

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

REPORT THREE:

WOMEN'S USE AND PERCEPTIONS OF RETREAT
MIDWIFE OBSTETRIC UNIT AND
T. C. NEWMAN (PAARL) HOSPITAL

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March 1998

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ISBN: 1-874826-72-2



EXECUTIVE SUMMARY

Introduction

This is the last in a series of 3 reports which present the findings of a study which sought to explore the health seeking practices and perceptions of quality of care of pregnant women attending obstetric services in and around Cape Town. This report presents data from interviews with women at Retreat MOU in Cape Town and T C Newman Hospital in Paarl.

Methods

Qualitative methods were used and minimally-structured, in-depth interviews were held with fifteen women recruited on their first antenatal visit at Retreat MOU (10) and T.C.Newman Hospital (5) and reinterviewed at intervals throughout pregnancy until after delivery.

Key Findings:

- the main reasons why women did not book early were: relatively late diagnosis of pregnancy due to reliance on signs which appear later; perceptions that the “right” time to book was at 3-5 months; difficulties arranging childcare; difficulties with transport from farms; delays because of considering termination; and not wanting to be pregnant the “whole year”.
- most women at Retreat were fairly satisfied with their antenatal care but highlighted the importance of good communication in the clinics in their assessments of quality of care. They expressed the wish to have more information about their progress, to be asked more about problems and given more advice on minor ailments, to have less confusion around their dates, and not to be scolded.
- antenatal care was not nearly so satisfactory for many women at T.C.Newman Hospital. There were problems of privacy in the consulting/history-taking area and staff were perceived to scold and humiliate patients. This was very unpleasant and clearly inhibited constructive health education as the women then did not want to discuss things with the midwives.
- the multigravida women had considerable knowledge of pregnancy and the practices of

obstetrics, but still had health promotion needs which were not well met. In particular more support with smoking cessation was identified and communication around contraception needed to be improved. At T.C.Newman Hospital there was substantial capacity for improving the health education given to patients and a need to ensure that informed consent is given before post-delivery contraceptive injections.

- the women particularly sought care from private doctors or self-medicated when experiencing symptoms or health problems in pregnancy which were not perceived as complications. This was because of strong perceptions that medication was necessary for health improvement. The women used a wide variety of substances including indigenous herbs and Dutch remedies for their health problems.
- most of the women at Retreat were very satisfied with the care they received when in labour, even though a member of staff scolded most of them at some stage or other. Overall they perceived the staff to be “nice” and “very helpful”.
- The experiences of women delivering at T.C.Newman Hospital were much more mixed and there is a need to improve attitudes towards patients through Values Clarification workshops, closer management and correction of staff found to verbally abuse patients and, if necessary, disciplinary action.

Conclusion

This study has reported on an area of the Cape Town obstetric service (Retreat MOU) where there is a relatively high level of patient satisfaction with care. The findings suggest that there was fairly considerable communication between staff and patients (particularly more educated ones) and that this was a very important ingredient in the service and helped to create a good atmosphere in the clinic. Despite this, patients still complained of being scolded both in the antenatal clinic and during delivery and there is still considerable scope of improving the health educational aspects in the MOU. T.C.Newman Hospital was identified as having considerable more problems in the organisation of its antenatal clinic and in staff attitudes towards and treatment of patients, and worrying instances of verbal abuse and humiliation were reported and observed. Recommendations are also made for improving health education at T.C.Newman Hospital.

ACKNOWLEDEGMENTS

The authors are extremely grateful to the women, who gave up their time to share intimate details of their lives, without whom this report would not have been possible. We would also like to thank Mrs. Vermeulen, Prof. H van C de Groote and Dr. Paul de Villiers for giving permission for the research and Matron Nero for allowing access. We would also like to thank Wynda van Eyssen and Elize de Kock for helping in the transcriptions of the tapes. This project received financial supported from the Health Systems Trust and the Medical Research Council.

WOMEN'S USE AND PERCEPTIONS OF RETREAT MIDWIFE OBSTETRIC UNIT AND T. C. NEWMAN (PAARL) HOSPITAL

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1 INTRODUCTION

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

This is the third of a series of three reports which have been produced for the study and focuses on women's perceptions of use of Retreat MOU and T.C.Newman Hospital in Paarl. The first report focused on midwives perceptions of the services in which they work and the main problems which they encounter in their daily working lives (Jewkes et al 1997), and the second on health seeking practices of Xhosa-speaking women using Khayelitsha MOU (Jewkes & Mvo 1997). In the discussion of this report an attempt is made to bring the three reports together and compare, in particular, perceived care and problems women reported at Khayelitsha MOU, Retreat MOU and T.C.Newman Hospital. The authors hope that the research findings and recommendations will be used to improve the quality of care of women delivering in the services.

