (2003) conclude that satisfaction with childbirth care is achieved if the care received corresponds with how women want to participate in decision-making. Iravani et al. (2015) affirm that mothers who participated in their study reported that they wanted to participate in decision making and be involved in the various aspects of care.

According to the NICE Clinical Guidelines (2007), all women in labour should be treated with respect and should be in control of and involved in what is happening to them and the way in which care is given.

2.2.7. Effect of induction, labour duration and augmentation of labour on childbirth experiences

Induction and augmentation of labour are some of the interventions commonly used for childbirth management. Rijnders, Aston, Schonbeck, Van Der Pal, Prins, Green and

Buitendijk (2008) report that several studies state that women who experience interventions have a negative birth experience and great dissatisfaction.

2.2.7.1. *Induction of labour (IOL)*

According to the World Health Organization's (2011) recommendations for induction, more and more pregnant women around the world have undergone induction of labour over the past decades. Up to 25% full term deliveries in developed countries involve IOL. Generally, the rate in developing countries is low but in some settings in developed countries the rate is higher. IOL is not free from risk and many women find it uncomfortable.

IOL is one of the most commonly performed interventions in the childbirth process. IOL is used to initiate the onset of labour in situations where the benefits to end pregnancy are greater than continuing it (Jay, 2013). Indications for IOL are based on a medical model of risk assessment and include non-acute maternal and foetal conditions. The most common reason for induction is a prolonged pregnancy, which is a pregnancy beyond 42 weeks. Other indications are hypertension, diabetes, pre-labour rupture of membranes, intrauterine growth restriction (IUGR) and intrauterine death (IUD), according to McCarthy and Kenny (2013).

With regard to women's experiences of the induction of labour during their childbirth, as the current provision of women-centred care is based on empowering women to participate and make informed choices and have control over their care and interventions; Jay (2013) conducted a qualitative study in the UK to examine women's experiences of induction of labour and to explore the circumstances in which women gain information and decide about induction, and its effects on their overall birth experiences. The findings indicate that women did not receive enough information from health care workers and that they should be given information specific to their needs as individuals. In addition, women who participated indicated that their expectations of induction were different from what they experienced; and some participants went as far as stating that they would consider a caesarean section in the future instead of IOL.

Unfavourable experiences of induction were also found in a study conducted to investigate women's experiences of IOL by Henderson and Redshaw (2013). This study was also conducted in the UK, and it was found that women who had labour induced were generally less satisfied with their care, suggesting the need for a more focussed service for women. It is

reported that women tend to have stronger and significantly more painful contractions with chemically induced or augmented labour. Induction of labour is associated with strong pain and results from a study done in Sweden show that women who were induced used more epidurals for pain relief. The study also reported that labour induction was associated with a less positive birth experience and women reported that they were scared that their babies would be damaged during birth (Hildingsson, Karlstrom and Nystedt, 2011).

2.2.7.2. *Labour duration and augmentation of labour*

According to the WHO (2015), augmentation of labour is defined as the process of stimulating the uterus to increase the frequency, duration and intensity of contractions after the onset of spontaneous labour. It is commonly been used to treat delayed labour (labour lasting more than 12 hours) when uterine contractions are assessed to be insufficient. Prolonged or delayed labour is associated with difficulties which can cause suffering that may have lifelong implications. It is one of the common delivery complications, is related to increased pain and often causes a negative childbirth experience for the mother (Dencker, Berg, Bergqvist, Ladfors, Thorse and Lilja, 2009; Nystedt and Hildingsson, 2014).

A study done in three hospitals in northern Sweden to analyse and describe women's different perceptions and experiences of childbirth following a prolonged or a normal labour found that women with prolonged labour had a mostly negative childbirth experience compared to those who had a normal labour. They reported that the difficulties they faced during delivery will mark them for life (Nystedt, Hogberg and Lundman, 2005).

Prolonged labour is also frequently associated with foetal and maternal distress and it is one of the major indications for an emergency caesarean section. Factors such as advanced maternal age, being primigravida, induction of labour, prolonged rupture of membranes, and early admission to the delivery unit, epidural use and maternal distress are some of the identified factors that may contribute to prolonged labour (Dencker et al., 2009).

While augmentation of labour may be beneficial in preventing prolonged labour, its inappropriate use may cause harm. Unwanted clinical interventions can deprive women of their autonomy and dignity during labour and may negatively impact their childbirth experience, assert Bugg, Siddiqui and Thornton (2011). Oxytocin is widely used for the augmentation of labour, to treat delayed and slow labour, however literature has reported that

the use of oxytocin is also associated with adverse outcomes such as low Apgar scores, leading to the admission of neonates to the neonatal intensive care unit (NICU), as well as the need for caesarean sections (Dencker et al., 2009; Nystedt and Hildingsson, 2014).

2.3. CONCEPTUAL FRAMEWORK

Two theories were used in combination for the current study to identify and describe women's experiences of labour and birth. They are Rubin's framework of Attainment of the Maternal Role (Rubin, 1967) and the Social Support Theory (Lakey, 2000). These theories are discussed independently first, followed by consideration of how they are applied to this study in combination.

2.3.1. Social Support Theory

The Social Support Theory describes support as the assistance that individuals provide and receive from others. Lakey (2000) presents a brief overviews of three important theoretical perspectives on social support; the stress and coping perspective, the social constructionist perspective and the relationship perspective.

2.3.1.1. Stress and coping perspective of the Social Support Theory

The stress perspective proposes that support contributes to health, protecting people from the adverse effects of stress. Support by close relatives and professionals, appears to contribute to coping ability with stress, thus having a positive effect on physical health and psychological wellbeing. The supportive actions approach predicts that received support enhances coping, which buffers the relation between stress and health outcomes, adds Lakey (2000).

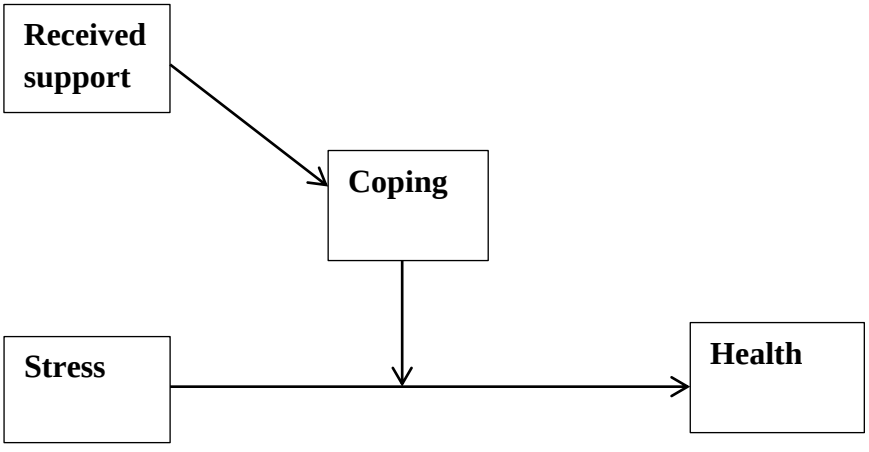


Figure 2.1 Stress and coping perspective of the Social Support Theory

2.3.1.2. Social constructionist perspective of the Social Support Theory

The social constructionist perspective of social support proposes that support directly influences health by promoting self-esteem and self-regulation, regardless of the presence of stress. Perceived support promotes self-esteem which leads to health outcomes. Perceived support also leads directly to health outcomes (Lakey, 2000).

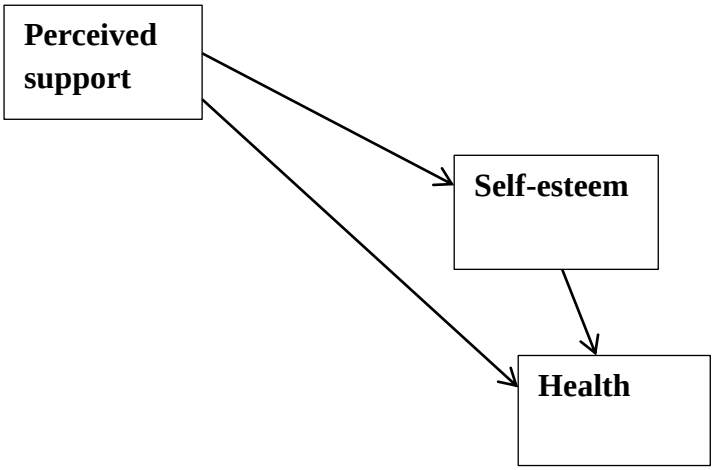


Figure 2.2 Social constructionist perspective of the Social Support Theory

2.3.1.3. Social relationship perspective of the Social Support Theory

The social relationship perspective predicts that the health effects of social support cannot be separated from the relationship process that often arises from companionship, intimacy, and low conflict. Support and health outcomes both result from companionship, low conflict and intimacy. The latter three variables overlap substantially, asserts Lakey (2000).

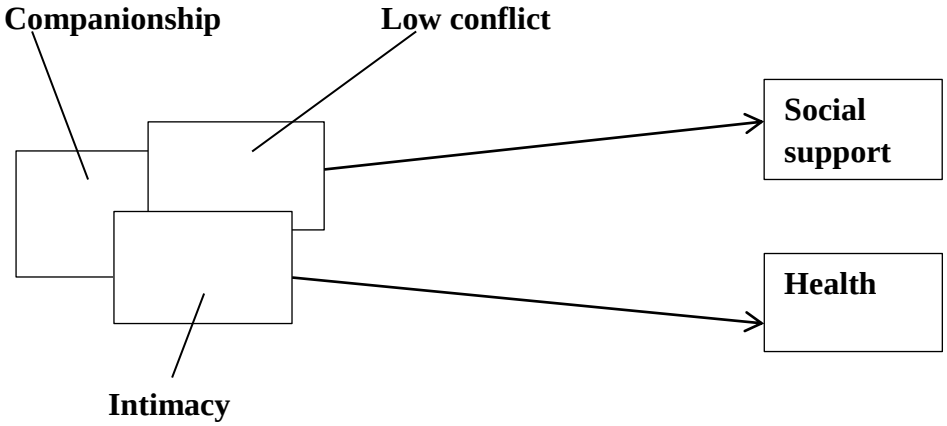


Figure 2.3 Social relationship perspective of the Social Support Theory

Social support is further described to be divided into three categories. Emotional support is what individuals do or say to make other individuals feel loved, supported or encouraged. Physical or instrumental support is when individuals provide needed material resources or assist with or complete a task for another individual. Another type of support identified by the social support theory is informational support, which involves the provision of advice, suggestions and information that a person can use to address problems and it is also regarded as an external or enabling factor (Lakey, 2000). Fahey and Shenassa (2013) also indicate that social support is thought to impact health positively by reducing the degree to which life events are perceived as stressful by an individual and by enhancing feelings of self-esteem and self-efficacy.

2.3.2 Rubin's Attainment of the Maternal Role Framework

"From onset to its destination, childbearing requires an exchange of a known self in a known world for an unknown self in an unknown world" (Rubin, 1967:52).

Rubin (1967) introduced the Attainment of the Maternal Role Framework and it is associated with the necessity for women to successfully exercise control over their health, their ability to mobilise social support, their self-efficacy and capacity, positive coping and the setting of realistic expectations and goals. Rubin describes women's cognitive work during pregnancy, in other words, how mothers think; in addition to describing the nursing care of pregnant women. Rubin's work is associated with pregnancy and maternal role attainment, focusing on the antepartum and postpartum period. Rubin's framework (1967) underpins the importance of the mother's experience, childbirth and maternity identity formation. It explains the birthing mother's socio-emotional setting, directing the support needed to improve childbirth outcomes and enhance the mother's self-esteem and identity as a mother. Rubin (1967) also implies a great deal about the need for nurses to provide supportive care to women in labour, as the mother perceives labour and birth as a threat to her wellbeing. Understanding the mother's fears and building on the mother's confidence is very important. This is true and very important, especially for first time mothers, to help them develop good self-esteem, positive feelings for the baby, and easier adjustment to the motherhood role and future pregnancies (Nilsson et al., 2013).

Rubin (1967) presents views of the role of the perinatal nurse and observations of mothers' needs and feelings during childbirth. The Attainment of Maternal Role Framework explains

the labouring mother's psychological milieu, guiding the support process that can ease labour, improve birth outcomes, enhance self-esteem and identity and provide a foundation for the role transition to motherhood. In describing the evolution in mothers' emotions, behaviour and self-view during and after birth, Rubin also affirms or implies a great deal about the need for nurses to provide supportive care to women in labour (Sleutel, 2003).
Furthermore, Rubin (1967) affirms that intrapartum nursing skills revolve around facilitating a woman's ability to completely give her body to a uniquely feminine role, which is giving birth. Those nursing skills involve how intrapartum nurses provide continuous emotional support, information, advice and physical support to the labouring woman (Sleutel, 2003).

2.3.3. Application of conceptual frameworks within this study

Rubin's Attainment of the Maternal Role Framework and Lakey's Social Support Theory are seen as a foundation for intrapartum nursing care (Sleutel, 2003). The most common features of social support provide the structure in which Rubin's descriptions of nursing care during labour and birth can be evaluated. Therefore, integrating both theoretical frameworks in this study creates a linkage between the childbearing mother's cognitive, emotional processes and capacity as well as the specific supportive nursing interventions tailored to meet the mother's needs and optimise the mother's birth experience. Social support is often described as an interpersonal transaction that contains emotional support, information or advice. The perception of support reflects the aid provided from the social environment, which, during labour, includes the nurse intrapartum care and support. Rubin writes that nurses must understand the mother's perception of the situation and have empathy in order to render care (MacKinnon, McIntyre and Quance, 2005).

The Attainment of the Maternal Role Framework and the Social Support Theory were chosen to guide this study because together they provide a perspective of intrapartum experiences, care and support needed to attain the maternal role (in this study this refers to the childbirth experience and the professional care and support required to achieve a positive experience). Combining these theoretical frameworks provides a perspective of intrapartum nursing practice.

The maternal role in the current study is seen in terms of women's ability to handle and cope with the process of labour, self-control and participation. These are amongst the identified contributing factors to either positive or negative childbirth experiences. It was identified

through the literature review (section 2.2.4) how professional support and care (mostly from midwives) contributes to a positive childbirth experience. Not only professional support, but also social support (partner and relative's roles) has been valued (Shimpuku et al., 2013). Giving birth is seen as one of the most important individualistic and unique events in a woman's life; requiring support and motivation, not only professionally but also from family members (Rudman, 2007). Therefore the Social Support Theory and Rubin's Framework give guidance to identifying the childbirth support needed to attain a desirable positive childbirth experience.

2.4. CONCLUSION

In summary, this chapter discussed the reviewed literature, both local and international, to gain an insight into the women's experiences of childbirth. Through reviewed literature, a major gap has been identified which shows that a number of studies in the field of maternal and child health mostly assessed isolated aspects of childbirth and focused on the risks and complications of childbirth outcomes. Consequently, existing research gives little attention to the experiences encountered by women during childbirth, especially in low and middle income countries where greater priority has been assigned to the prevention of pregnancy related deaths. The chapter also discussed the theoretical frameworks that guided this study.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1. INTRODUCTION TO THE RESEARCH METHODOLOGY

The purpose of this section is to provide and describe an overview of the research methodology used in this study. The discussion is focused on the following aspects: research paradigms, research approach, research design, research setting, population, sampling methods and sample size, strategies and procedures for data collection, instruments, validity and reliability, ethical considerations, data analysis, data management, data storage and data disposal, as well as the dissemination of the findings.

3.2. RESEARCH PARADIGMS

A paradigm is a way of looking at the world. It is composed of certain philosophical assumptions that guide and direct thinking and action, explains Mack (2010). For the context of this study, the researcher adopted a positivist paradigm; a paradigm underlying the traditional scientific approach, which assumes that there is a fixed, orderly reality that can be objectively studied, and it is often associated with quantitative research (Polit and Beck, 2014). A quantitative approach which is closely allied with the positivist tradition was used. Positivist philosophy also assumes that there are social facts with an objective reality apart from the beliefs of individuals.

Based on the aim of this study, which was to survey women's childbirth experiences in an attempt to identify women's experiences of labour; the researcher believes that the childbirth experience is a social reality which exists independently of people's minds. In addition, the researcher considered the positivist paradigm to be relevant for identifying women's childbirth experiences, as it assumes that truth is absolute and that there is a single reality that one may discover whenever reliable measures are applied (Burns and Grove, 2009). The data from the respondents is subjective truth that exists among them and which can be explained and measured scientifically.

3.3. RESEARCH DESIGN

A non-experimental, quantitative research approach was used in this study. Mouton (2001) considers that a quantitative descriptive research approach gives a broad view of the population through a study of a representative sample. Bowling and Ebrahim (2005) write

that there are many quantitative methods for measuring people's psychological attributes, such as preference for a specific health service. The systematic collection of quantitative information by doing a survey was the approach employed in this study. This approach was chosen because the study aims at quantifying data and describing the findings on women's experiences of childbirth. A descriptive survey was done which, according to Polit and Beck (2014), is an approach designed to obtain information about different aspects of people. The main aim of descriptive research is the accurate portrayal of the characteristics of individuals' situations or that of groups, and the frequency with which certain phenomena occur, using statistics to describe and summarise the data (Polit and Hungler, 2013).

3.4. RESEARCH SETTING

This study was conducted in two selected state hospitals (hospital A and B) located in the eThekwini District, KwaZulu-Natal province in South Africa. They were both selected purposefully based on the fact that they are situated in the same health district, serving a population from the same context, thus with a high probability of sharing some similarities. They are both regional and referral hospitals in KZN, serving a large population from different surrounding communities and having large and busy maternity departments. In addition, as highlighted by Glicken (2003) and Polit and Hungler (2013), descriptive survey research on a concept, people or situation that the researcher knows something about and just wants to describe what has been found or observed. The researcher being an employee (a midwife) in hospital A and trained in hospital B, as well as having knowledge about childbirth situations in both hospitals, additionally contributed to the choice of the research setting.

3.4.1. Hospital A

The second largest hospital in South Africa has a bed status of 922 with +/- 360 000 outpatients per annum. This hospital provides a tertiary service for the entire province of KwaZulu-Natal (with a population of approximately 5 million), part of Mpumalanga and the Eastern Cape. The hospital is also the main teaching hospital in the Province. The hospital is situated in ward 33 in the eThekwini District of the KwaZulu-Natal Province of South Africa. It has several departments comprising of both outpatient and inpatient units with different specialities. Among them is the department of Obstetrics and Gynaecology, which is comprised of the gynaecology ward, two wards for antenatal and postnatal care, the nursery and the labour ward. The bed capacity for these wards is: labour ward - 18 beds; high care -

four beds; antenatal ward - 59 beds; and the postnatal ward - 70 beds. The obstetric unit caters for approximately 8000 deliveries per year. Since the beginning of the year 2016, statistics from the birth register show that of the normal vaginal deliveries (NVDs), there were: 230 in January, 224 in February, 259 in March and 271 in April; making a total of 984 NVDs within four months.

3.4.2. Hospital B

This is a state hospital situated in a peri-urban area of the eThekwini District of KwaZulu-Natal Provence, South Africa. It is a 571 bedded district and regional hospital, where obstetrics and gynaecology services are offered at a district level. According to the proposed pattern of referral between the levels of care for the KwaZulu-Natal Department of Health, this hospital is a referral hospital for 16 clinics in its catchment area, and this contributes to the high number of childbirths for this hospital. Statistics from the birth register show that since the beginning of the year 2016, normal vaginal deliveries (NVD) numbered 150 in January, 144 in February, 179 in March and 201 in April; giving a total of 674 NVDs within four months.

3.5. POPULATION, SAMPLE AND SAMPLING

Burns and Grove (2005) describe population as the entire set of individuals having some common characteristics. In this study the population included all post-partum patients in urban KZN hospitals where the research was conducted. The study sample was selected from low risk postpartum mothers in the postnatal units of the selected hospitals who had uneventful vaginal deliveries of healthy live full term infants. Those who were already discharged from hospital and were just waiting for the completion of paperwork and to be picked up by relatives were identified from the discharge register to respond to the questionnaire.

The study used purposive sampling whereby the participants were selected according to criteria which were relevant to the topic. Purposive sampling was chosen because it enabled the researcher to obtain useful information as the respondents had the characteristics of the population being studied (De Vos, Delport, Fouche and Strydom, 2005).

The researcher consulted a statistician to decide on the appropriate sample size adequate for the study. The sample size was calculated using the effect size and the desired statistical

power. The results were as follow:

Effect size: 0.26

Type 1 error: 0.05 (recommended for medical studies)

Type 2 error: 0.20 (recommended for medical studies)

Power (1-type 2 error): 0.80

Number of groups : 5

Critical F: 2.42

Total sample size: 185 respondents were suggested

Inclusion criteria were women who were 18 years or older, who had had a normal vaginal delivery of a live and healthy infant, and who were already discharged from hospital and waiting to go home. Exclusion criteria were women whose babies had died or were admitted to the Neonatal Unit, those who had had a caesarean section or other instrumental (forceps/vacuum) delivery, and any women who were below 18 years of age.

3.6. DESCRIPTION OF THE RESEARCH INSTRUMENT

An instrument entitled "The Childbirth Experience Questionnaire" (CEQ) was used. The CEQ was chosen for this study because it contains items which measure different important dimensions of the childbirth experience, as most other existing instruments either assess isolated aspects of the childbirth experience or combine different aspects into single overall scores (Dencker et al., 2010).

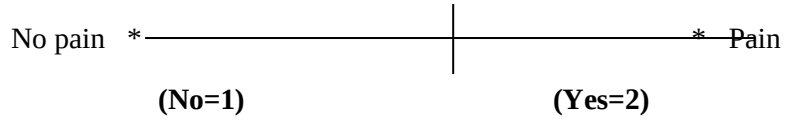
The CEQ was developed by Dencker, Taft, Bergqvist, Lilja and Berg of Sweden in 2010. It is a structured questionnaire of 22 items developed to study women's perceptions of their childbirth experiences. Amongst them, 19 items have a four point Likert scale, and three items are assessed with visual analogue scales (VAS) (see appendix 5a). The 22 items include four basic domains representing own capacity, professional support, perceived safety and participation (Walker, Wilson, Bugg, Dencker and Thornton, 2015). High scores on items indicate a better childbirth experience. Scaling of negatively worded statements was reversed.

For the purposes of this study, the subscale scores and the overall score of the CEQ were examined. To suit the context of the study, the CEQ was modified to include the demographic and clinical data of the respondents. The response format was transformed to a 5-point Likert scale to include a neutral option. Responses were: Strongly agree = 5, agree =

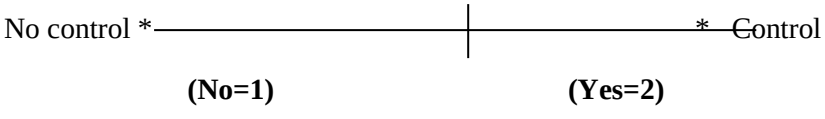
4, neutral = 3, disagree = 2, strongly disagree = 1. The three negative statements were reversed when being scored.

The VAS scores were transformed to categorical values and 1 represented= No; whereas 2= yes. For example with control, a mark on the left side of the middle line indicates no or little control and a mark on the right side indicates a high level of control experienced (refer to the illustration below).

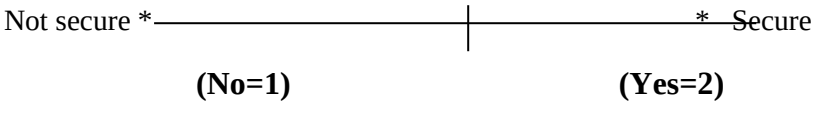
1. As a whole, how painful did you feel childbirth was?



2. As a whole, how much control did you feel you had during childbirth?



3. As a whole, how secure did you feel during childbirth?



The questionnaire has also a section named additional comments which refers in this study as an open-ended question, where respondents were asked to add any information/comment about their childbirth experience in their own words.

The questionnaire was also translated into IsiZulu and IsiZulu responses to the open-ended question were also translated by professional language translators in the IsiZulu Department at the University of KwaZulu-Natal, as most of the respondents were women from the KwaZulu-Natal Province who predominantly speak and read IsiZulu. Permission to use and translate the questionnaire was obtained from the corresponding author (refer to Appendix 8).

3.7. VALIDITY AND RELIABILITY

Validity expresses the degree to which inferences made in a study are accurate and well founded in measurement, in other words, the degree to which an instrument measures what it

is intended to measure (Polit and Beck, 2014). Several varieties of validity tests have been described and include face, construct, criterion and content validity which have also been tested for in the CEQ.

According to Walker et al. (2015), face validity of the CEQ was tested in the UK among 25 postnatal mothers and it was demonstrated by all respondents stating that it was easy to understand and complete. Criterion validity was also tested by calculating the Pearson correlation coefficient for the CEQ and the 2010 Maternity Survey scores. The CEQ was found to be a valid and reliable measure of the childbirth experience in the UK population. According to Polit and Beck (2012), content validity concerns the degree to which an instrument has the appropriate sample of items for the construct being measured and adequately covers the construct domain.

For the current study, the items on the instrument were evaluated against the objective of the study and the research questions that they intended to answer, as shown in Table 3.1 below:

Table 3.1: Content validity

Objective	**Research questions**	**Items on the questionnaire**
To identify women's experiences of labour in two state hospitals in KZN	What is the level of capacity experienced by women during childbirth?	Question: 1, 2, 4, 5, 6, 19, 20, 21
	What degree of control, involvement and participation in the labour and birth management process is experienced by women during childbirth?	Question: 10, 11, 12,
	What is the level of professional care and support experienced by women during childbirth?	Question: 13, 14, 15, 16, 17
	What is the level of safety experienced by women during childbirth?	Question: 3, 7, 8, 9, 18, 22

Content validity of the questionnaire was also checked by a midwifery expert in the discipline of Nursing at the University of KwaZulu-Natal.

Polit and Beck (2012) define reliability as the consistency with which an instrument measures the target attribute. Reliability of the CEQ was measured by calculating Cronbach's alpha for each subscale and for the total scale. A weighted kappa of 0.68 demonstrated test-retest reliability of the CEQ. It was concluded that the CEQ was reliable in the UK population by Walker et al. (2015).

Since the researcher used a validated questionnaire in another part of the world, the questionnaire was modified to suit the current study. To ensure validity and reliability of the instrument for this study after modification, the questionnaire was pilot-tested on a small group of five postnatal women in the postnatal units (three in hospital A and two in hospital B) before the actual study was conducted. The English questionnaire was used for pilot study and this was due to the participants' preferences. No changes were made to the questionnaire after the pilot study. The results from this pilot study showed that the instrument was understandable and easy to complete. The data from the pilot study was not included in the data analysed for the actual study. For the actual study, the researcher administered the same questionnaire to all respondents in the sample population.

3.8. DATA COLLECTION

Data was collected after authorisation from the regulatory bodies was obtained: Ethics Committee of the University of KwaZulu-Natal (reference number: HSS/0917/016M), Ethics Committee of the Department of Health of KwaZulu-Natal Province (Reference number: HRKM228/16), and permission from the management of the selected hospitals (refer to appendices 1, 2, 3 and 4).

Authorised by the labour ward unit managers, the researcher identified respondents who met the criteria of the study from the births register in the labour ward. Those who were identified were followed up in the postnatal units by the researcher. Authorised by the postnatal unit managers and assisted by the midwives, as well as other staff in the postnatal ward, the researcher identified those mothers who had already been discharged and were waiting to be picked up by relatives. After introducing herself, the researcher distributed a detailed information letter to the women in the ward and those who were willing to participate in the study signed the consent form. Thereafter, questionnaires were distributed by the researcher and collected immediately after completion. The questionnaires were collected by means of dropping them into a box, so that they were not handed directly to the researcher, and this ensured confidentiality. Data was collected over the months of September and October 2016.

3.9. DATA ANALYSIS

A statistician was consulted for the appropriate data analysis method. Microsoft Excel was used for data capturing and the data analysis was done using the Software Package for Social Science (SPSS-24). The five point Likert scale was condensed to form a three point Likert scale; disagree, neutral and agree. Descriptive statistics such as frequencies and percentages were used to describe the data and the results were presented in tables or figures. Inferential statistics using the Chi-square test was used to determine the relationship between the demographic data as well as the midwifery-related demographics (age, level of education, parity, ANC, IOL, augmentation and duration of labour), with scores on childbirth experience items on the questionnaire. The result was considered significant if the probability of occurrence (P-value) was equal to or less than 0.05. The open ended questions were analysed by reading and re-reading the responses and looking for similarities (patterns) which were then grouped into categories.

3.10. ETHICAL CONSIDERATIONS

Research ethics involve requirements on daily work, the protection of the dignity of subjects and the publication of information from the research (Fouka and Mantzorou, 2011). According to Brink (2006) the researcher is responsible for conducting research in an ethical manner and failure to do so undermine the scientific process and may have negative consequences. Complying with such standards, the researcher has to keep in mind the moral worth of each individual participant, and the concrete situations in which their need for protection and the safeguarding of their rights arises.

The research was reviewed and approved by the Research Ethics Committee of the University of KwaZulu-Natal (refer to Appendix 1) and the KwaZulu-Natal Health Research Committee (Appendix 2). Permission to conduct the study was obtained from the Management of Hospital B (Appendix 3) and Hospital A (Appendix 4). The study started after approval from the above officials was granted.

Prior to the commencement of data collection, respondents were given an information letter (refer to Appendix 6) to clarify that participation in the study was voluntary and that there was no monetary benefit from the study. They were then given an informed consent form (Appendix 7) to sign when they had agreed to participate. Thereafter the researcher started collecting data. According to Nijhawan, Jonodia, Muddukrishna, Bhat, Bairy, Udupa and

Musmade (2013), informed consent is the major ethical issue in conducting research. Obtaining consent involves the process of providing sufficient information to the participants in a language which is easy to understand by them, so that they can make the voluntary decision to participate or not in the research study. This was ensured in this study by the researcher providing an information letter in both the IsiZulu and English languages.

Furthermore, in order to avoid unethical research practices, the researcher took into account all ethical principles pertinent to a research study involving human participation. The ethical principles that guided the study, as prescribed by Holloway and Wheeler (2010) were:

- *The principle of respect for autonomy*: the respondents in this study were allowed to make a free, independent and informed choice, without force. The researcher ensured respect of the human right of free choice and self-determination, and ensured that the informed consent form was completed before carrying out the data collection. The respondents were informed about the option to withdraw from the study at any time they felt the need to do so and that there would be no punishment or undue influence on their management if they chose to withdraw.

- *The principle of beneficence and non-maleficence*: The researcher believed that the findings from the study would benefit midwifery practice and future patients, and cause no harm to the respondents, institutions or society as whole. The aim of the researcher was to positively contribute to the health care system, nursing education, nursing practice, nursing research, and improve the standards of care without harming anyone. Respondents were assured that they would be protected from any kind of harm or deception if they consented to participate in the study, and confidentiality, fidelity and veracity were maintained at all times. Protection of the respondents' identities was ensured as no names were used on the questionnaire and the data was coded.

- *The principle of justice*: all research strategies were fair and just. No false information was included in the final report as the results presented were from the responses on the questionnaires, with no addition or subtraction of information.

- *Protection of the vulnerable participants*: although the study involved participants from a group which was associated with being vulnerable, namely children, the mentally

unstable, pregnant women, people depending on medical support etc., any participant in a study can be physically or emotionally vulnerable at some point. Although no incidents happened, the researcher was aware of the referral mechanisms within the two hospitals selected for the study, for further support in case any of the participants needed social or emotional support services during the data collection process. The researcher ensured the fairness of selection and treatment of the population in general and of the subjects in particular. Participation was voluntary, no exploitation occurred and the right to privacy was respected. Informed consent was given and only those who consented to participate responded to the questionnaire.

3.11. DATA MANAGEMENT, STORAGE AND DISPOSAL

To ensure safe storage of the information, each response was kept in a computerised file only accessible by the researcher and her research supervisor. The data on the computer was protected by a password known only by the researcher and the supervisor. All paper records will be kept by the researcher and the supervisor for a period of five years in the School of Nursing, University of KwaZulu-Natal, and will be destroyed by shredding thereafter.

3.12. DISSEMINATION OF THE FINDINGS

A copy of the marked final report will be submitted to the School of Nursing, Faculty of Health Sciences UKZN, where it will be accessible to the UKZN library. A final copy will also be submitted to the KZN Department of Health and to the management of the two hospitals used for this study.

3.13. CONCLUSION

This chapter outlined the research methodology used to guide this study. The research paradigm, as well as the study design was discussed, and the research settings presented. The instrument for data collection was described and the extent to which the measurement was credible was displayed by its validity and reliability. Finally, the procedure used for data collection, the measures taken to ensure the ethical considerations, the data management and the procedures for the dissemination of the findings were highlighted.

CHAPTER FOUR: PRESENTATION OF RESULTS

4.1. INTRODUCTION TO THE STUDY RESULTS

This chapter presents the findings of the study, the aim of which was to identify women's childbirth experiences in two selected state hospitals of KwaZulu-Natal in South Africa. Data was intended to be collected from a total of 210 postnatal women who met the inclusion criteria and agreed to participate in the study. The researcher handed out 210 self-administered questionnaires on different occasions and 201 completed questionnaires were returned, which indicates a return rate of 96%. Although 201 questionnaires were completed, some of returned questionnaires had missing values; therefore results were presented based on the number of responses available on each item on the questionnaire.

For the analysis of data, negative responses of 'strongly disagree' and 'disagree' are grouped together, and the positive responses of 'agree' and 'strongly agree' are grouped together. Descriptive statistical results are presented in the form of frequency tables and percentages and some of the results are illustrated graphically. The Chi-square test has been done to determine the relationships between the demographic variables and the respondents' scores on the questionnaire. The findings are presented in accordance with the sections of the research instrument; frequencies are described first, followed by the relationships between the scores and the demographic data. Finally, the findings of the open-ended question are presented and discussed.

4.2. DEMOGRAPHIC PROFILE

Demographic data in this study included age, level of education, gravidity, parity, antenatal class attendance, IOL, augmentation, mode of delivery and duration of labour.

4.2.1. Age of respondents

The results of the variable within the sample demographics related to age are displayed in Figure 4.1, according to age group.

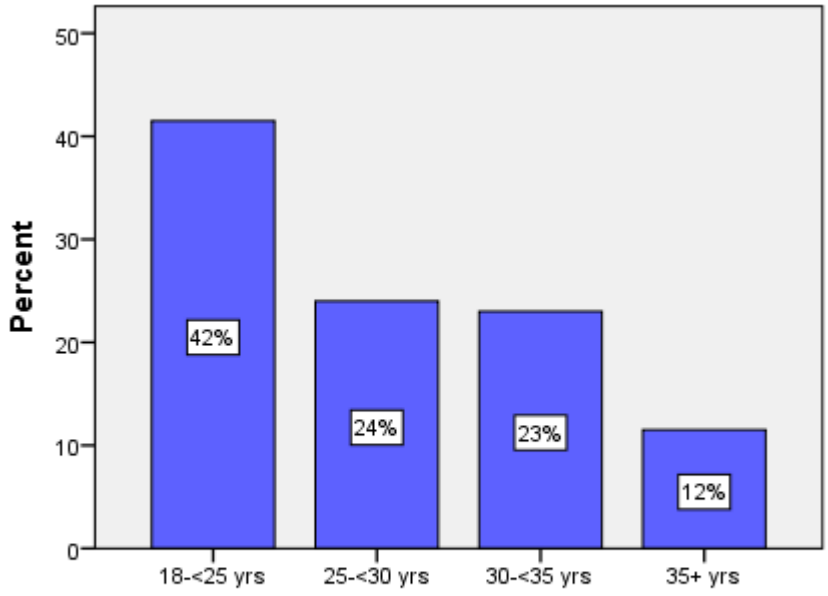


Figure 4.1: Age group of respondents (n=200)

The minimum age of the respondents in the sample was 18 years and the maximum age was 43, with a mean age of 26.83 and a standard deviation (SD) of 5.736. The majority of the respondents (42%) ranged between 18 and 25 years of age. These results suggest that the sample within the study was mostly young.

4.2.2. Level of education

The results on the respondents' level of education are displayed in Figure 4.2 below.

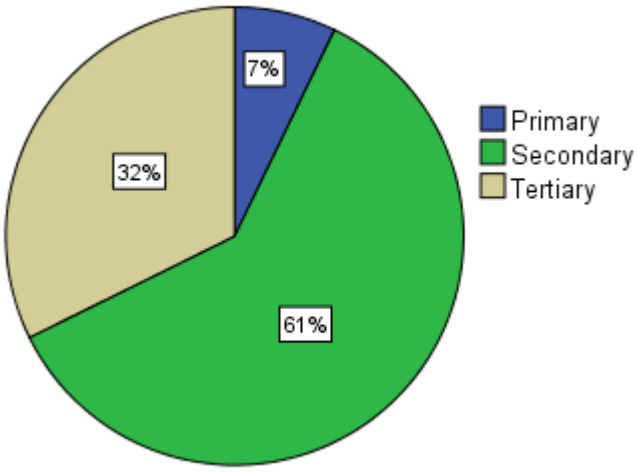


Figure 4.2: Level of education (n=195)

The results in Figure 4.2 show that the majority of the respondents (61%) were educated at a secondary (high school) level. There were no respondents who did not attend school on at least one of the three levels of education presented.

4.2.3. Midwifery related demographics

The results on the midwifery related demographics are presented in Table 4.1 and include gravidity and parity, antenatal class attendance, induction, augmentation and duration of labour.

Table 4.1 Midwifery related demographics

Variable	Category	Frequency	Percentage
Gravidity (n=200)	1	65	32%
	2	70	35%
	3	37	18%
	4	20	10%
	5	7	4%
	7	1	1%
Parity (n=201)	1	77	38%
	2	70	35%
	3	33	16%
	4	16	8%
	5	3	2%
	6	2	1%
Attended antenatal classes (n=199)	Yes	177	89%
	No	22	11%
Induction of labour (n=197)	Yes	62	31%
	No	135	69%
Augmentation of labour (n=191)	Yes	90	47%
	No	101	53%
Duration of labour (n=198)	< 12hrs	135	68%
	≥12hrs	63	32%

The results related to the gravidity and parity of the respondents, presented above in Table 4.1, revealed that the majority were in their early childbearing period. This was evident as the majority of the respondents (35%) were Gravida 2, and in relation to the parity, the majority (38%) were Para 1.

The results related to the attendance of antenatal classes displayed a positive and high level of antenatal care service use by the respondents. More than half (89%) of the respondents reported that they had attended antenatal classes.

Results also showed low use of obstetric interventions amongst the respondents. The number of respondents requiring labour induction was low as more than half (69%) had spontaneous labours. The majority (53%) of the labours were not augmented.