2 METHODS

The study was conducted at two study sites to include both urban and rural women. Data was collected by the first author (NA), who was herself pregnant at the start, using the techniques of minimally structured in-depth interviews and participant observation. The interviews were undertaken in the women's preferred language (Afrikaans mostly, or English) and were audio-taped. They were translated (where necessary), transcribed into English and analysed using ethnographic methods (by NA and RJ). A total of fifteen women were interviewed of whom ten attended the Retreat MOU and Groote Schuur Hospital and five attended the T.C. Newman Hospital in Paarl. The women were recruited on their initial booking visit and were re-interviewed at intervals. Most of the women had four interviews of between 1 and 2-hour duration, resulting in a total of 50 interviews. In addition, a pregnant friend of one of the informants from Retreat joined the discussions in all her follow up interviews.

The initial interviews were held at Retreat MOU and T C Newman Hospital. All the follow-up interviews took place at the homes of the women and each built upon the previous interview with the final interview occurring after the birth of the baby. The scope of inquiry included symptoms and problems which they were experiencing, how decisions were made to attend a health care provider, knowledge and perceptions of pregnancy, use of lay medication, their experiences with and perceptions of the quality of care provided. The follow up interviews were usually relaxed occasions, often with lunch or tea and a considerable amount of "baby talk" and breaks for breast feeding (for interviewer and interviewee) interspersed the more focussed questioning.

The women attending Retreat MOU delivered at the MOU, with the exception of three who were at high risk of complications and so were referred to GSH for continuation of antenatal care and delivery. The interviews took place between November 1995 - February 1997 (the researcher was on maternity leave during the study). The women were chosen to include both urban and rural (4 of the Paarl women lived on farms), a range in age (17 - 38 years), and parity (0 - 4) and the stage of pregnancy at which they booked (9 booked in the 2nd trimester, 2 in 3rd trimesters and 4 in the 1st trimester). Ethical approval for the study was given by the Medical Research Council Ethic's Committee and the Ethics Committee of Groote Schuur Hospital. Access was approved by both Groote Schuur and T. C Newman Hospital.

3 RESULTS

3.1. Pregnancy and its diagnosis

The majority of the pregnancies in this study were said not to have been planned or, at the time of conception, wanted. Many became pregnant because they had problems with the contraceptives and either stopped the injection, “*skipped a pill*” or used a condom incorrectly (as one woman explained that she did not know that “*these drops at the beginning of the intercourse can also make you pregnant*”). One tried to abort secretly, but delayed until it was too late for Groote Schuur to accept her. One woman described her boyfriend tried to “*force*” her “*to leave the contraception*” (as it “*eats up the kids*”) by destroying her pills and she had to devise plans to hide them, which ultimately failed.

Most of the women had known they were pregnant when they observed changes in their bodies. Most said that they noticed missed periods, but differed in the number which had to be missed before to should be taken as an indication of pregnancy. Some perceived that one would be enough, whereas another said it should be “*more than three*” missed periods. Some women placed more emphasis on other signs, such as having a “*bitter mouth*” or kicking, which one of the Paarl women said usually started at 3 months. Most of the women who had previous pregnancies described signs of pregnancy which they recognise, for example one said “*I just felt the life inside of me... my breast was getting bigger... the nipples around it started to get black*”; nausea was also mentioned. Primigravidas demonstrated markedly less knowledge, as one described “*I did not know what was happening to me [when I] saw water coming from my breast*”.

At both Retreat MOU and at T. C Newman Hospital the women were expected to have confirmed their pregnancies before being accepted for booking. Most of them knew about this and had already attended a private doctor, but those who did not, were sent away and were not booked until they returned with confirmation. Two women reported having some difficulty getting confirmation from a private doctor or clinic, and had to struggle to persuade staff to do a pregnancy test. In one case three visits had to be made just to get the pregnancy confirmed.

3.2 Antenatal Care

3.2.1 Timing of booking and problems attending

All the women interviewed were recruited through the antenatal clinics and so had booked before delivery. Most had done so between three and seven months of pregnancy. In many cases the reasons why women booked late were linked to their prior experience with the system and it would seem that with increasing parity, women sought antenatal care later. Some women perceived that they booked at the 'right' time, whereas others suggested that the time had been rather determined by other factors, such as the availability of child care or transport.

Women differed, however, in their perceptions of what the 'right' time was. The woman who booked the earliest (three months) did so because her previous child had Down's Syndrome and she was concerned about the risk to the present pregnancy. Some of the other women also indicated that three months was a good time to book. In contrast, a woman who had had a previous still birth booked at five months, asserting that it was "too early" to book before that time.

Most women booked later in their second or third trimester and explained this in terms of the pregnancy being unwanted, spending time searching for an alternative place to attend because of fears of poor care at Retreat MOU, economic factors such as not having transport money or delaying to accumulate the user fees (although these were not necessary), difficulty getting transport during busy times on the farms or an unwillingness to book early because of not wanting to be pregnant "the whole year". Work was a constraint cited by many women who either were paid only for work done or were discouraged or not allowed by their employers to take time off to attend at particular times. For farm workers this was a problem at busy times on the farms and one woman working as a domestic worker/nanny was not allowed to attend when the children she cared for were ill. Women at Retreat and Paarl both described problems with arranging care of their own children during visits. One of the women interviewed was a particularly caring and concerned mother and she explained "you can't just leave your children behind and walk away", because of this problem she missed all her follow up appointments at Groote Schuur Hospital, which she was supposed to attend because of previous hypertension in pregnancy.