This study only targeted women who had a normal vaginal birth. Most of the respondents did not experience prolonged labour, considering that (68%) reported that they had a labour which lasted less than 12 hours, which is the average duration of a normal labour.

4.3. CHILDBIRTH EXPERIENCES

The results of the childbirth experiences in this study were analysed based on six sections of the questionnaire comprising of own capacity, professional support, perceived safety, participation, VAS and additional comments (open-ended question).

4.3.1. Own capacity

This portion of the questionnaire dealt with the women's perceived capacity during childbirth. See Table 4.2 on the following page.

Table 4.2: Own capacity

Item	Likert Scale	Frequency	Percentage
Labour and birth went as I had expected (n=201)	Disagree	54	27%
	Neutral	31	15%
	Agree	116	58%
I felt strong during labour and birth (n=201)	Disagree	53	26%
	Neutral	43	22%
	Agree	105	52%
I felt capable during labour and birth (n=192)	Disagree	39	20%
	Neutral	34	18%
	Agree	119	62%
I was tired during labour and birth (n=196)	Disagree	86	44%
	Neutral	25	13%
	Agree	85	43%
I felt happy during labour and birth (n=197)	Disagree	73	37%
	Neutral	32	16%
	Agree	92	47%
I felt that I handled the situation well (n=200)	Disagree	25	12%
	Neutral	28	14%
	Agree	147	74%

The results shown in the above Table 4.2 summarise the capacity exhibited by the majority of the respondents during childbirth. All items on own capacity displayed a high positive response. Labour expectations were fulfilled for majority of the respondents, given that more than half (58%) agreed that their labour and birth went as they expected. When asked whether they felt strong or not during childbirth, more than half (52%) of the respondents agreed that they felt strong. These results denote that despite the belief that labour could be difficult; women in this study were capable of finding a way to keep strong to deal with the stressful labour process. This is evidenced by majority of the respondents (62%) who agreed that they felt capable during labour and birth. Of the respondents, (47%) reported that they felt happy during labour and birth. Moreover, capacity was indicated by a considerable number of respondents (74%) who felt that they handled the whole situation well.

4.3.2. Professional support

This section of the questionnaire dealt with the midwife's support and care given to the woman and her partner during labour and birth. Results are presented in Table 4.3 below.

Table 4.3: Midwife support during labour and birth

Item	Likert Scale	Frequency	Percentage
My midwife devoted enough time to me (n=201)	Disagree	28	14%
	Neutral	10	5%
	Agree	163	81%
My midwife devoted enough time to my partner (n=174)	Disagree	43	25%
	Neutral	42	24%
	Agree	89	51%
My midwife kept me informed about what was happening during labour and birth (n=200)	Disagree	29	14%
	Neutral	13	7%
	Agree	158	79%
My midwife understood my needs (n=199)	Disagree	26	13%
	Neutral	19	10%
	Agree	154	77%
I felt very well cared for by my midwife (n=201)	Disagree	15	8%
	Neutral	21	10%
	Agree	165	82%

Results presented in Table 4.3 show that the majority of the respondents appreciated the support received from their midwife. A considerable number of respondents (81%) agreed that the midwife devoted enough time to them. The majority (51%) also agreed that the midwife devoted enough time to their partners. Besides this, (79%) appreciated being kept informed about their labour process by the midwife. With regard to how their needs were understood; once again positive responses were noted as more than half (77%) of the respondents agreed that their needs were met. Finally, a great number (82%) admitted that they were well cared for by their midwife. In summary, the overall results on midwife support and care during labour and birth denotes that majority of the respondents were satisfied with the midwifery support and care received.

4.3.3. Perceived safety

This portion of the questionnaire dealt with the women's perceived safety during childbirth, including their memories of their childbirth experiences and their impression of the team's medical skills. Refer to Table 4.4 for the results.

Table 4.4: Perceived safety

Item	Likert Scale	Frequency	Percentage
I felt scared during labour and birth (n=200)	Disagree	47	24%
	Neutral	42	21%
	Agree	111	55%
I have many positive memories from childbirth (n=201)	Disagree	35	17%
	Neutral	38	19%
	Agree	128	64%
I have many negative memories from childbirth (n=197)	Disagree	113	57%
	Neutral	37	19%
	Agree	47	24%
Some of my memories from childbirth make me feel depressed (n=200)	Disagree	122	61%
	Neutral	24	12%
	Agree	54	27%
My impression of the team's medical skills made me feel secure (n=201)	Disagree	25	12%
	Neutral	25	12%
	Agree	151	76%

The results presented in the table above revealed that the process of giving birth could be scary for women. More than half of the respondents (55%) in this study reported that they felt scared during labour and birth. It was noted, however, that although they felt scared, the competence and skill of the medical team resulted in a considerable number (76%) felt that they were in safe hands. In addition, majority of the respondents (64%) agreed that they had positive memories of their childbirth and more than half of the respondents (61%) disagreed with the statement that they felt depressed due to memories of their childbirth experience.

4.3.4. Participation

This section dealt with the women's perceived involvement and participation during their labour and birth process, and results are indicated in Table 4.5.

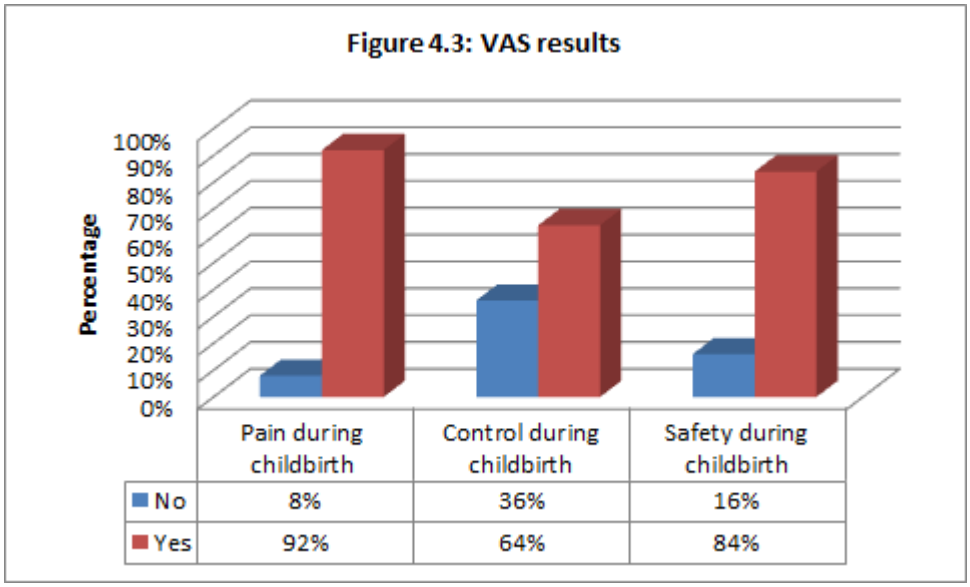
Table 4.5: Participation

Item	Likert Scale	Frequency	Percentage
I felt I could have a say in whether I could be up and about or lie down (n=201)	Disagree	77	38%
	Neutral	42	21%
	Agree	82	41%
I felt I could have a say in deciding my birthing position (n=201)	Disagree	87	43%
	Neutral	39	20%
	Agree	75	37%
I felt I could have a say in the choice of pain relief (n=201)	Disagree	64	32%
	Neutral	32	16%
	Agree	105	52%

Table 4.5 indicates that majority of the respondents (41%) felt they could have a say in whether they could be up and about or lie down while in labour. It was also evident that majority (43%) did not feel that they could have a say in deciding on their birthing position. With regard to pain relief, results suggest that women experienced painful labour and that majority (52%) felt they could have a say in the choice of pain relief.

4.3.5. Visual Analogue Scale results

In this section incorporating a Visual Analogue Scale (VAS), respondents indicated on two end point lines whether they experienced painful labour or not; if they had control or not and if they felt secure or not during childbirth. (Section 3.6: Description of the research instrument gives explanations of how the scaling was done). See Figure 4.3 below for the results.



The results presented in Figure 4.3 suggest that labour was extremely painful and almost all of the respondents (92%) indicated that they experienced a very painful labour. The results on feeling in control were positive: of the respondents, more than half (64%) indicated that they had control during labour and birth. It was also evident that safety was well maintained as the majority (84%) indicated that they felt secure during childbirth.

4.4. RELATIONSHIP BETWEEN DEMOGRAPHIC VARIABLES AND RESPONDENTS' SCORES ON EXPERIENCES OF CHILDBIRTH

The relationships were computed between the demographic variables (age, level of education, parity, ANC, IOL, augmentation and duration of labour) and the respondents' scores on their experiences of childbirth. The Chi-square test was used and the result was deemed significant if the probability of occurrence (*p*-value) was equal to or less than 0.05.

4.4.1. Own capacity

The Chi-square was performed to determine the relationships between all items involving own capacity with the age groups, level of education, parity, attendance of antenatal classes and IOL, and no statistical significance was found. A relationship was, however, found between feeling capable and the augmentation of labour (p=0.036). Women's capacity seemed to be more affected by the duration of labour. A statistical significance was found between feeling capable (p=0.014), feeling strong (0.028), feeling tired during childbirth (p=0.023), and how well the situation was handled (p=0.004) with labour duration. These results are tabled in Table 4.6.

Table 4.6: Relationship between own capacity and demographic variables

Own capacity	***p*-value**						
Item	**Age**	**Level of education**	**Parity**	**Attended ANC**	**IOL**	**Augmentation of labour**	**Duration of labour**
Labour and birth went as I expected	0.307	0.269	0.164	0.510	0.768	0.377	0.661
I felt strong during labour and birth	0.096	0.226	0.687	0.961	0.839	0.661	**0.028**
I felt capable during labour and birth	0.477	0.757	0.309	0.183	0.894	**0.036**	**0.014**
I was tired during labour and birth	0.447	0.347	0.253	0.279	0.677	0.385	**0.023**
I felt happy during labour and birth	0.743	0.201	0.496	0.972	0.943	0.268	0.423
I felt that I handled the situation well	0.553	0.155	0.370	0.987	0.932	0.593	**0.004**

4.4.2. Professional support

On professional support items, a statistical significance was only found between midwife devoted time to the partner (p=0.020) and age, and these results were found mostly among the age group between 18-25 yrs. The results appear in Table 4.7.

Table 4.7 Relationship between professional support and demographic variables

Professional support	***p*-value**						
Item	**Age**	**Level of education**	**Parity**	**Attended ANC**	**IOL**	**Augmentation of labour**	**Duration of labour**
My midwife devoted enough time to me	0.686	0.418	0.801	0.371	0.184	0.243	0.955
My midwife devoted enough time to my partner	**0.020**	0.545	0.706	0.752	0.580	0.488	0.815
My midwife kept me informed about what was happening during labour and birth	0.843	0.101	0.750	0.905	0.668	0.170	0.234
My midwife understood my needs	0.639	0.274	0.971	0.248	0.696	0.745	0.243
I felt very well cared for by my midwife	0.414	0.289	0.530	0.501	0.906	0.879	0.341

4.4.3. Perceived safety

For the perceived safety, a relationship between feeling scared during labour and birth and the augmentation of labour was found (p=0.039), as well as between feeling scared and labour duration (p=0.032). A significance relationship (p=0.035) was found between feeling depressed from childbirth memories and the augmentation of labour. Feeling secure as a result of the impression of the medical team's skills was related with ANC attendance (p=0.012). See Table 4.8 below.

Table 4.8 Relationship between perceived safety and demographic variables

Perceived safety	***p*-value**						
Item	**Age**	**Level of education**	**Parity**	**Attended ANC**	**IOL**	**Augmentation of labour**	**Duration of labour**
I felt scared during labour and birth	0.546	0.534	0.112	0.438	0.440	0.039	**0.032**
I have many positive memories from childbirth	0.840	0.980	0.954	0.232	0.987	0.416	0.430
I have many negative memories from childbirth	0.306	0.2992	0.679	0.356	0.435	0.239	0.107
Some of my memories from childbirth make me feel depressed	0.284	0.854	0.664	0.379	0.338	**0.035**	0.239
My impression of the team's medical skills made me feel secure	0.302	0.226	0.577	**0.012**	0.203	0.170	0.398

4.4.4. Participation

No statistical significance was found between any of the items on participation with the demographic variables, as can be seen in Table 4.9 below.

Table 4.9: Relationship between participation and demographic variables

Participation	***p*-value**						
Item	**Age**	**Level of education**	**Parity**	**Attended ANC**	**IOL**	**Augmentation of labour**	**Duration of labour**
I felt I could have a say in whether I could be up and about or lie down	0.439	0.144	0.472	0.929	0.186	0.886	0.441
I felt I could have a say in deciding my birthing position	0.355	0.826	0.877	0.284	0.326	0.330	0.712
I felt I could have a say in the choice of pain relief	0.167	0.061	0.527	0.318	0.596	0.122	0.915

4.4.5. VAS results

A statistical significance was identified between safety during childbirth and age (p=0.016); as well as between safety and ANC attendance (p=0.008). A p-value = 0.038 was found between control during childbirth and the level of education. No relationship was found with pain during childbirth. See Table 4.10 below.

Table 4.10: Relationship between VAS results and demographic variables

VAS results	***p*-value**						
Item	**Age**	**Level of education**	**Parity**	**Attended ANC**	**IOL**	**Augmentation of labour**	**Duration of labour**
Safety during childbirth	**0.016**	0.178	0.547	**0.008**	0.801	0.128	0.398
Control during childbirth	0.543	**0.038**	0.216	0.985	0.285	0.461	0.194
Pain during childbirth	0.324	0.495	0.762	0.848	0.320	0.971	0.307

4.5. ADDITIONAL COMMENTS (OPEN-ENDED QUESTION) (N=117)

Response to the open-ended question was optional, therefore not every woman who participated responded to it. Of the 201 respondents, 117 (58.2%) responded to the open-ended question. The responses given by the women were subjective and were related to both positive and negative childbirth experiences.

4.5.1. Positive childbirth experiences

A positive childbirth experience was grouped into four categories namely, support and care from health care workers, health care providers' skills, safety and the labour process and the outcomes.

4.5.1.1. Support and care from health care workers (nurses/midwives and doctors)

The respondents reported that staff were nice to them, that they were treated and cared for very well and that they had no problems with the level of support and care provided. They reported that although giving birth was difficult, they were given the needed support by their midwives. This was supported by the following statements:

God bless the staff for everything they have done for me; they looked after me very well (Respondent from hospital A).

I was well cared for, they treated me very good. I can't complain about anything (Respondent from hospital B).

4.5.1.2. Health care provider's skills

The mothers' impression of the health care workers' skills contributed to their labour and birth experiences. Some of those who were impressed by their midwives' skills expressed themselves in the following statements:

I felt happy. I wish I could give my midwife something because she was supportive and she knows her job (Respondent from hospital A).

Staff were efficient and attentive; caring and compassionate (Respondent from hospital A).

I was comfortable with my midwife, she treated me very well and she knows what she was doing (Respondent from hospital B).

4.5.1.3. Safety

Safety reported by women seems to be associated with delivering well with the help of the nurses/midwives. Labour contractions could cause women to feel scared, however when they were treated well by nurses in the hospital they felt safe and secure. They attributed their safety to the professional care:

Nurses who were there delivered me well. They did not shout at me. I felt safe (Respondent from hospital A).

I felt safe during childbirth even though contractions were strong, but nurses in hospital treated me well (Respondent from hospital B).

4.5.1.4. Labour process and outcomes

This study's results indicate that there is a link between positive labour outcomes and a positive labour experience. Women reported being satisfied and happy when their delivery went well and resulted in a healthy infant. Although the majority reported that giving birth was painful, they also felt happy at the end when the labour process was successfully completed:

> *…Unique and eye opening experience. You feel vulnerable and need as much help as you can get. In the end it is rewarding and relieving to see your child alive* (Respondent from hospital A).

> *Labour pains are the worst pain ever, but I feel that if you listen to what the midwife or doctor tells you during labour and birth, it makes it much easier/better to get through it successfully and faster than it could be* (Respondent from hospital A).

> *I have no complaints, everything went well* (Respondent from hospital B).

> *It was a good experience* (Respondent from hospital B).

4.5.2. Negative childbirth experiences

Negative experiences were grouped in six categories, including the severity of labour pain, poor treatment by the staff, a shortage of staff, lack of privacy, poor sanitation and a lack of control and communication.

4.5.2.1. Severity of labour pain

Some of the women reported that labour pain was the worst pain they had ever felt in their lives and they wished that they had been given pain relief. It was a traumatic experience causing fear and anxiety, which has the potential to affect how they think about future pregnancies. This was revealed by the following statements:

> *Giving birth for me was not enjoyable because of the pain I felt during birth, and falling pregnant again is something that I would have to put my mind into more and do what best for me* (Respondent from hospital A).

During my labour it was very difficult. I never felt like that before… they must provide pain killers (Respondent from hospital B).

4.5.2.2. Poor treatment by the staff

Women reported being shouted at, neglected and abandoned during labour and birth. This was supported by the following statements:

I suggest that doctors and nurses should stop treating people who are in labour as if they are not human, like shouting at them while they are feeling so much pain. They need to understand that these people have rights just as they have (Respondent from hospital A).

I was not fully happy with midwives and often felt neglected because they were not around me when I did my first push of the baby, and only attended to me when they realised the head was out (Respondent from hospital B).

4.5.2.3. Shortage of staff

Women reported that they were not provided with enough time and care expected because of the shortage of midwives and they requested an increase of nurses/midwives.

The nurse was very busy because we were many and sometimes she did not have time to tell me everything (Respondent from hospital A).

I think if they increase the number of nurses, they will be able to give enough time to the patients (Respondent from hospital B).

4.5.2.4. Lack of privacy

Women reported that they felt uncomfortable in the labour ward due to the limited privacy. Lack of privacy also deprived them from getting their partners' support. This was revealed by their statements:

No privacy respected. I could see other women in the next bed and opposite me, the very same way they could see me. The curtains are not good to keep my privacy. My husband could not come in to provide support; it was not allowed because of the

limited privacy. The hospital must provide private labour rooms for each delivering woman (One respondent from hospital A).

4.5.2.5. Poor sanitation

Women expressed dissatisfaction with regard to the hygiene in the hospital. They reported being scared of contracting infections due to poor hygiene and they expressed the wish that something be done to improve the hygiene and therefore the safety of the patients.

Government should put more effort into the hygiene of the hospital facilities to make things safer for mothers and babies (Respondent from hospital A).

The condition of the bathroom is scary; I may catch disease (Respondent from hospital B).

4.5.2.6. Lack of control and communication

Women reported a lack of control and communication during labour and birth and that they had no choice but to follow instructions so they could feel safe. This was expressed in the following statements:

I didn't have much to say or to do. I had to do what I had been told to do so I could feel safe (Respondent from hospital A).

I was not aware of anything during and after birth. There is a need for better patient-staff communication skills to be maintained (Respondent from hospital B).

4.6. CONCLUSION

This chapter presented the results of the study. Findings were presented in frequency tables and percentages and graphs were used. The *p*-values relating to the test of association were presented. The respondents' responses to the open-ended question added to the quantitative data and qualified and elaborated on the women's experiences of childbirth.

CHAPTER FIVE: DISCUSSION OF THE RESULTS

5.1. INTRODUCTION TO THE DISCUSSION

This chapter presents the discussion of the findings in line with the study objective, which was to identify women's experiences of childbirth and the factors that women perceived as having contributed to a positive labour and birth experience. The study took place in two state hospitals in KwaZulu-Natal.

To start with, the demographic data of the respondents is discussed, followed by discussions based on the research questions which the research findings intend to answer:

- What is the level of capacity experienced by women during childbirth?
- What is the level of professional care and support experienced by women during childbirth?
- What is the level of safety experienced by women during childbirth?
- What degree of control, involvement and participation in the labour and birth management process is experienced by women during childbirth?

The significant findings will be highlighted, compared and discussed according to the literature related to childbirth.

5.2.DEMOGRAPHIC DATA

This section discusses the demographic data and the midwifery related demographics which include age, level of education, gravidity, parity, antenatal classes, IOL, augmentation, mode of delivery and duration of labour.

5.2.1. Age of respondents

The results of the variables within the study sample demographics indicated ages ranging from 18 to 43 years, with a high number of respondents falling into the age group between 18-25 years of age. The majority of them had given birth for the second time and they had at least one child already. This suggested that the respondents within the sample were young and had started childbearing at an early age. This could be explained by the fact that South Africa is one of the countries facing high rates of teen pregnancy. These findings were consistent with the findings from a study done in urban South Africa by Marteleto, Lam and Ranchhod (2006), who reported that about 35% of 20 year old girls had given birth at least

once. Similar findings in Karra and Lee's (2012) report of their research done using data from Cape Town and rural KwaZulu-Natal indicated that recent trend analyses from South Africa has shown that approximately 2.7 million South African women (about one out of every four women aged between 20 to 50 years) had given birth before the age of 20. In addition, over 35% of children under the age of 20 (about 7 million children) were born to teen mothers. It was not only South Africa facing a high rate of childbearing at an early age, however. Similar findings were found in a report by Sedgh, Finer, Bankole, Eilers and Singh (2015) involving 21 countries with liberal abortion laws. The report indicated that although the adolescent pregnancy rates had declined since the mid-1990s in most developed countries with reliable trend data, the rate remained exceptionally high in the United States and even higher in Sub-Saharan Africa and in some former Soviet countries where the data quality was variable.

5.2.2. Level of education

Educational background results in this study indicated that the respondents were educated. All the women had attained some level of education, with majority of the respondents having completed secondary education (high school). This may be advanced by the fact that education has been a priority of the South African government for many years and that there has been remarkable progress in achieving the Education for All goals (Education for all: country report, South Africa, 2010).

5.2.3. Midwifery related demographics

The results of the current study revealed adequate use of ANC services amongst the respondents. Majority (89%) reported that they had attended antenatal classes. This may indicate that the respondents had a good understanding of the importance of antenatal care needed by a pregnant woman, because health knowledge is important as it enables women to be aware of their health status and the value of appropriate ANC (Rosliza and Muhamad (2011). In their study in Malaysia, Rosliza and Muhamad (2011) reported that majority (94.2%) of the participants knew that a pregnant woman should go for ANC check-ups. Similar findings by Matyukira (2014) at a clinic in Ekurhuleni found that majority of the respondents had knowledge and understanding of the services offered by the clinics. Results in a study done in Ethiopia by Gebremeskel, Dibaba and Admassu (2015) suggested that pregnant women who participated had a high level of knowledge of the importance of antenatal care for the health of both mother and foetus. Solarin and Black (2013) reported similar findings in their study done in inner-city Johannesburg, South Africa, where they

interviewed women post-delivery about their ANC experience and ANC attendance was found to be high (97%). A study in Nigeria by Onasoga, Afolayan and Oladimeij (2012) also reported similar findings, where most of the respondents (83.3%) knew of the services rendered at antenatal clinics and had adequate knowledge of the importance of antenatal care.

With regard to IOL and the augmentation of labour, results indicated that the numbers of inductions and augmentations of labour in the present study were low. More than half of the respondents had spontaneous labours with a low number of labour augmentations and the majority of them had a labour which lasted less than 12 hours, which is the normal average labour duration. This could be associated with the fact that the study targeted only low risk mothers. Besides this, IOL and augmentation are not routinely used. This is in line with the WHO (2011) recommendations for the induction of labour, which stipulate that induction of labour should be performed only when there is a clear medical indication for it and the expected benefits outweigh its potential harms. Consistent with this, an overview of systematic reviews at the University of Medical Sciences in Isfahan, Iran, reported that some of the routine interventions that are common during labour and birth might not always be essential or beneficial for women with uncomplicated and low-risk pregnancies (Iravani et al., 2015). As for IOL, the WHO (2014) recommendations on the augmentation of labour stipulate that the procedure should only be performed when the medical need for it is clear and the expected benefits will outweigh the potential negative effects.

5.3. CHILDBIRTH EXPERIENCES

Discussion on the childbirth experience results in this study is based on four sections of the questionnaire, including capacity during childbirth, professional care and support, perceived safety and control, involvement and participation. VAS results and the open-ended question are discussed, each in combination with the section it is related to.

5.3.1. Capacity during childbirth

The overall findings with regard to women's experienced capacity suggest that majority of the women in this study were confident in their ability to cope with the childbirth process. Capacity included items regarding labour expectations and emotions such as feeling strong, happy and the ability to handle the whole childbirth situation very well; in other words their exhibited levels of self-efficacy. The fulfilment of expectations, coping with labour pain and

self-efficacy determine the postpartum experience and the evaluation of the birth (Christiaens and Bracke, 2007).

Fulfilled childbirth expectations in this section were the most important consistent determining factor of childbirth capacity. Majority of the respondents from both hospitals A and B agreed with the statement that their labour and birth went as expected. Having expectations met could contribute to positive and satisfying childbirth experiences, and the results of this study were in line with the findings from a study done in Western Australia by Hauck, Fenwick, Downie and Butt (2007), whose results revealed that to perceive birth as positive, a woman had to achieve her priority expectations. Similar findings were reported in a study done in China by Zhang and Lu (2014), who identified in majority of their participants a high level of labour expectations in maternity care and reported that these expectations were linked with a positive ability to cope with labour and therefore with improved self-efficacy. Sengane (2013) reported similar findings from a study conducted in Gauteng in South Africa. Sengane (2013) found that different mothers develop different expectations and that when these expectations are not met they become dissatisfied and hence experience their labour negatively.

Although the current study did not investigate whether fulfilled expectations were associated with positive or negative experiences, a study in Thailand by Tanglakmankhong (2010) addressed the gap between expectations and experiences and results showed that a match between childbirth expectations and experiences were more predictive of satisfaction with the childbirth experience. Tanglakmankhong (2010) indicated that fulfilled expectations made a unique contribution to satisfaction, while unexpected experiences were not significant; therefore, a greater number of fulfilled expectations were associated with higher levels of satisfaction with childbirth experiences.

Furthermore, statistical results indicated that respondents in the current study experienced a high level of capacity, evidenced by the majority who indicated positive feelings of being capable, happy and strong during childbirth. Experiencing the ability and strength to cope with childbirth could have been grounded in the women's attitude of trust in themselves, trust in their ability to give birth and the fact that their expectations were met. Positive capacity contributed to the feelings of confidence and self-efficacy, which was clearly expressed by the high percentage (74%) of respondents who indicated that they were able to handle the

whole process of labour and birth very well. In their open-ended question responses, they indicated that having a caring and supportive midwife or the presence of trustworthy partner contributed to their self-efficacy, and hence with their ability to cope with labour pain.

Previous literature has identified similar findings and reported on the contributing factors for capacity during childbirth. For example, Karlström et al. (2015) found that Swedish women's capacity and self-efficacy resulted from their own ability and strength, a trustful and respectful relationship with their midwife and support from the father of the child. The positive effect of a supportive partner on a woman's childbirth self-efficacy and capacity was also reported by Schwartz, Toohill, Creedy, Baird, Gamble and Fenwick (2015), in a study conducted to identify factors associated with childbirth self-efficacy in Australian childbearing women. Carlsson, Ziegert and Nissen (2015) found similar results as well in their study which aimed at identifying the relationships between childbirth self-efficacy and aspects of well-being, birth interventions and birth outcomes. Their results showed a positive correlation between self-efficacy and maternal support, and women who reported high childbirth self-efficacy had less epidural analgesia.

5.3.2. Professional care and support during childbirth

One of the research questions was to identify the women's experienced levels of professional care and support during childbirth. To answer this, assessment was made of the women's responses to the questionnaire's questions; including the amount of time devoted by the midwife to the mother, the time devoted by the midwife to the partner, the information given to the labouring women about their birthing process and progress, the midwife's understating of the woman's needs and in summary, the mother's feeling of being very well cared for by the midwife. Open-ended responses on the questionnaire by the respondents qualified and elaborated on their experiences of support and care received.

The results of the current study indicated that majority (82 %) of the respondents felt very well cared for by the midwives, and this suggested that they were satisfied with the support and care received. Similar findings were reported in a study done to identify the midwifery care experiences of mothers during labour and delivery in Eritrea by Ghebreyohans (2011), who reported that the overall care that mothers received during childbirth was rated as good. Satisfaction with midwifery care was also studied in the Lorestan province in Iran; where

results showed that the recipients of the maternity care were satisfied with the level of care and support received (Changee, Iraipour, Simbar and Akbari, 2015).

Support given to the women in labour by the midwives, and being given the opportunity to participate in their own care and decision making empowers them to build trusting relationship and increase the possibility of a positive birth experience. Midwives play a central role in supporting women and ensuring that they have positive and safe childbirth experiences (Hodnett et al., 2011). In their open-ended question's responses, a number of women in the present study reported that they had a good relationship with the midwives, that there was communication and understanding; and that there were passionate and caring midwives who empowered them and contributed to their ability to cope with labour challenges. They valued midwife support, stating that it was very important for the woman during childbirth.

Similar findings by Sengane (2013) in a study done in one of the public hospitals in Gauteng revealed that women feel valued when they are given support by midwives during labour and birth. Childbirth support was also studied in Iran at the Educational Hospital of Arak University of Medical Science by Kordi, Bakhshi and Tara (2014); their findings indicated that midwifery support improves coping strategies to deal with childbirth stress, thereby enabling mothers to experience a more comfortable labour with less anxiety, as identified in most of the comments made by the mothers who participated in that study. This Iranian study's results confirmed that the relationship between a midwife and a woman during labour and delivery is an essential facilitator for a positive childbirth experience.

Supporting the mother during childbirth might reduce the intensity of labour pain, facilitates childbirth, shortens the duration of labour and contributes to the positive aspect of the experience of birth, asserted Pascalo-Bonaro and Kroger (2004). Respondents in the current study indicated in their response to the open-ended question that although labour was very painful, having supportive midwives on their side helped them to cope with their labour pain and ultimately all went well. These results supported the previous findings of many studies, as evidenced by literature. For instance, similar findings were identified in another Iranian study by Akbarzadeh, Masoudi, Hadianfard, Kasraeian, and Zare (2014), whose findings suggested that continuous support significantly reduced the intensity of labour pain among participants; and a study by McGrath and Kennel (2008) in the USA showed that continuous support during labour considerably decreased the need for analgesia. When mothers'

expectations regarding midwives' care during labour are not met they become dissatisfied and eventually have negative experiences of their labour, thus from the mothers' viewpoints, the main contributing factor to a pleasant childbirth experience is the full support provided by midwives (Sengane, 2013).

Although majority of the respondents in the current study reported satisfaction with their midwifery care, this did not mean that every aspect of midwifery care and support was perfectly rendered and this should be given attention in order to strive for perfection and improvement of the childbirth experience. When describing birth experiences statistically, majority of the women in the current study portrayed support and encounters with midwives as relatively satisfactory; however, in response to the open-ended question, a few women elaborated and recounted events or circumstances that were described as unpleasant and negative experiences, such as feeling ignored or neglected, poor treatment and being shouted at.

Similar negative experiences including poor relationships with staff, lack of information, neglect and abandonment were reported by South African women in a study by Chadwick, Cooper and Harries (2014). Moreover, similar findings on poor treatment were also reported by a number of studies and reviews on both local and global level: Ghebreyohans (2011) in Eritrea; McMahon, George, Chebet, Mosha, Mpembeni and Winch (2014) in Tanzania; Bohren, Vogel, Hunter, Lutsiv, Makh and Souza's (2015) review by the Research Council of South Africa; Abuya, Warren, Miller, Njuki, Ndwiga, Maranga, Mbehero, Njeru and Bellows (2015) in Kenya; Jha, Christensson, Svanberg, Larsson, Sharma and Johansson (2016) in India; a systematic review by Mannava, Durrant, Fisher, Chersich and Luchters (2015) which involved studies mostly from Africa, Asia and the Pacific; and Bradley, McCourt, Rayment and Parmar (2016) in a qualitative systematic review on disrespectful intrapartum care during facility-based delivery in sub-Saharan Africa.

Furthermore, mothers in the present study observed and reported a shortage of staff, which contributed to them feeling, neglected and abandoned while the midwife was attending to other women. A shortage of maternity staff does not only have negative implications for the women; health care providers are affected as well. A review of safe staffing levels for nursing care revealed that shortage contributes to staff stress, personal injury, illness, frequent errors and delays in carrying out emergency tasks (Gerein et al., 2006). Shortage of staff was similarly reported in a study in Tanzania by Shimpuku et al. (2013), whose findings indicated

that a shortage of health care providers, mostly in rural areas of Tanzania, makes it challenging to provide mothers with the support they need in hospital and therefore mothers feel neglected. A shortage of midwives was also identified by Kungwimba, Maluwa and Chirwa (2013) in their study in all hospitals in Malawi, where labouring women in these hospitals have little contact with the midwives as they have to attend to many women at the same time, and consequently failing to provide the continuous and adequate support needed by the women during labour and birth. This contributes to the women feeling abandoned and neglected.

Childbirth support did not only involve midwives. Women who described a bad relationship with their midwives regarded the father to-be as their most important support. The rresults from the open-ended question, however, indicated that a lack of support from partners was a concern, and that the women wished that the circumstances could have been different. Their partners were not allowed to accompany them and provide continuous support, predominantly because of the lack of privacy in the labour wards.

Results were similar to those of Ghebreyohans (2011) in Eritrea, where partners or family members expressed their dissatisfaction with not being allowed in the labour room because the labouring mothers were placed in one open room.

In Tanzania, Simpuku et al. (2013) reported on the value of having a family member present during childbirth. Most women who participated in their study valued having a family member present to provide support and affection. Their study found that having a relative present could help with the issue of the nursing shortage, as the relatives could take on the role of providing continuous support to the laboring women. This suggested that increasing women-centred childbirth support and recognising family as important contributors could provide a strategy to meet the needs of both women as well as health care workers in the under-resourced hospitals. Similar findings were found in an overview of 23 systematic reviews done in Iran by Iravani et al. (2015); those reviews reported that the presence and support of a partner during labour and childbirth were of paramount importance for women. The women reported that allowing their husbands to support them physically and emotionally would be the best thing for them. In addition, the presence of a family relative or a friend was also important to them while in labour as they reported feelings of loneliness, with many wishing for their mothers to be present.

Contrary to this, literature has also revealed that not every woman wants to have a partner or family members around them during childbirth. The presence of a skilled and professional attendant was identified to be far more important in these instances. Lundgren, Karsdottir and Bondas (2009) reported that according to their data, the presence of a partner could not replace the presence of a midwife. They indicated that even if a partner is present, a woman could still feel lonely, insecure and abandoned by their midwife. Iravani et al. (2015) reported that some women in the reviewed studies indicated their preferences for the partner not to be present in the labour room, reporting that they appreciated the continuous support of a midwife far more as it made them feel relaxed and relieved, resulting in them feeling much more in control and coping with their labour pain. Thus, this affirms once again the uniqueness and individualistic characteristics of childbirth experience.

5.3.3. Perceived safety during childbirth

Experiences of perceived safety were assessed against feeling scared during labour and birth, having positive, negative or depressive memories from childbirth and feeling secure from the impression of the health care workers' skills.

Childbirth is considered to be a scary and traumatising event. The current study results indicated that more than half (55%) of the respondents agreed with the statement that they felt scared during their labour and birth. They elaborated on their fear in the open-ended responses, where they reported that they feared for their lives and those of their babies, mostly due to the intensity of the labour pain. Toohill, Fenwick, Gamble, Creedy, Buist and Ryding (2014) conducted a study in Australia and reported that women who participated reported high levels of fear, and some of them reported experiencing moderate or extreme levels of anxiety or depression at some point. Nilsson and Lundgren (2007), in their study in Sweden, found that women were suffering and were affected by a fear of childbirth because of the care they received during childbirth, which mainly concerned pain and negative experiences with staff.

Although women reported experiencing fear during childbirth, conversely, the majority of these respondents (76 %) reported that their impression of the medical team's skills made them feel secure. This indicates that having skilled attendants could contribute to women's perceived childbirth safety, hence resulting in positive childbirth experiences for them. This was also evidenced by the open-ended question's responses, where respondents voiced their positive impressions of the professional skills which contributed to their feelings of safety.

These results supported the findings from previous studies where women valued good clinical skills and competent practitioners (Floyd, Coulter, Asamoah and Agyare-Asante, 2014; Renfrew, McFadden, Bastos, Campbell, Channon, Cheung, Silva, Downe, Kennedy, Malata and McCormic, 2014; Paudel, Mehata, Paudel, Dariang, Aryal, Poudel, King and Barnett, 2015). The results on the value placed by the women on the team's medical skills were also similar to the findings from a study done in Australia by Homer, Passant, Brodie, Kildea, Leap, Pincombe, and Thorogood (2009), which indicated that amongst all their data, skilled care was a strong theme and that women valued midwives' competency and expert care. Women in a study done in a military hospital in Accra, Ghana by Mensah, Mogale and Richter (2014) indicated that the competencies and attributes possessed by the nurse-midwives at this hospital offered them an element of ownership regarding their labouring processes.

Additionally, privacy and sanitation in the labour rooms, bathrooms and toilets were identified in the current study as some aspects of childbirth safety which could affect women's childbirth experiences. In their comments, women expressed their dissatisfaction with the lack of privacy and the poor sanitation in the labour rooms. They felt that they were at risk of catching infections, especially in the bathrooms and toilets, and suggested that the government should make a concerted effort to make health facilities clean and safe for mothers and their infants. In addition, women reported that privacy was not well maintained in the labour wards, which made them feel uncomfortable. The importance of privacy and the cleanliness of the childbirth environment were mentioned in a number of previous studies as a contributing factor to a positive childbirth experience. For example, Paudel et al. (2015) conducted a study in Nepal to identify women's satisfaction with maternity care. The suggestions made by the women in the Nepalese study included a need for privacy and a need for improved cleanliness. The same findings were identified by Floyd et al. (2014) who examined women's view and experiences of their maternity care in Ghana. Women also described valuing cleanliness in another study conducted in Ghana by Mensah et al. (2014). The women in these studies described the importance of tranquillity and the cleanliness of the environment during both labour and delivery. In addition, Iravani et al.'s (2015) study findings indicated that the physiological needs of birthing women were very important for the women who participated in their study. These physiological needs were associated with their nutritional needs, physical environmental conditions, individuals, hygienic needs, the provision of physical comfort and the insurance of privacy. They reported that the study

participants indicated a desire for comfort and safety, a pleasant environment and that clean rooms were most important to them.

Results of the psychological safety of the women in the current study, which were assessed against the memories they had from their childbirth experience, whether positive, negative or depressive, indicated that majority of the respondents (64%) had a positive remembrance of their labour and birth; negative memories were reported by 24%, while depressive memories were indicated in 27% of the respondents. In their comments, the respondents indicated that positive memories were associated with a positive childbirth experience and the major contributing factors to such an experience seemed to be the existence of a good relationship with and support from the midwives, feelings of safety and a positive labour outcome. In Karlstrom, Nystedt and Hildingsson's (2015) study in northern Sweden, similar results were found. In their study, all women looked back very positively on their birth experience. Women related their positive experience memories to their own ability and strength, a trustful and respectful relationship with their midwife, support from the father of the child, and feeling secure in a supportive environment; all of which contributed to gaining personal control over the process (Lundgren, Karlsdottir and Bondas, 2009; Nilsson et al., 2013; Halperin, Sarid and Cwikel, 2015).

Although the current study results were based on women's perceptions upon discharge from the hospital, the low percentage of negative and depressive memories found in the current study could also have been indicative of the existence of post-partum depression in those particular women at that stage, which could then potentially have affected their health and wellbeing. Literature has reported a high risk for post-partum depression, especially for those women who had traumatic labour and birth experiences, and that it negatively impacted on their health and wellbeing (Rijindres, Baston, Schonbeck, Van Der Pal, Prins, Green and Buitendijk, 2008; Mohammad et al., 2014; Karlstrom et al., 2015). Mina, Balhara, Verma and Mathur (2012) also reported a high incidence of depression in their study which assessed anxiety and depression amongst the urban females of Delhi in their ante-partum and post-partum periods.

5.3.4. Participation

A woman's control and involvement in the management of the labour and birth was derived from active participation in the process. The level of control experienced by the respondents in this study was assessed based on the women's feelings of having a say in whether they

could be up and move about or they had to lie down during their labour, having a say regarding their birth position and in having a say on the choice of pain relief. Control was assessed by asking women to rate their level of experienced control on VAS.

Results on participation indicated a low number of respondents who felt they could have had a say in whether they could walk around while in labour. The number of those who agreed to having felt that they could have had a say on their birthing position was lower than the number of those who disagreed that this was the case. The open-ended responses did not present any comments related to the women's feelings of having a say or participating in the choice of mobility and birthing position during childbirth. This therefore could indicate that most women did not think about or have any information on their choice for mobility and birthing position during childbirth. Instead, they focussed on labour pain which was the most concerning for them, evidenced by the majority of the respondents who stated that they felt they could have had a say in the choice of pain relief. It was, however, again not clear that they were sure about their involvement in labour pain management, as mobility and position seem to play an important role in labour pain management. It was thus evident that they were not well informed about labour pain coping mechanisms. These findings showed that women handled labour pain in their own way because of a lack of information about the childbirth process.

Lally, Thomson, MacPhail and Exley (2014) indicated in their findings that women in their study expressed a degree of uncertainty about the level of pain they would experience in labour, and the effect of different methods of pain relief. Their study suggested that women should be informed and be engaged in discussions around specific choices and decision making. Their findings also indicated that some of the women still relied on health care providers to help them to decide and explain to them about the choice of pain relief and coping mechanisms that could work for them, as they didn't have enough knowledge themselves. Consistent findings were found in a Scottish study which reported that women talked about putting themselves in others' hands by trusting their care providers to make decisions about pain control on their behalf (Snowden, Martin, Jomeen and Martin 2011).

Labour pain was, however, only one of the overall birth experiences, according to Aksoy, Yucel, Aksoy, Acmaz, Aydin and Babayigit (2016) and participation implied women's involvement in labour pain management. As stated before, the feeling of having had a say in

the choice of pain relief was reported by the majority of the respondents (52%) in the current study. In respect of the VAS results, most of the respondents (92%) reported that they had experienced severe pain. In their responses to the open-ended question, women reported that giving birth was very painful and difficult, and that they should have been given pain relief. This supported the need for women's empowerment; to be involved in the choice of their labour pain management.

The severity of labour pain was reported in many previous studies. For instance, in a study conducted by Beigi, Broumandfar, Bahadoran and Abedi (2010) in Iran, participants reported that labour pain was unbearable and indescribable and associated it with fear. Similarly, a critical review which included ten studies conducted in Australia, England, Finland, Iceland, Indonesia, Iran and Sweden found that women felt vulnerable during childbirth and perceived labour pain as challenging, although they showed understanding of the reason for pain while birthing their children (Van der Gucht and Lewis, 2015).

Research has suggested that maternal position may positively influence the labour process, reducing maternal pain and that women should be encouraged to move and to deliver in the most comfortable position (Zwelling, 2010). Iravani et al.'s (2015) findings showed that participants also spoke about the need for physical comfort and wished to be allowed ambulation; walking and changing positions rather than being told that they could only lie down. Furthermore, a study by Jenkinson, Josey and Kruske (2014) in Australia found that women who used upright positions and were mobile during labour had shorter labours, less interventions, reported less severe pain, and described more satisfaction with their childbirth experiences than women in recumbent positions. The benefits of mobility and choice of position during childbirth were similarly reported in another Australian study by Priddis, Dahlen and Scmied (2012).

Studies have explained the factors which hindered women's mobility and choice of position during childbirth. Sometimes the routines of the labour unit and the physical environment were not conducive to the freedom of movement and the choice of position during childbirth. In most birthing environments today, women are restricted from walking or moving freely, not because it is intrinsically dangerous, but rather because, with conventional obstetric management, it is impossible or the environment is not conducive to this practice (Lawrence, Lewis, Hofmeyr, Dowswell and Styles, 2009; Gaboury, Capaday, Somera and Purden, 2017).

Drawing on the results of the current study, one of the major concerns with regard to participation and involvement was the wish for adequate pain relief and for the women's ability to control the pain. It was evident that pain management during childbirth was related to personal labour control, but it was also associated with the women having an active role during the course of childbirth.

Therefore, control in this study described the degree to which the women were or perceived themselves to be in charge of their own experiences, including their involvement in decision making and choices such as pain management, etc. Personal control is a central feature of women's involvement in their childbirth experience (Wright, McCrea, Stringer and Murphy-Black, 2000). The control experienced during labour and birth could contribute to positive or negative childbirth experiences and the current study results indicated that the majority of the respondents (64%) reported that they had good control during the process of childbirth.

Similar findings were seen in a study by Fair and Morrison (2012) in the USA, where control experienced during labour and birth was assessed using six questions taken from the 'Birth Satisfaction Scale' that indicated the mothers' experiences of control. Regression analyses indicated that experienced control significantly predicted birth satisfaction. The study concluded that the experience of control during childbirth was important for birth satisfaction. Cook and Loomis (2012) in their study in Ontario, Canada to identify the choice and control in women's childbirth experiences also found that control over physical, emotional and mental aspects of childbirth were important for women's satisfaction. Similarly, another study conducted in Ireland by O'Hare and Fallon (2011) to identify women's control in labour and birth found that experiences of control in childbirth were both positive and negative, and their findings suggested that control was indeed important in the experience of childbirth. Being in control was perceived as a positive component of labour, with a preponderance of women affirming that it was essential to maintain personal dignity during labour in order for them to achieve a positive childbirth experience (Ahmar and Tarraf, 2014).

The concept of control differs from one woman to another and some women are worried about being in control of the process of labour while others are concerned with their involvement and participation in decisions about labour and birth (Ahmar and Tarraf, 2014). The results of the open-ended question in the current study showed a few women who reported a loss of control and power over their labour and birth. They reported that they had

to do what they were told to do, and a loss of control contributed to their dissatisfaction. Negative and positive experiences of control therefore coexisted in the current study with positive experience being dominant.

5.4. RELATIONSHIP BETWEEN DEMOGRAPHIC VARIABLES AND SCORES ON EXPERIENCES

5.4.1. Relationship between own capacity and demographic variables

A relationship was found between the items; I felt capable during childbirth and the augmentation of labour (p=0.036). It could be explained that when augmentation of labour is performed, women might feel incapable and as having failed to fulfil their duty of delivering through a natural process. A test for association revealed that labour duration and the augmentation of labour had a strong impact on women's capacity. Those results indicated that most of the items on own capacity presented a statistically significant relationship with labour duration: duration of labour and I felt strong during childbirth (p=0.028); duration of labour with I felt capable during labour (p=0.014); duration of labour with I felt tired during labour (p=0.023); duration of labour and I felt I handled the whole situation well (p=0.004). These results show that women's capacity during childbirth was mostly affected by the duration of their labour. In this study, women's capacity and labour duration indicated positive childbirth experiences and satisfaction in the majority of the respondents. This was evident because the majority of women portrayed the ability to cope and their labour duration was within the normal range.

When labour is prolonged, however, childbirth experiences become negative. This could be due to the fact that with prolonged labour, women became exhausted and lose control over the process of labour. The intensity of prolonged labour pain results then in fear, anxiety and a loss of physical strength; leading to the need for medical and obstetric interventions. Women who experienced interventions reported having a negative birth experience and great dissatisfaction in the study by Rijnders et al. (2008). These findings were supported by Nystedt, Hogberg and Lundman's (2006) Swedish study which reported that after prolonged labours, women portrayed their emotions and experiences as ones of being caught up in soreness and panic, having lost control of the situation and being forced to be reliant on others. They had lost their capacity to cope and had abandoned themselves to the physicians and midwives, added Nystedt and Hildingsson (2014).

5.4.2. Relationship between professional support and demographic variables

A significant relationship (p=0.020) between age and midwife devoted time to the partner was identified. This was found mostly among young respondents between 18-25 years old. This could be understood as usually young mothers are also mostly first time mothers who are more vulnerable during childbirth due to being less experienced, having a fear of the unknown and therefore tending to be in need of more support, not only from midwives but also from their partners. No literature has been found to support the specific relationship determined in this study between midwifery devoted time to the partner and the age of the childbearing mothers, however a study by Nilsson et al. (2013) conducted in Sweden to identify the factors influencing positive birth experiences for first time mothers indicated that support and a feeling of being empowered was due to the presence of trustful relationships with the professionals and their partners. Findings by Karlström et al. (2015) also affirmed that women who participated in their study reported that giving birth required teamwork where the women and their partners worked together with the midwives.

5.4.3. Relationship between perceived safety, VAS results and demographic variables

With regard to safety, a statistical significance was found between level of safety on VAS and age (p=0.016). These results therefore indicated that the perceived safety of childbirth was related to and influenced by the mothers' age. Safety during childbirth generally involves fear, and feeling scared during childbirth was reported by the younger mothers in the current study. This could be explained by the fact that the majority of these young mothers were also first time mothers and they did not know what to expect; thus their first exposure to the unfamiliar experiences contributed to their feelings of fear.

This was supported by the findings in a study done in Australia, which reported that dread of the unfamiliar was a widespread subject amongst first time mothers, and that they often stated that they did not know what to expect (Hauck, Fenwick, Downie and Butt, 2007). Safety and age may also contribute to positive or negative childbirth experiences. Ahmar and Tarraf (2014) reported that the childbirth experience was satisfying and positive in older and multiparous women. Similarly, in another study done in Australia, Fisher, Hauck and Fenwick (2006) found that the majority of women who evaluated their birth experience as positive and fulfilling were also multiparous.

Furthermore, a statistical significance (p=0.012) was also found between the item: I felt secure from the impression of the team's medical skills (one of the items on the perceived safety section) and ANC attendance. In addition, on the VAS results, experienced level of safety was also associated with ANC attendance (p=0.008). Attendance of antenatal clinics may foster a sense of security for a pregnant woman as it provides the woman with education and knowledge on self-care, detection, prevention and treatment of the risks associated with pregnancy and childbirth. In addition, women develop relationships and become familiar with health care workers as well as the hospital/clinic environment. Onasoga et al.'s (2012) findings in a study conducted in Nigeria affirmed that majority of the respondents agreed that attendance of ANC helped to detect possible complications during pregnancy, as well as helping to reduce maternal and neonatal morbidity and mortality, thereby contributing to maternal safety. These results thus indicated that attendance of antenatal classes was very important for pregnant women as they received information on the process of labour and birth, and therefore gained an understanding of what to expect during labour and from their professional care providers. This was in line with literature which suggested that antenatal classes enhance women's abilities to overcome fear and self-doubt about coping with pain, develop trusting relationships with health care providers and led to feelings of pride, elation, safe and empowerment (Larkin et al., 2009).

Moreover, a relationship was identified between the items on perceived safety: I felt scared during labour and birth (p=0.039) with augmentation, as well as with the duration of labour (p=0.032). This could be explained by the fact that augmentation of labour is performed when labour is prolonged to increase contractions, with a resultant increase in labour pain intensity. In this study, painful labour was reported by almost all of the respondents and literature has reported that labour pain is dreadful and causes fear and anxiety amongst women during childbirth (Beigi, et al., 2010; Ahmar and Tarraf, 2014). Labour interventions could cause increased fear and discomfort for women as they are mostly performed when complications present. In addition, augmentation of labour increases labour pain intensity and women move suddenly from having mild contractions to strong contractions (Bugg et al., 2011).

In addition, prolonged labours tend to happen in women with a fear of childbirth, which in turn requires interventions such as augmentation. Prolonged and augmentation of labour are

indications of labour complications and the associated risks, which could then, in turn, cause or increase the level of fear for the woman in labour. Fear related to the intensity of labour pain, birth related problems, treatment and attitudes from staff, procedures and interventions was identified in previous studies. For example, fear and depression were reported in a study by Sercekus and Okumus (2009) in Turkey, where women reported fear related to labour pain, birth complications, the attitudes of health care providers and sexuality. An association between labour duration and a fear of childbirth was identified in a study conducted in Norway by Adams et al. (2012). They found that labour duration was significantly longer in women with a fear of childbirth, when compared with women without the fear of childbirth.

5.4.4. Relationship between participation, VAS results and demographic variables

A statistical significance (p=0.038) was found between the level of control on the VAS results and the level of education. This could be explained by the fact that education develops a person's ability to gather and interpret information and solve problems; and it increases one's potential to control events and outcomes in life. Thus in this study, education would have enabled positively the women to solve difficult problems, such as their labour pain, and develop strategies to cope with the labour pain when encountered. They thus may have developed problem-solving skills and confidence. Education could also have influenced their personal control, thereby impacting on their attitudes and behaviours. Education could also promote a sense of mastery and control, which could in turn mediate stress, possibly by facilitating better coping mechanisms (Zimmerman and Woolf, 2014). Almost similar findings were found in a study conducted to identify factors related to childbirth satisfaction in America, where personal control was a statistically significant predictor of total childbirth satisfaction (Goodman, Mackey and Tavakoli, 2004).

5.5. CONCLUSION

This chapter discussed the study findings based on the study's objective which was to identify women's experiences of childbirth in two state hospitals in KwaZulu-Natal. The results were compared with findings from previous studies done in the field of childbirth. The overall results indicated that childbirth could be positive or negative, and that positive and satisfying childbirth experiences were dominant amongst the majority of the respondents in the current study.

CHAPTER SIX: SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

6.1. INTRODUCTION

This chapter concludes the study by summarising the research process and findings, briefly discussing its limitations and drawing up recommendations. According to the reviewed literature, the childbirth experience is affected positively or negatively by different factors, and this study contributes to the existing body of knowledge by identifying the women's experienced capacity, experienced professional support and care, perceived safety, as well as their experienced control and their involvement and participation during childbirth. Correlation scores on items from the questionnaire and demographic variables were presented in the preceding chapter.

6.2. SUMMARY OF THE RESULTS

The researcher's conclusions were based on the objective of the study, which was to identify women's experiences of childbirth in two state hospitals in KwaZulu-Natal Provence of South Africa. The research questions assisted with reaching the objective of the study. The study findings were well understood by drawing on Rubin's Framework of Maternal Role Attainment and the Social Support Theory (Sleutel, 2003). Both theoretical frameworks used in this study created a linkage between the childbearing mother's cognitive and emotional process and the specific supportive nursing interventions required to meet the mother's needs and optimise the birth experience.

6.2.1. What is the level of capacity experienced by women during childbirth?

Rubin's Framework of Maternal Role Attainment underpins the importance of the mothers' experiences, childbirth and maternal identification (Sleutel, 2003). It is also associated with the necessity for women's capacity and the setting of realistic expectations and goals during the intrapartum period. In the current study, capacity was understood as self-efficacy and the personal ability to cope with the childbirth process. Based on Rubin's (1967) writings, there was a linkage between their capacity and the attainment of their maternal role and maternal identification, which could thereafter be understood as the women's sense of achievement. The current study results indicated a positive and satisfying childbirth experience, which resulted from the women's identified high levels of capacity and self-efficacy, their ability to birth their children and become mothers, the meeting of their expectations, their ability to

cope with the stressful process of labour, feeling strong and handling the whole situation very well. Their experienced positive capacity thus contributed to the achievement and attainment of their role and identification as mothers.

6.2.2. What is the level of professional care and support experienced by women during childbirth?

The Social Support Theory describes an interpersonal transaction that contains emotional support, information or advice; and describes support as the assistance that individuals provide and receive from others (Lakey, 2000). In addition, according to Rubin's framework (1967), perception of support reflects aid provided from the social environment, which during labour includes the nurse intrapartum support. Rubin wrote that nurses must understand the mother's perception of her situation and have empathy in order to render care (MackKinnon, McIntyre and Quance, 2005). The study results denoted both positive and negative experiences of the professional support and care, with the positive experiences being dominant. Women indicated a positive and satisfying experience of care and support received from the midwives and this was emphasised by the majority of the women who mentioned that they felt very well cared for and that the midwives understood their childbirth needs. In response to the open-ended question, a number of women appreciated the support and care received from efficient and compassionate midwives, however, some of the mothers reported poor treatment and abandonment by staff professionals, which contributed towards their negative experience.

6.2.3. What is the level of safety experienced by women during childbirth?

Rubin's Framework (Sleutel, 2003) indicates the importance of the physical and psychological milieu in labour and the delivery room. Studies attested that physical and psychological milieus are essential for the improvement of birth outcomes and safety (Sleutel, 2003; Mackinnon et al. 2005) and this was also emphasised by the women in the current study. The importance of the physical environment in childbirth experiences was found to be essential as it incorporates tangible facets of care like the physical layout of the ward, material resources and competent personnel who would provide psychological support throughout labour and delivery; thereafter contributing to safety of childbirth.

Both positive and negative experiences of childbirth safety were identified among the respondents in the current study. Positive experiences were reported by the majority of

women, yet in response to the open-ended question, few women relayed a negative experience of safety and dissatisfaction, which resulted from poor sanitation and a lack of privacy in labour rooms. Support and comfort from partners was limited due to the lack of privacy in the labour rooms, therefore limiting women's access to the support needed and contributing to their feelings of being unsafe. The Social Support Theory also describes the importance of support by close relatives and its positive effect on the physical health and psychological wellbeing of the birthing mother. Studies attested that giving birth was seen as one of the most important individualistic and unique events in a woman's life that requiring support and motivation, not only professionally but also from family members (Rudman, 2007).

According to Rubin (1967), the physical and psychological environments also incorporate competent intrapartum staff. Analysis of the data provided results which indicated that the birthing women felt safe and secure due to competence and professional skills of the midwives. The knowledge and skills of the practicing midwives and medical team thus enhanced the whole labour experience for these mothers. The competencies and attributes that the midwives and medical team in these hospitals possessed thus offered the women the sense of a positive experience with regards to safety and security, both for themselves and their infants.

6.2.4. What is the degree of control, involvement and participation in the labour and birth management process experienced by women?

Positive and negative experiences of control, involvement and participation during childbirth were identified in the current study, with positive experiences being exhibited by majority of the respondents. The current study results presented a high level of positive labour control among the respondents who reported their ability to cope with the labour process. Control also involved participation in pain management. Majority of the women experienced intense labour pain, however, the results indicated that women were not involved in pain management and were not well informed about coping mechanisms. In response to the open-ended question, few women mentioned their lack of control and had to only follow instructions. Rubin's Attainment of the Maternal Role Framework (1967) is associated with the necessity for women to successfully exercise control over their health, their ability to mobilise social support, self-efficacy and positive coping mechanisms. In addition, the Social Support Theory predicts that support received enhances coping skills, which buffers the relationship between stress and health outcomes.

6.3. LIMITATIONS

The following were identified as limitations to the study:

- The study was conducted in two hospitals in the same health district. Although the hospitals represent different levels of care, the findings could not be generalised to hospitals in other districts.
- Due to the time restriction, data was collected intensively within a short period of time (from 02 September to 08 October 2016), thus the information could have been obtained from subjects who may have been exposed to certain circumstances or a crisis within the hospital that existed only during that period, and that may have influenced their experiences of childbirth and impacted on their responses to the questionnaire.
- Although the researcher involved mothers who were discharged and waiting to be picked up by their relatives, the fact that the questionnaire was administered to them while they were still on the hospital's premises may have influenced and contributed to possible limited disclosure of information on the questionnaire. In addition, their perceptions were obtained during the discharge period and they could have been different if asked later on.
- The fact that the researcher was a midwife may have influenced the respondents, making them more likely to give the researcher socially desirable responses and reporting what they thought the researcher wanted to hear.
- Some of the returned questionnaires had missing data and this could have resulted in the limitation of important information to the study.
- There is some evidence to suggest that the participants may not have fully understood how to answer the visual analogue scale and thus gave conflicting responses regarding pain.

6.4. RECOMMENDATIONS

Based on the study findings, following recommendations have been made in relation to nursing practice, nursing education, nursing management and nursing research.

6.4.1. Nursing practice

Maternity health care workers should involve women in their childbirth care. Health education and information should be given to prepare and empower women with knowledge

on the process of labour, starting at the antenatal care level, and engage them in discussions around specific choices and decisions, including labour pain management and coping mechanisms available to them. Practice should also facilitate women's mobility and choices for their birthing positions during childbirth.

6.4.2. Nursing education

Professional support and skills were valued by majority of the women in the study. Although women were impressed with professionals' skills and competencies, to keep them at this high standard, ongoing skills development and advanced midwifery training should be of paramount consideration. Some mothers reported poor treatment, such as being shouted at by health care workers while in labour. Interventions aimed at improving interpersonal communication, connection and rapport between midwives and labouring women are central to improving the quality of care. Education, courses, seminars and workshops can be arranged regularly at an institutional level to create awareness of this. They also need to be informed and trained about physical coping mechanisms, such as allowing mobility and different possible birthing positions which can assist women to cope with pain during childbirth.

6.4.3. Nursing management

Findings from this study indicated that some women raised concerns about the poor childbirth environment in terms of privacy and sanitation. Nursing management needs to motivate and engage in discussions with hospital management regarding the physical and psychological organisation of the labour and maternity wards. Management needs to put more effort into improving quality of the maternity care services. A friendly, conducive and safe environment for mothers, their infants, as well as the health care workers must be provided, with adequate equipment. Privacy and cleanliness must be maintained. Labour rooms should be designed to facilitate the laboring women to receive support from close relatives and allow free mobility and different birthing positions as labour coping strategies.

A shortage of staff which contributed to feelings of abandonment and neglect was identified from the study results. A shortage of maternity staff does not only have negative implications for birthing women; health care providers are affected as well. Staff shortage contributes to staff stress, personal injury, illness, frequent errors and delays in performing emergency tasks, therefore hospital management should ensure the allocation of enough health care

workers (Nurses/midwives and doctors) to provide continuous support for laboring women; hence ensuring safety for mothers, their infants as well as for health care workers.

Labour was reported to be the worst pain ever experienced by the women; therefore management should ensure that analgesia is available all the time.

6.4.4. Nursing research

Women communicate better by telling stories and create meaning as they articulate their feelings about pivotal life events such as childbirth (Shahoei et al., 2014). This study therefore suggests further studies using individual interviews, as no birth story is exactly the same and it is crucial that women are able to have the opportunity to express their feelings, evidenced by the responses to the open-ended question.

In addition, a study using a follow-up questionnaire a few weeks after discharge may also give respondents better freedom of expression and time to reflect on their experiences, thereby eliciting further useful information.

Literature revealed a limited availability of studies regarding childbirth experiences in Sub-Saharan Africa, including South Africa; therefore more studies are needed on childbirth experiences to add to the existing body of knowledge on childbirth experiences in Africa.

6.5. CONCLUSION

This study aimed to survey women's childbirth experiences in two state hospitals in KwaZulu-Natal province in South Africa. The study revealed that both positive and negative experiences coexisted, thus confirming the multidimensional character of the childbirth experience. Women's experiences were mostly influenced by both physical and psychological factors comprising of the women's own capacity and expectations, the professional support and care received, safety, control, participation and involvement in their childbirth management, including decision making and coping mechanisms. Women exhibited both positive and negative experiences in all domains of the CEQ, with positive experiences being dominant in majority of the respondents. How women experienced labour and birth, whether positive or negative, was found to be related to their individual experienced labour process and outcomes; therefore from the women's perspective, the study described childbirth experience as a multi-dimensional experience.

REFERENCES

Abuya, T., Warren, C.E., Miller, N., Njuki, R., Ndwiga, C., Maranga, A., Mbehero, F., Njeru, A. and Bellows, B., 2015. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. *PLoS One,* 10(4), 1-13.

Adams, S.S., Eberhard-Gran, M. and Eskild, A., 2012. Fear of childbirth and duration of labour: a study of 2206 women with intended vaginal delivery. *BJOG: An international Journal of Obstetrics and Gynaecology,* 119(10), 1238-1246.

Al Ahmar, E. and Tarraf, S., 2014. Assessment of the socio-demographic factors associated with the satisfaction related to the childbirth experience. *Open Journal of Obstetrics and Gynaecology*, 4(10), 585-611.

Akbarzadeh, M., Masoudi, Z., Hadianfard, M.J., Kasraeian, M. and Zare, N., 2014. Comparison of the effects of maternal supportive care and acupressure (BL32 acupoint) on pregnant women's pain intensity and delivery outcome. *Journal of Pregnancy*, 2014, 10-16.

Aksoy, H., Yucel, B., Aksoy, U., Acmaz, G., Aydin, T. and Babayigit, M. A., 2016. The relationship between expectation, experience and perception of labour pain: an observational study. *SpringerPlus*, 5(1), 1766-1771.

Artieta-Pinedo, I., Paz-Pascual, C., Grandes, G., Remiro-Fernandezdegamboa, G., Odriozola-Hermosilla, I., Bacigalupe, A. and Payo, J., 2010. The benefits of antenatal education for the childbirth process in Spain. *Journal of Nursing Research*, 59(3), 194-202.

Banda, G., Kafulafula, G., Nyirenda, E., Taulo, F. and Kalilani, L., 2010. Acceptability and experience of supportive companionship during childbirth in Malawi. *BJOG: An International Journal of Obstetrics and Gynaecology,* 117(8), 937-945.

Beigi, N.M.A., Broumandfar, K., Bahadoran, P. and Abedi, H.A., 2010. Women's experience of pain during childbirth. *Iranian Journal of Nursing and Midwifery Research*, 15(2), 72-77.

Bohren, M.A., Vogel, J.P., Hunter, E.C., Lutsiv, O., Makh, S.K. and Souza, J.P., 2015. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. *PLoS Med*, 12(6), 1-32.

Bowling, A. and Ebrahim, S., 2005. *Handbook of health research methods: investigation, measurement and analysis*, 8th ed. UK: McGraw-Hill Education.

Bradley, S., McCourt, C., Rayment, J. and Parmar, D., 2016. Disrespectful intrapartum care during facility-based delivery in sub-Saharan Africa: a qualitative systematic review and thematic synthesis of women's perceptions and experiences. *Social Science & Medicine*, 169, 157-170.

Brink, H., 2006. *Fundamentals of research methodology for health care professionals*, 2nd ed. Cape Town: Juta and Company Ltd.

Bugg, G.J., Siddiqui, F. and Thornton, J.G., 2011. Oxytocin versus no treatment or delayed treatment for slow progress in the first stage of spontaneous labour. *Cochrane Database of Systematic Reviews:* [online] 7 (CD007123).
Available at: http://onlinelibray.wiley.com/doi/10.1002/14651858.CD00&pub2/abstract [Accessed 29October 2016].

Bryanton, J., Gagnon, A.J., Johnston, C. and Hatem, M., 2008. Predictors of women's perceptions of the childbirth experience. *Journal of Obstetric, Gynaecologic and Neonatal Nursing*, 37(1), 24-34.

Burns, N. and Grove, S.K., 2005. *The practice of nursing research: conduct, critique and utilisation*, 5th ed. St Louis: Elsevier/Saunders.

Burns, N., & Grove, S. K. 2009. *The practice of nursing research: appraisal, synthesis, and generation of evidence*, 18th ed. St. Louis: Saunders/Elsevier.

Callister, L.C., Getmanenko, N., Garvrish, N., Eugenevna, M.O., Vladimirova, Z.N., Lassetter, J. and Turkina, N., 2007. Giving birth: The voices of Russian women. *MCN: The American Journal of Maternal/Child Nursing*, 32(1), 18-24.

Carlsson, M., Ziegert, K. and Nissen, E., 2015. The relationship between childbirth self-efficacy and aspects of wellbeing, birth interventions and birth outcomes. *Midwifery*, 31(10), 1000-1007.

Chadwik, R.J., Cooper, D. and Harries, J., 2014. Narratives of distress about birth in South African public maternity settings: a qualitative study. *Journal of Midwifery*, 30(7), 862-968.

Changee, F., Irajpour, A., Simbar, M. and Akbari, S., 2015. Client satisfaction of maternity care in Lorestan province, Iran. *Iranian Journal of Nursing and Midwifery Research*, 20(3), 398-404.

Chin, G.S., Warren, N., Kornman, L. and Cameron, P., 2011. Patients' perceptions of safety and quality of maternity clinical handover. *BMC Pregnancy and Childbirth*, 11(58), 1-8.

Christiaens, W. and Bracke, P., 2007. Assessment of social psychological determinants of satisfaction within childbirth in a cross-national perspective. *BMC Pregnancy and Childbirth*, 7(1), 26-37.

Cook, K. and Loomis, C., 2012. The impact of choice and control on women's childbirth experiences. *The Journal of Perinatal Education*, 21(3), 158-168.

Cook, R.J. and Dickens, B.M., 2005. *Surviving pregnancy and childbirth. Centre for Reproductive Rights: An international human right: Integrating medicine, ehics and law.* Oxford, New York: Clarendon press.

Dencker, A., Berg, M., Bergqvist, L., Ladfors, L., Thorsen, L.S. and Lilja, H., 2009. Early versus delayed oxytocin augmentation in nulliparous women with prolonged labour: a randomised controlled trial. *BJOG: An International Journal of Obstetrics and Gynaecology*, 116(4), 530-536.

Dencker, A., Taft, C., Bergqvist, L., Lilja, H. and Berg, M., 2010. Childbirth experience questionnaire (CEQ): development and evaluation of a multidimensional instrument. *BMC Pregnancy and Childbirth,* 10(1), 81-88.

De Vos, A.S., Delport, C.S.L., Fouche, C.B. and Strydom, H., 2005. Research at grass roots for social science and human professions, 3rd ed. Pretoria: Van Schaik Publishers.

Du Preez, A., 2010. Quality improvement intervention programme (QIIP) for intrapartum care. [Online doctoral dissertation]: North-West University.
Available at: http://dspace.nwu.ac.za/handle/10394/4816
[Accessed 6January 2016].

Fahey, J.O. and Shenassa, E., 2013. Understanding and meeting the needs of women in the postpartum period: the perinatal maternal health promotion model. *Journal of Midwifery and Women's Health,* 58(6), 613-621.

Fair, C.D. and Morrison, T.E., 2012. The relationship between prenatal control, expectations, experienced control, and birth satisfaction among primiparous women. *Midwifery,* 28(1), 39-44.

Fisher, C., Hauck, Y. and Fenwick, J., 2006. How social context impacts on women's fears of childbirth: a western Australian example. *Social Science and Medicine,* 63(1), 64-75.

Fisher, J., Mello, M.C.D., Patel, V., Rahman, A., Tran, T., Holton, S. and Holmes, W., 2012. Prevalence and determinants of common perinatal mental disorders in women in low-and lower-middle-income countries: a systematic review. *Bulletin of the World Health Organization*, 90(2), 139-149.

Floyd, L., Coulter, N., Asamoah, S. and Agyare-Asante, R., 2014. Women's views and experience of their maternity care at a referral hospital in Ghana. *African Journal of Midwifery and Women's Health,* 8(4), 168-175.

Fouka, G. and Mantzorou, M., 2011. What are the major ethical issues in conducting research? Is there a conflict between the research ethics and the nature of nursing? *Health Science Journal*, 5(1), 3-14.

Gaboury, J., Capaday, S., Somera, J. and Purden, M., 2017. Effect of the postpartum hospital environment on the attainment of mothers' and fathers' goals. *Journal of Obstetric, Gynaecologic and Neonatal nursing*, 46(1), 40-50.

Gebremeskel, F., Dibaba, Y. and Admassu, B., 2015. Timing of first antenatal care attendance and associated factors among pregnant women in Arba Minch Town and Arba Minch District, Gamo Gofa Zone, south Ethiopia. *Journal of Environmental and Public Health*, 2015, 1-7.

Gerein, N., Green, A. and Pearson, S., 2006. The implications of shortages of health professionals for maternal health in sub-Saharan Africa. *Reproductive Health Matters*, 14(27), 40-50.

Ghebreyohans, G., 2011. Midwifery care experiences of mothers during labour and delivery at Orota Maternity National Referral Hospital in Asmara, Eritrea. *International Journal of Sciences: Basic and Applied Research*, 22(1), 96-110.

Glicken, M.D., 2003. *Social research: a simple guide*. Boston: Allyun and Bacon.

Goodman, P., Mackey, M.C. and Tavakoli, A.S., 2004. Factors related to childbirth satisfaction. *Journal of Advanced Nursing*, 46(2), 212-219.

Green, J., Amis, D. and Hotelling, B.A., 2007. Care practice# 3: continuous labour support. *The Journal of Perinatal Education*, 16(3), 25-28.

Haines, H.M., Rubertsson, C., Pallant, J.F. and Hildingsson, I., 2012. The influence of women's fear attitudes and beliefs of childbirth on mode and experience of birth. *BMC Pregnancy and Childbirth*, 12(1), 55-55.

Halperin, O., Sarid, O. and Cwikel, J., 2015. The influence of childbirth experiences on women's postpartum traumatic stress symptoms: a comparison between Israeli Jewish and Arab women. *Midwifery*, 31(6), 625-632.

Harrison, M.J., Kushner, K.E., Benzies, K., Rempel, G. and Kimak, C., 2003. Women's satisfaction with their involvement in health care decisions during a high-risk pregnancy. *Birth*, 30(2), 109-115.

Hauck, Y., Fenwick, J., Downie, J. and Butt, J., 2007. The influence of childbirth expectations on western Australian women's perceptions of their birth experience. *Midwifery*, 23(3), 235-247.

Hildingsson, I., Karlstrom, A. and Nystedt, A., 2011. Women's experiences of induction of labour - findings from a Swedish regional study. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 51(2), 151-157.

Hodnett, E.D., Gates, S., Hofmeyr, G.J. and Sakala, C., 2011. Continuous support for women during childbirth(Review). *The Cochrane Database of Systematic Reviews*, [online] 2 CD00376).
Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003766.pub3/abstract [Accessed 6January 2016]

Hodnett, E.D., Gates, S., Hofmeyr, G.J. and Sakala, C., 2013. Continuous support for women during childbirth. *The Cochrane Library*, [online] 7 (CD003766). Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003766.pub5/pdf [Accessed 20February 2016].

Holloway, I. and Wheeler, S., 2010. *Qualitative research in nursing and healthcare, 3rd* ed. London: Wiley-Blackwell.

Homer, C.S., Passant, L., Brodie, P.M., Kildea, S., Leap, N., Pincombe, J. and Thorogood, C., 2009. The role of the midwife in Australia: views of women and midwives. *Midwifery*, 25(6), 673-681.

Hornby, A.S., 2005. *Oxford advanced learner's dictionary of current English*, 7th ed. New York: Oxford University Press.

Howarth, A., Swain, N. and Trehrne, G., 2013. The safety-net: what influences New Zealand first-time mothers' perceptions of safety for self and unborn child? *New Zealand College of Midwives Journal*, 48, 24-28.

Hunter, L.P., 2009. A descriptive study of "being with women" during labour and birth. *Journal of Midwifery & Women's Health,* 54, 111-118.

Iliadou, M., 2012. Supporting women in labour. *Health Science Journal,* 6(3), 385-391.

Iravani, M., Zarean, E., Janghorbani, M. and Bahrami, M., 2015. Women's needs and expectations during normal labour and delivery. *Journal of Education and Health Promotion*, 4(1), 6.

Jay, A., 2013. Experiencing induction. *Midwives,* 16(2), 42-43.

Jenkinson, B., Josey, N. and Kruske, S., 2013. BirthSpace: an evidence-based guide to birth environment design. Brisbane, QLD, Australia: *The Queensland Centre for Mothers and Babies. The University of Queensland.*

Jenkinson, B., Josey, N. and Kruske, S., 2014. BirthSpace: An evidence-based guide to birth environment design. *The Queensland Centre for Mothers and Babies. The University of Queensland, S,* 2-33.

Jha, P., Christensson, K., Svanberg, A.S., Larsson, M., Sharma, B. and Johansson, E., 2016. Cashless childbirth, but at a cost: a grounded theory study on quality of intrapartum care in public health facilities in India. *Midwifery,* 39, 78-86.

Karlström, A., Nystedt, A. and Hildingsson, I., 2015. The meaning of a very positive birth experience: focus groups discussions with women. *BMC Pregnancy and Childbirth*, 15(1), 1-8.

Karra, M. and Lee, M., 2012. Human capital consequences of teenage childbearing in South Africa. Population Reference Bureau. *Research Network,* 1-5.

Khadivzadeh, T., Katebi, M.S., Sepehri Shamloo, Z. and Esmaily, H., 2015. Assessment of midwives' communication skills at the maternity wards of teaching hospitals in Mashhad in 2014. *Journal of Midwifery and Reproductive Health,* 3(3), 394-400.

Kordi, M., Bakhshi, M. and Tara, F., 2014. The effect of continuous support during labour on labour progress in primigraviga women. *The Iranian Journal of Obstetrics, Gynaecology and Infertility,* 14, 7-14.

Kungwimba, E., Maluwa, A. and Chirwa, E., 2013. Experiences of women with the support they received from their birth companions during labour and delivery in Malawi. *Health,* 5(1), 45.

Lakey, B. and Cohen, S., 2000. *Social Support and Theory*. *Social support measurement and intervention: A guide for health and social scientists*, 29-52.

Lally, J.E., Thomson, R.G., MacPhail, S. and Exley, C., 2014. Pain relief in labour: a qualitative study to determine how to support women to make decisions about pain relief in labour. *BMC Pregnancy and Childbirth*, 14(1), 6-16.

Langer, A., 2007. Continuous support for women during childbirth: RHL practical aspects. *The WHO Reproductive Health Library*. Geneva: World Health Organization.

Larkin, P., Begley, C.M. and Devane, D., 2009. Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery,* 25(2), 49-59.

Lawrence, A., Lewis, L., Hofmeyr, G.J., Dowswell, T. and Styles, C., 2009. Maternal positions and mobility during first stage labour. *The Cochrane Library*, [online] 2 (CD003934)
Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003934.pub2/abstract [Accessed 4February 2017].

Leap, N. and Hunter, B., 2016. *Supporting women for labour and birth: a thoughtful guide*. London and New York: Routledge.

Lewallen, L.P., 2011. The importance of culture in childbearing. *Journal of Obstetric, Gynaecologic and Neonatal Nursing,* 40, 4-8.

Lundgren, I., 2004. Releasing and relieving encounters: experiences of pregnancy and childbirth. *Scandinavian Journal of Caring Sciences,* 18(4), 368-375.

Lundgren, I., Karlsdottir, S.I. and Bondas, T., 2009. Long-term memories and experiences of childbirth in a Nordic context: a secondary analysis. *International Journal of Qualitative Studies on Health and Wellbeing,* 4(2), 115-128.

Mack, L., 2010. The philosophical underpinnings of educational research. *Polyglossia*, 19, 5-11.

MacKinnon, k., McIntyre, M. and Quance, M., 2005. The meaning of the nurse's presence during childbirth. *Journal of Obstetric, Gynaecologic and Neonatal Nursing,* 34(1), 28-36.

Magee, H. and Askham, H., 2008. *Women's views about safety in maternity care. A qualitative study. London: King's Fund.*

Mannava, P., Durrant, K., Fisher, J., Chersich, M. and Luchters, S., 2015. Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review. *Globalisation and Health,* 11(36), 1-17.

Marteleto, L., Lam, D. and Ranchhod, V., 2006. *Schooling and early childbearing in urban South Africa*. PSC Research Report No. 06-610. 2006.

Mathebula, P.M., 2013. *Exploring experiences of quality intrapartum care in a public hospital in Gauteng.* [Online doctoral dissertation]: North-West University.
Available at: http://repository.nwu.ac.za/handle/10394/10762
[Accessed 20February 2016].

Matyukira, S.P., 2014. *Knowledge and utilisation of antenatal care services by pregnant women at a clinic in Ekurhuleni.* [Online dissertation]: University of South Africa.
Available at: http://hdl.handle.net/10500/13617
[Accessed 4February 2017].

McCarthy, F. and Kenny, L., 2013. Induction of labour. *Obstetrics, Gynaecology and Reproductive Medicine,* 24(1), 9-15.

McGrath, S.K. and Kennell, J.H., 2008. A Randomised controlled trial of continuous labour support for middle-class couples: effect on caesarean delivery rates. *Birth,* 35(2), 92-97.

McMahon, S.A., George, A.S., Chebet, J.J., Mosha, I.H., Mpembeni, R.N. and Winch, P.J., 2014. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. *BMC Pregnancy and Childbirth,* 14(1), 268.

Melender, H.L., 2006. What constitutes a good childbirth? A qualitative study of pregnant Finnish women. *Journal of Midwifery and Women's Health,* 51(5), 331-339.

Mensah, S., Mogale, R. and Richter, M., 2014. Birthing experiences of Ghanaian women in 37th Military Hospital, Accra, Ghana. *International Journal of Africa Nursing Sciences,* 1(1), 29–34

Mina, S., Balhara, Y.P.S., Verma, R. and Mathur, S., (2012). Anxiety and depression amongst the urban females of Delhi in ante-partum and post-partum period. *Delhi Psychiatry Journal,* 15(2), 347–351.

Mohammad, K.I., Alafi, K.K., Mohammad, A.I., Gamble, J. and Creedy, D., 2014. Jordanian women's dissatisfaction with childbirth care. *International Nursing Review,* 61(2), 278-284.

Mouton, J., 2001. *How to succeed in your master's and doctoral studies: a South African guide and resource book.* Pretoria: Van Schaik Publishers.

Newburn, M. and Singh, D., 2005. *Are women getting the birth environment they need? A report of a national survey of women's experience*. London: National Childbirth Trust.

NICE Clinical Guidelines, No. 55., 2007. Intrapartum care: care of healthy women and their babies during childbirth. *National Collaborating Centre for Women's and Children's Health,* London: RCOG Press.

Nijhawan, L.P., Janodia, M.D., Muddukrishna, B.S., Bhat, K.M., Bairy, K.L., Udupa, N. and Musmade, P.B., 2013. Informed consent: issues and challenges. *Journal of Advanced Pharmaceutical Technology & Research*, 4(3), 134.

Nikula, P., Laukkala, H. and Polkki, T., 2015. Mothers' perceptions of labour support. *MCN. The American Journal of Maternal Child Nursing,* 40(6), 373.

Nilsson, C. and Lundgren, I., 2007. Women's lived experience of fear of childbirth. *Journal of Midwifery,* 25(2), 1-9.

Nilsson, L., Thorsell, T., Wahn, E.H. and Ekstrom, A., 2013. Factors influencing positive birth experiences of first-time mother. *Journal of Nursing Research and Practice*, 2013 (2013), 1-6. Available at: http://dx.doi.org/10.1155/2013/349124 [Accessed on 6January 2016].

Nyango, D.D., Mutihir, J.T., Laabes, E.P., Kigbu, J.H. and Buba, M., 2010. Skilled attendance: the key challenges to progress in achieving MDG-5 in north central Nigeria. *African Journal of Reproductive Health*, 14(2), 129-139.

Nystedt, A., Hogberg, U. and Lundman, B., 2005. The negative birth experience of prolonged labour: a case referent study. *Journal of Clinical Nursing*, 14(5), 579-586.

Nystedt, A., Hogberg, U. and Lundman, B., 2006. Some Swedish women's experiences of prolonged labour. Midwifery, 22(1), 56-65.

Nystedt, A. and Hildingsson, I., 2014. Diverse definitions of prolonged labour and its consequences with sometimes subsequent inappropriate treatment. *BMC Pregnancy and Childbirth*, 14(1), 233.

O'Hare, J. and Fallon, A., 2011. Women's experience of control in labour and childbirth. *British Journal of Midwifery*, 19(3), 164-169.

Onasonga, O.A., Afolayan, J.A. and Oladimeij, B.D., 2012. Factors influencing utilisation of antenatal care services among pregnant women in Ife Cental LGA, Osun State, Nigeria. *Advances in Applied Science Research*, 3(3), 1309-1315.

Overgaard, C., Fenger-Gron, M. and Sandall, J., 2012. The impact of birthplace on women's birth experiences and perceptions of care. *Social Science and Medicine*, 74(7), 973-981.

Pascalo-Bonaro, D. and Kroger, M., 2004. Continuous female companionship during childbirth: a crucial resource in time of stress or calm. *Journal of Midwifery & Women's Health*, 49, 19-27.

Paudel, Y.R., Mehata, S., Paudel, D., Dariang, M., Aryal, K.K., Poudel, P., King, S. and Barnett, S., 2015. Women's satisfaction of maternity care in Nepal and its correlation with intended future utilisation. *International Journal of Reproductive Medicine*, 2015, 1-9.

Pearson, L., Larsson, M., Fauveau, V. and Standley, J., 2007. *Childbirth care. World health Organization: opportunities for Africa's newborns: practical data, policy and programmatic support for newborn care in Africa*. Geneva: WHO.

Priddis, H., Dahlen, H. and Schmied, V., 2012. What are the facilitators, inhibitors and implications of birth positioning? A review of the literature. *Women and Birth*, 25(3), 100-106.

Polit, D.F. and Beck, C.T., 2012. *Nursing research: generating and assessing evidence for nursing practice*. 9th. Philadelphia: Lippincott Williams and Wilkins.

Polit, D.F. and Beck, C.T., 2014. *Essentials of nursing research: appraising evidence for nursing practice*, 18th ed. Philadelphia: Wolters Kluwer Health/Lippincott Williams Wilkins.

Polit, D.F. and Hungler, B.P., 2013. *Essentials of nursing research: methods, appraisal, and utilisation*, 8th ed. Philadelphia: Lippincott Williams &Wilkins.

Raven, J., van den Broek, N., Tao, F., Kun, H. and Tolhurst, R., 2015. The quality of childbirth care in China: women's voices: a qualitative study. *BMC Pregnancy & Childbirth*, 15(1), 113.

Redshaw, M., Rowe, R., Hockley, C. and Brocklehurst, P., 2006. *Recorded delivery: a national survey of women's experience of maternity care*. Oxford: National Perinatal Epidemiology Unit (NPEU).

Renfrew, M.J., McFadden, A., Bastos, M.H., Campbell, J., Channon, A.A., Cheung, N. F., Silva, D.R.A.D., Downe, S., Kennedy, H.P., Malata, A. and McCormick, F., 2014. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet*, 384(9948), 1129-1145.

Rijnders, M., Baston, H., Schonbeck, Y., Van Der Pal, K., Prins, M., Green, J. and Buitendijk, S., 2008. Perinatal factors related to negative or positive recall of birth experience in women three years postpartum in the Netherlands. *Birth*, 35(2), 107-116.

Rosliza, A.M. and Muhamad, J.J., 2011. Knowledge, attitude and practice on antenatal care among Orang Asli women in Jempol, Negeri Sembilan. *Malaysian Journal of Public Health Medicine*, 11(2), 13–21.

Rubin, R., 1967. Attainment of the maternal role. Part 1: processes. *Nursing Research*, 16(3), 237-245.

Rudman, A.I., 2007. *Women's evaluations of intrapartum and postpartum care*. Stockholm: Karolinska Institute, Department of Women's and Children's Health.

Rudman, A., El-Khouri, B. and Waldenström, U., 2007. Women's satisfaction with intrapartum care – a pattern approach. *Journal of Advanced Nursing*, 59(5), 474-487.

Sandall, J., Manthorpe, J., Mansfield, A. and Spencer, L., 2007. Support workers in maternity services. London: King's College London.

Schwartz, L., Toohill, J., Creedy, D.K., Baird, K., Gamble, J. and Fenwick, J., 2015. Factors associated with childbirth self-efficacy in Australian childbearing women. *BMC Pregnancy and Childbirth*, 1(15), 1-9.

Sedgh, G., Finer, L.B., Bankole, A., Eilers, M.A. and Singh, S., 2015. Adolescent pregnancy, birth, and abortion rates across countries: levels and recent trends. *Journal of Adolescent Health*, 56(2), 223-230.

Sengane, M., 2013. Mothers' expectations of midwives' care during labour in a public hospital in Gauteng. *Curationis*, 36(1), 1-9.

Sercekus, P. and Okumus, H., 2009. Fears associated with childbirth among nulliparous women in Turkey. *Midwifery*, 25(2), 155-162.

Shahoei, R., Khosravy, F., Zaheri, F., Hasheminasab, L., Ranaei, F., Hesame, K. and Shahoei, F., 2014. Iranian Kurdish women's experiences of childbirth: a qualitative study. *Iranian Journal of Nursing and Midwifery Research,* 19(7), 112-117.

Shimpuku, Y., Patil, C.L., Norr, K.F. and Hill, P.D., 2013. Women's perceptions of childbirth experience at a hospital in rural Tanzania. *Health Care for Women International,* 34(6), 461-481.

Sleutel, M.R., 2003. Intrapartum nursing: integrating Rubin's Framework with Social Support Theory. *Journal of Obstetric, Gynaecologic and Neonatal Nursing,* 32(1), 76-82.

Smith, A. and Dixon, A., 2007. The safety of maternity services in England. London: King's Fund.

Soet, J.E., Brack, G.A. and Dilorio, C., 2003. Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth,* 30(1), 36-46.

South Africa, 2010. *Education for all: country report*. Pretoria, Department of Basic Education.

Stenglin, M. and Foureur, M., 2013. Designing out the fear cascade to increase the likelihood of normal birth. *Midwifery,* 29(8), 819-825.

Stevens, N.R., 2011. *Perceived control and maternal satisfaction with the childbirth experience.* Doctoral dissertation, University of Kansas.

Snowden, A., Martin, C., Jomeen, J. and Martin, C.H., 2011. Concurrent analysis of choice and control in childbirth. *BMC Pregnancy and Childbirth,* 11(1), 40.

Solarin, I. and Black, V., 2013. They told me to come back: women's antenatal care booking experience in inner-city Johannesburg. *Maternal and Child Health Journal*, 17(2), 359-367.

Sydsjo, G. Blomberg, M. Palmquist, S., Angerbjorn, L., Bladh, M. and Josefsson, A., 2015. Effects of continuous midwifery labour support for women with severe fear of childbirth. *BMC Pregnancy and Childbirth,* 1(15), 1-5.

Tanglakmankhong, K., 2010. Childbirth expectations and childbirth experiences among Thai pregnant women. *Scholar Archive*, Paper 535.
Available at: http://digitalcommons.ohsu.edu/etd

Toohill, J., Fenwick, J., Gamble, J., Creedy, D.K., Buist, A. and Ryding, E.L., 2014. Psycho-social predictors of childbirth feat in pregnant women: an Australian study. *Open Journal of Obstetrics and Gynaecology,* 4(9), 531-543.

Van der Gucht, N. and Lewis, K., 2015. Women's experiences of coping with pain during childbirth: a critical review of qualitative research. *Midwifery,* 31(3), 349-358.

Waldenstrom, U. and Schytt, E., 2009. A longitudinal study of women's memory of labour pain from two months to five years after the birth. *BJOG: An International Journal of Obstetrics and Gynaecology,* 116(4), 577-583.

Walker, K.F., Wilson, P., Bugg, G.J., Dencker, A. and Thornton, J.G., 2015. Childbirth experience questionnaire: validating its use in the United Kingdom. *BMC Pregnancy and Childbirth,* 15(1), 86.

Walsh, D., 2007. *Evidence-based care for normal labour and birth: a guide for midwives*. London: Routledge.

Wright, M. E., McCrea, H., Stringer, M. and Murphy-Black, T. (2000), Personal control in pain relief during labour. *Journal of Advanced Nursing,* 32, 1168–1177.

World Health Organization, 2011. *WHO recommendations for induction of labour*. Geneva: World Health Organization.

World Health Organization, 2014. *WHO recommendations for augmentation of labour.* Geneva: World Health Organization.

World Health Organization, 2015. *WHO recommendations for augmentation of labour.* Geneva: World Health Organization.

Yeh, J. and Nagel, E.E., 2010. Patient satisfaction in obstetrics and gynaecology: individualised patient-centred communication. *Women's Health,* 3, 23-32.

Zhang, X. and Lu, H., 2014. Childbirth expectations and correlates at the final stage of pregnancy in Chinese expectant parents. *International Journal of Nursing Sciences,* 1(2), 151-156.

Zimmerman, E. and Woolf, S.H., 2014. *Understanding the relationship between education and health: discussion paper.* Washington, DC, Institute of Medicine.

Zwelling, E., 2010. Overcoming the challenges: maternal movement and positioning to facilitate labour progress. *MCN: The American Journal of Maternal/Child Nursing,* 35(2), 72-78.

APPENDIX 1: UKZN RESEARCH ETHICS APPROVAL LETTER

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

01 July 2016

Mrs Uwonkunda P Mutabazi 205504980
School of Nursing and Public Health
Howard College Campus

Dear Mrs Mutabazi

Protocol reference number: HSS/0917/016M
Project Title: "Descriptive survey of women's childbirth experiences in two state hospitals in KwaZulu-Natal".

Full Approval – Expedited Application

In response to your application received 22 June 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....

Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Professor Petra Brysiewicz
Cc Academic Leader Research: Professor M Mars
Cc School Administrator: Ms Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 **Facsimile:** +27 (0) 31 260 4609 **Email:** ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

APPENDIX 2: DOH RESEARCH & KNOWLEDGE MANAGEMENT APPROVAL LETTER

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

330 Langalibalele street,
Private Bag X9051 PMB, 3200
Tel: 033 395 2805/3189/3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management (HKRM)

Reference: **HRKM228/16**
KZ_2016RP12_758

27 July 2016

Dear Mrs U P Mutabazi
(University of KwaZulu-Natal)

Subject: Approval of a Research Proposal

1. The research proposal titled **'Descriptive survey of women's childbirth experiences in two state hospitals in KwaZulu-Natal'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at King Edward VIII and Addington Hospitals.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 04/08/16

APPENDIX 3: PERMISSION LETTER FROM HOSPITAL B

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

ADDINGTON HOSPITAL
OFFICE OF THE CHIEF EXECUTIVE OFFICER

P.O. BOX 977
DURBAN
4000
Tel: 031-327-2970 Email: reshma.boodhai@kznhealth.gov.za
www.kznhealth.gov.za

Reference: 9/2/3/R

Date: 22nd August 2016

Principal Investigator:
- **Mrs Mutabazi**

PERMISSION TO CONDUCT RESEARCH AT ADDINGTON HOSPITAL: "DESCRIPTIVE SURVEY OF WOMEN'S CHILDBIRTH EXPERIENCES IN TWO STATE HOSPITALS IN KWAZULU-NATAL"

I have pleasure in informing you that permission has been granted to you by Addington Hospital Management to conduct the above research.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Addington Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to Addington Hospital.

DR M NDLANGISA
HOSPITAL MANAGER
ADDINGTON HOSPITAL

APPENDIX 4: PERMISSION LETTER FROM HOSPITAL A

Department:
Health
PROVINCE OF KWAZULU-NATAL

OFFICE OF THE HOSPITAL CEO
KING EDWARD VIII HOSPITAL

[redacted]

Ref.. KE 2/7/1/(39/2016
Enq.: Mrs. R. Sibiya
Research Programming

15 August 2016

Ms. PU Mutabazi
School of Nursing and Public Health
Howard College Campus
UNIVERSITY OF KWAZULU-NATAL

Dear Ms. Mutabazi

Protocol: **"Descriptive survey of women's childbirth experiences in two state hospitals in KwaZulu -Natal" at King Edward VIII Hospital.**

Your request to conduct research at King Edward VIII Hospital has been approved.

Please ensure the following:

- That King Edward VIII Hospital receives full acknowledgment in the study on all publications and reports and also kindly present a copy of the publication or report on completion.

Before commencement:

* Discuss your research project with our relevant Clinical Head/Assistant Nursing Man
* Sign an indemnity form at Room8, CEO's Complex, Admin. Block.

The Management of King Edward VIII Hospital reserves the right to terminate the permis for the study should circumstances so dictate.

Yours faithfully

SUPPORTED/NOT SUPPORTED

07/09/
DATE

DR. R. GREEN-THOMPSON
CLINICAL HEAD: OBSTETRICS & GYNAECOLOGY

SUPPORTED/~~NOT SUPPORTED~~

15/09/2
DATE

DR. SA MOODLEY
ACTING SENIOR MEDICAL MANAGER

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX 5a: RESEARCH INSTRUMENT (ENGLISH VERSION)

CHILDBIRTH EXPERIENCE QUESTIONNAIRE

Instructions for completing the Questionnaire

Dear respondent,

Thanks for taking the time to read and complete this questionnaire.

Please:

a) Use the spaces provided to write your answers to the questions and mark with an X in the space to indicate the applicable response (section A).

b) Circle the number under the word(s) which come closest to your own opinion (section: B, C, D, E).

c) Please be sure to mark every statement.

d) Below are examples that may help you in completing the questionnaire:

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
A. I was very confident during labour and delivery	1	2	3	4	5
B. I needed to know more about labour and delivery than I possibly could	1	2	3	4	5

C. As a whole, how painful did you feel childbirth was?

X _____**x**_____**X**

- If the answer to example A is 'Strongly Agree' which is marked as 5, this indicates that you are quite certain that you were confident during your labour and delivery.
- If the answer to example B is 'Neutral' which is marked as 3, this indicates that you cannot quite decide whether to agree or disagree with this statement.
- If the answer to Example C, which is marked as x, is closer to the right this indicates that you experienced severe pain, but if x is closer to the left it indicates tolerable pain.

The questionnaire begins on the next page.

Section A: Demographic and clinical data

1. How old are you? _____
2. What is your highest level of education? Primary: ____Secondary: ____Tertiary: ___
3. How many pregnancies have you had? _____
4. How many children do you have? _____
5. Attended antenatal classes: Yes _____ No _____
6. Was your labour induced: Yes _____No _____
7. Augmentation of labour: Yes _____No _____
8. Mode of delivery : Normal vaginal delivery_____
9. How long was your labour: Less than 12 hours: _____ More than 12 hours: _____

Section B: Own capacity

	Strongly disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Labour and birth went as I had expected	**1**	**2**	**3**	**4**	**5**
I felt strong during labour and birth	**1**	**2**	**3**	**4**	**5**
I felt capable during labour and birth	**1**	**2**	**3**	**4**	**5**
I was tired during labour and birth.	**1**	**2**	**3**	**4**	**5**
I felt happy during labour and birth	**1**	**2**	**3**	**4**	**5**
I felt that I handled the situation well	**1**	**2**	**3**	**4**	**5**

Section C. Professional Support

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
My midwife devoted enough time to me	**1**	**2**	**3**	**4**	**5**
My midwife devoted enough time to my partner	**1**	**2**	**3**	**4**	**5**
My midwife kept me informed about what was happening during labour and birth.	**1**	**2**	**3**	**4**	**5**
My midwife understood my needs	**1**	**2**	**3**	**4**	**5**
I felt very well cared for by my midwife	**1**	**2**	**3**	**4**	**5**

Section D: Perceived safety

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I felt scared during labour and birth	**1**	**2**	**3**	**4**	**5**
I have many positive memories from childbirth	**1**	**2**	**3**	**4**	**5**
I have many negative memories from childbirth	**1**	**2**	**3**	**4**	**5**
Some of my memories from childbirth make me feel depressed	**1**	**2**	**3**	**4**	**5**
My impression of the team's medical skills made me feel secure	**1**	**2**	**3**	**4**	**5**

Section E: Participation

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I felt I could have a say in whether I could be up and about or lie down	**1**	**2**	**3**	**4**	**5**
I felt I could have a say in deciding my birthing position	**1**	**2**	**3**	**4**	**5**
I felt I could have a say in the choice of pain relief	**1**	**2**	**3**	**4**	**5**

Section F: Indicate your opinion by marking on the line between the two end points.

1. As a whole, how painful did you feel childbirth was?

X _____ X

No pain **Pain**

2. As a whole, how much control did you feel you had during childbirth?

X_____ X

No control **Control**

3. As a whole, how secure did you feel during childbirth?

X_____ X

Not at all secure **Secure**

Additional comments:

Thank you for your input!

APPENDIX 5b: RESEARCH INSTRUMENT (ISIZULU)

Imibuzo mayelana nezimo ohlangana nazo uma uteta

Imiyalelo yokugcwalisa iphepha lemibuzo

Mphenywa othandekayo,

Ngiyabonga ngokuba uthathe isikhathi sakho ufunda futhi ugcwalisa leli phepha lemibuzo

Uyacelwa:

e) Usebenzise isikhala onikezwe sona ukubhala izimpendulo zemibuzo bese ubeka uphawu X empendulweni oyikhethile (siqephu A)
f) Zungezela inombolo encike kakhulu embonweni wakho (engxenyeni: B, C, D, E)
g) Qinisekisa ukuthi ziphawulwe zonke izitatimende
h) Ngezansi izibonelo ezingasiza ukuphendula iphepha lemibuzo:

	Ukungavumi kakhulu	**Ukungavumi**	**Ukuba phakathi nendawo**	**Ukuvuma**	**Ukuvuma kakhulu**
C. Nganginokuzethemba ngenkathi ngisikwa noma sengibeletha	1	2	3	4	5
D. Ngangifisa ukwazi kabanzi ngokusikwa nokubeletha okunalokhu bengikwazi	1	2	3	4	5

C. Sekukonke, wakuzwa kubuhlungu kangakanani ukubeletha?

X _____**x**_____**X**

- Uma impendulo yakho yesibonelo A ithi “Ukuvuma kakhulu” okuphawulwe njengo-5 okusho ukuthi uqinisekile ukuthi wawunokuzethemba ngenkathi usikwa nangenkathi ubeletha.

- Uma impendulo yakho yesibonelo A ithi “ukuba phakathi nendawo” okuphawulwe njengo-3 okusho ukuthi ukhethe ukungavumelani noma uphikisane nesitatimende.

- Uma impendulo yesibonelo C ithi “kuseduze kwesokudla” nokumakwe njengo **x** kusho ukuthi uzwe ubuhlungu kodwa uma u-**x** esondele kwesobunxele kusho babubekezeleleka ubuhlungu.

Iphepha lemibuzo liqala ekhasini elilandelayo.

Isiqephu A: Imininingo yezibalo neyasemtholampilo

10. Uneminyaka emingaki? _____
11. Yilipji ibanga eliphezulu lemfundo yakho? Eliphansi: ____Eliphezulu: ____Eliphakeme: ___
12. Usuwakhulelwa kangaki? _____
13. Unabantwana abangaki? _____
14. Uwathathile amakilasi abakhulelwe/Uyaxukuza: Yebo _____ Cha _____
15. Kwakubekezeleleka ukusikwa kwakho: Yebo _____Cha _____
16. Kwakwanda ubuhlungu bokusikwa: Yebo _____Cha _____
17. Indlela yokubeletha: Wazibelethela_____
18. Wasikwa isikhathi esingakanani: Amahora ayi-12 nangaphansi: _____ Amahora angaphezulu kwayi-12_____

Isiqephu B: Ngokusemandleni akho

	Ukungavumi kakhulu	**Ukungavumi**	**Ukuba phakathi nendawo**	**Ukuvuma**	**Ukuvuma kakhulu**
ukusikwa nokubeletha kwahamba ngendlela engangiyilindele	**1**	**2**	**3**	**4**	**5**
Ngankathi yokusikwa nokubeletha ngazizwa nginamandla	**1**	**2**	**3**	**4**	**5**
Ngazizwa ngikulungele ukusikwa nokubeletha ngaleyo nkathi	**1**	**2**	**3**	**4**	**5**
Ngangikhathele ngenkathi ngisikwa noma sengibeletha	**1**	**2**	**3**	**4**	**5**
Ngaziwa ngithokozile ngekathi ngisikwa nangenkathi ngibeletha	**1**	**2**	**3**	**4**	**5**
Ngazizwa ngimelane kahle nalesi simo	**1**	**2**	**3**	**4**	**5**

Isiqephu C. Usizo lweqophelo

	Ukungavumi kakhulu	**Ukungivumi**	**Ukuba phakathi nendawo**	**Ukuvuma**	**Ukuvuma kakhulu**
Unesi obelethisayo wanginika isikhathi esanele.	**1**	**2**	**3**	**4**	**5**
Unesi obelethisayo wanikeza umlingani wami isikhathi esanele.	**1**	**2**	**3**	**4**	**5**
Unesi obelethisayo wangazisa ngokwenzekayo ngenkathi yokusikwa nokubeletha.	**1**	**2**	**3**	**4**	**5**
Unesi obelethisayo wayezazi izidingo zami.	**1**	**2**	**3**	**4**	**5**
Ngazizwa ngiphatheke kahle kakhulu kunesi obelethisayo.	**1**	**2**	**3**	**4**	**5**

Isiqephu D: Ukuphepha ngokwakho

	Ukungavumi kakhulu	**Ukungivumi**	**Ukuba phakathi nendawo**	**Ukuvuma**	**Ukuvuma kakhulu**
Ngesikhathi sokusikwa nokubeletha ngezwa nginokusaba	**1**	**2**	**3**	**4**	**5**
Nginemicabango eminingi emihle ngokubelethwa kwengane	**1**	**2**	**3**	**4**	**5**
Nginemicabango eminingi emibi ngokubelethwa kwengane	**1**	**2**	**3**	**4**	**5**
Eminye yemicabango yokubelethwa kwengane yangenza ngazizwa ngikhathazekile.	**1**	**2**	**3**	**4**	**5**
Imicabango yami Ngolwazi lokwelapha yeqembu ingenze ngazizwa nginakekelwe.	**1**	**2**	**3**	**4**	**5**

Isiqephu E: Ukuzibandakanya

	Ukungavumi kakhulu	**Ukungivumi**	**Ukuba phakathi nendawo**	**Ukuvuma**	**Ukuvuma kakhulu**
Ngazizwa ngathi ngingabanovo ngokuthi ngingavuka noma ngilale phansi	**1**	**2**	**3**	**4**	**5**
Ngazizwa ngathi ngingabanovo ngokukhetha isikhundla sokubeletha.	**1**	**2**	**3**	**4**	**5**
Ngazizwa ngathi ngingabanovo ngokhetho lwamaphilisi ezinhlungu.	**1**	**2**	**3**	**4**	**5**

Isiqephu F: Veza umbono wakho ngokumaka phakathi kwezimpawuziphetho zomugqa.

4. Sekukonke, wakuzwa kubuhlungu kangakanani ukubeletha?

X _____ X

Akubuhlungu Kubuhlungu

5. Sekukonke, wazizwa unokulawula okungakanani ngenkathi ubeletha.?

X _____ X

Akulawuleki Kuyalawuleka

6. Ngokugcwele wazizwa uphephe kangakanani ngesikhathi sokubeletha?

X _____ X

Ukungaphephi neze Ukuphepha

Ukuphawula okwengeziwe:

Ngibonge igalelo lakho!

APPENDIX 6a: INFORMED CONSENT LETTER TO PARTICIPANTS (ENGLISH)

Information Sheet and Consent to Participate in Research

Date:

Dear respondent,

My name is Uwonkunda Providence Mutabazi, I am a registered student at the University of KwaZulu-Natal (Howard Collage Campus), undertaking a Masters of Nursing Degree in Maternal and Child Health. My contact details are: cell phone number: 0724776580, email address: 205504980@ukzn.ac.za.

You are being invited to consider participating in the research study that involves a descriptive survey of women's childbirth experiences. The aim of this research is to describe women's childbirth experiences in order to identify women's needs. The study is expected to enroll 185 participants from two selected hospitals in KwaZulu-Natal. You are only required to spend 15 minutes to answer the questionnaire attached. Please be assured that there are no physical or psychological risks associated with this study. Although the study may not provide any direct and monetary benefits to you, I hope that it will contribute to ensuring positive childbirth care for the mothers. Your answers, along with those of other mothers, will be used to learn more about women and childbirth.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____). Should you have any further questions now or during the time you are completing the questionnaire, you are free to ask me. You can also contact me on the contact details provided above. You can also contact my research supervisor, Professor Petra Brysiewicz, on 0312601281 or the UKZN Humanities and Social Sciences Research Ethics Committee: Tel: +27 31 2604557; Fax: + 27 31 260 4609; email: HSSREC@ukzn.ac.za.

Participating is voluntary and before participating, you will be asked to complete the consent form attached which indicates your willingness to participate. You may withdraw from the project at any stage without any prejudice and it will not affect your care in any way. There are no right or wrong answers. Your response is a matter of your personal opinion and your name will not appear anywhere. The information you give will be completely confidential.

Thank you for your time and your help.

Yours faithfully

Uwonkunda Providence MUTABAZI

APPENDIX 6b: INFORMED CONSENT LETTER TO PARTICIPANTS (ISIZULU)

Ikhasi lolwazi nemvume yokubamba iqhaza ocwaningweni:

Mphenywa othandekayo,

Igama lami ngingu-Uwonkunda Providence Mutabazi, Ngingumfundi waseNyuvesi yaKwaZulu-Natali (egatsheni laseThusini/ekholeji laseHoward), Ngenza iziqu zeMastazi kwezobuHlengikazi eziphathelene nempilo yabesifazane abazithwele/abakhulelwe kanye nezingane. Ungakwazi ukuxhumana nami kanje: umakhalekhukhwini: 0724776580, Umbikombani: 205504980@ukzn.ac.za.

Uyamenywa ukuba uzibandakanye ocwaningweni oluhlanganisa ukuhlola okujulile izimo ezihlangabezana nabesifazane uma bebeletha. Inhloso yalolu cwaningo ukuthola izimo ezihlangabezana nabesifazane ngenkathi bebeletha ukuze kuhlonzwe izidingo zabo. Lolu cwaningo kulindeleke ukuba lube nababambiqhaza abangama-185 abaphuma ezibhedlela ezimbili zaKwaZulu-Natali ezikhethiwe. kudingeka ukuba uchithe imizuzu eyi-15 kuphela ugcwalisa iphepha lemibuzo elinanyathelisiwe. Uyaqinisekiswa ukuthi abukho ubungozi emzimbeni noma engqondweni yakho obuhambisana nalolu cwaningo. Nakuba ucwaningo lungeke luhlinzeke ngenzuzo eqondene nawe noma imali, ngiyethemba luyoba nomthelela omuhle ekuqinisekiseni ukunakekelwa ngendlela komama ngenkathi bebeletha. Izimpendulo zakho kanye kanye nezabanye omama ziyosetshenziswa ukufunda kabanzi ngamakhosikazi kanye nokubeletha.

Lolu cwaningo selucutshunguliwe ngokwenkambiso elungileyo lwase lungunyazwa iKomidi lase-UKZN lenakambiso elungileyo kwezocwaningo kwezoluntu kanye nezenhlalo (KZN Humanities and Social Sciences Research Ethics Committee) (Inombolo yegunya _____). Uma unemibuzo ethile manje noma ngenkathi ugcwalisa ifomu yemibuzo, wamukelekile ukuba ubuze mina. Ungaxhumana nami futhi emininingwane enikezelwe ngenhla. Ungaphinda uxhumane nomeluleki wami wocwaningo uSolwazi uPetra Brysiewicz kule nombolo: 0312601281 noma iKomidi lase-UKZN lenakambiso elungileyo kwezocwaningo kwezoluntu kanye nezenhlalo: kule nombolo +27 31 2604557; Isikhahlamezi + 27 31 260 4609; nombikombani HSSREC@ukzn.ac.za .

Ukuzibandakanya kulolu cwaningo ukwenza ngokuzithandela ngaphambu kokuba uzibandakanye uyocelwa ukuba ugcwalise ifomu lemvume elinanyathiselwe nokuyilona elikhombisa isifiso sakho sokuzibandakanya. Ungayeka noma yinini ukuzibandakanya nalolu cwaningo ngaphandle kokulimala futhi ngeke kube nomthelela ongemuhle ekunakekelweni kwakho noma ngayiphi indlela. Azikho izimpendulo okuyizo nokungeyizo. Ukuphendula kwakho kuyimicabango yakho futhi negama lakho alizuvela noma yikuphi. Ulwazi olinikezelayo luyogcinwa luyimfihlo.

Ngiyabonga ngesikhathi nosizo lwakho.

Ozithobayo

Uwonkunda Providence Mutabazi

APPENDIX 7a: INFORMED CONSENT FORM (ENGLISH)

CONSENT FORM

I, _____ have been informed about the study entitled **'Descriptive survey of women's childbirth experiences in two state hospitals in KwaZulu-Natal'** by Uwonkunda Providence Mutabazi, a Masters' student in Nursing at the University of KwaZulu-Natal (Howard College Campus).

I understand the purpose and procedures of the study and what will be requested of me.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without any prejudice.

I have been informed about risks and benefits associated with participating in the study.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher on cell number 0724776580 or email: 205504980@ukzn.ac.za.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about any aspect of the study then I may contact the UKZN Humanities and Social Sciences Research Ethics Committee: Tel: +27 31 2604557; Fax: + 27 31 260 4609; email: HSSREC@ukzn.ac.za.

I hereby provide consent to participate in this study.

_____ _____

Signature of Participant **Date**

APPENDIX 7b: INFORMED CONSENT FORM (ISIZULU)

IFOMU LEMVUME

Mina, _____ ngitsheliwe ngocwaningo olusihloko sithi "Ukuhlola okujulile izimo ezihlangabezana nabesifazana uma bebeletha ezibhedlela ezimbili zikahulumeni KwaZulu-Natali" olwenziwa ngu-Uwonkunda Providence Mutabazi, ongumfundi weziqu zeMastazi kwezobuhlengikazi eNyuvevi yaKwaZulu-Natali (ophikweni lwaseThusini/Howard College Campus).

Ngiyayiqonda inhloso nezinqubo zocwaningo kanye nokuzodingeka kumina.

Ngiyaqinisekisa ukuthi ukuzibandakanya kwami kulolu cwaningo kungukuzithandela futhi ngingayeka noma inini ngaphandle kokulimala konakekelo lwami.

Ngazisiwe ngobungozi nezinzuzo ezihambisana nokuzibandakanya kulolu cwaningo.

Uma ngiba nemibuzo, ukukhathazeka noma izikhalazo ngizothinta umcwaningi kumakhalekhukhwini othi: 0724776580 noma kumbikombani othi: 205504980@ukzn.ac.za.

Uma nginemibuzo noma ukukhathazeka ngamalungelo ami njengombambiqhaza ocwaningweni noma ngabe ngikhathazeke ngezinto zocwaningo ngiyothinta iKomidi lase-UKZN lenakambiso elungileyo kwezocwaningo kwezoluntu kanye nezenhlalo: kule nombolo +27 31 2604557; Isikhahlamezi + 27 31 260 4609; nombikombaniShould HSSREC@ukzn.ac.za

Ngiyavuma ukubambiqhaza kulolu cwaningo.

_____ _____

Isayini yombambiqhaza **Usuku**

APPENDIX 8: PERMISSION TO USE THE QUESTIONNAIRE (VIA EMAIL)

Anna Dencker <anna.dencker@gu.se> 10/20/15 à 10:44 PM

À uwonkunda providence
Cc Brysiewiczp@ukzn.ac.za

Dear Uwonkunda Providence MUTABAZI,

Thank you for email, you are very welcome to use the CEQ! Do you intend to translate the questionnaire? If you would like to translate we can have a communication about translation. I would like to hear a brief description of your study plan, if it is ok.

I attach the English CEQ and instructions for scoring. You can change information/text on first page, please just be sure the instructions for how to answer the items are kept. You can also add own questions before or after the CEQ. I also attach the Swedish and an English validation study.

Please let me know if you have further questions! I look forward to hear from you again!

Best wishes, Anna

Anna Dencker
RN, RM, PhD, senior lecturer, research fellow
Institute of Health and Care Sciences
The Sahlgrenska Academy
University of Gothenburg

APPENDIX 9: LETTER OF EDITING

Pauline Fogg
54 Grundel Road
Carrington Heights
Durban
4001
074 782 5234

3 April 2017

Letter of Editing

This report serves to state that the dissertation submitted by Uwonkunda Providence Mutabazi, in fulfillment of the requirements for the degree of Masters in Nursing has been edited.

The dissertation was edited for errors in syntax, grammar, punctuation and the referencing system used.

The edit will be regarded as complete once the necessary changes have been effected and all of the comments addressed.

Thank-you for your business.

Pauline Fogg