Only one of the women interviewed had the experience of being turned away when she came to book. She was a teenager who only managed to book at Retreat MOU on her third occasion. On her first attempt she described being informed by the security guard that there was no booking on a Monday and on her second attempt (at 8am on the Tuesday) she was told there were no more cards available which meant the number of bookings for the day were full. She booked the following day. During the course of the study the policy at Retreat was said to have been changed and thereafter women were allowed to book all day, surprisingly this women tried to book after the said change of policy.

Geographical access was particularly a barrier for the women attending T. C Newman Hospital. The majority of the women interviewed lived on farms and some were dependent on farm transport to attend the clinic. Difficulty getting this during busy times could contribute towards late booking and was cited as the main reason for this by one woman who booked at seven months. Even for women living in the Retreat area, some complained that attending clinics was inconvenient if they were working in another part of the city. This was not cited as a major barrier for most women.

At both the sites women gave similar explanations for missing the follow-up visits as those given as barriers to booking, particularly transport factors, the inconvenience and the reluctance to loose money if they took time off work, child care and near the end of the pregnancy women described being “*tired*” and “*lazy*”. It was apparent that the women loosely weighted up the cost and benefits of attending bookings and the follow-up visits with a greater effort being made to attend for booking compared with overcoming similar barriers for the follow-up visits. The follow-up visits were perceived, by many women, as less important.

3.2.2 *Organisation of antenatal care*

The two sites had different service delivery models. Retreat MOU was managed exclusively by midwives whereas at T. C Newman Hospital the women saw a doctor at each antenatal visit and at delivery. At Retreat MOU women spent on average four to five hours at the clinic when they booked, with most of the time spent waiting for the next activity. At T. C. Newman Hospital, booking took the whole day for most women as they saw midwives in the morning and the doctor after 14h00 in the afternoon. The follow-up visits at Retreat were shorter (2 - 3 hours) than the

booking visit but this depended on the staff levels and number of women attending for the day. At T. C. Newman Hospital, women coming for follow-up were seen by a doctor in the morning but many had to spend the rest of the day at the hospital waiting for their farm transport to collect them in the afternoon. The woman in the study had between one and six antenatal visits. The number of visits varied depending on the stage of the pregnancy, the health risks of each woman and the women's socio-economic circumstances.

At both antenatal clinics booking involved opening a folder, history taking, taking blood, weight and height measurement, urine testing and measuring blood pressure. At Retreat most of these tasks were performed by different staff members. Each woman was seen individually by a family planning advisor and a group educational talk was given by a midwife while they sat in the waiting area. At Paarl, most of the tasks were also separated but family planning advice and health education were integrated into the history taking process. The women attending Retreat were not physically examined on their first visit but were given a card with the date for this to occur the next time they came. All the woman attending Paarl were examined in the afternoon by a doctor and were given a Pap smear. At both the sites the women reported few opportunities to develop a relationship with a single staff member because of the number of people involved in their care. This made it harder for women to speak to the staff and many said they hesitated to express their feelings and concerns. One woman at Retreat commented that when they took her blood, weighed her and gave the iron tablets they did not explain why they were doing it.

Most of the women were fairly familiar with what was expected of them at the clinics as a result of previous experience or discussions with other women. Many of the Paarl women came with gowns in preparation for the examination by the doctor and women came with food, sometimes books to read and one even brought work to do to dispel the boredom. Many found the long waits "*exhausting*" and those that were working complained that they were not able to return to work afterwards.

Since there were no doctors at Retreat MOU, women with complications or in need of investigation had to be referred to Groote Schuur Hospital for antenatal care and delivery. Three of the ten women interviewed from Retreat delivered at Groote Schuur; a further three were referred for ultrasound or genetic counselling and one was transferred after delivery because of

the baby's low birth weight. Most of the women indicated that they did not mind being referred to Groote Schuur as they perceived they would get better care.

3.2.3 *Communication in the antenatal clinics*

The women interviewed indicated that the attitudes of the staff towards them, the friendliness of the clinic and the degree to which the clinic met their perceived needs were critical in determining women's assessment of their time in the clinic and its usefulness to them. Communication between staff and patients and the related question of continuity of care (or lack of it), in turn, were critical in influencing these perceptions. This was well illustrated in patients' constructions of 'nice' nurses which were visible in their narratives, these were sensitive to their needs, treated them as "*human beings*", were respectful, warm, friendly and provided them with information. The more educated patients met more nice nurses. They reported being given more information by the staff and were less likely to have negative experiences. Many of the women attending Retreat MOU on a Tuesday morning remarked about how much they appreciated the tea and sandwiches served by Friends of Retreat MOU and the accompanying talk on breast feeding. This undoubtedly contributed considerably to creating a better atmosphere in the MOU on that morning.

Dates

Most of the women had knowledge of the expected length of pregnancy and often spoke in terms of 'weeks'. Most of these calculated their own expected date of delivery from their last period and this was often in conflict with the date that the sister gave at the clinic. Women's confusion over their expected date of delivery was compounded by their seeing different staff members at each antenatal visit and with the result that their given dates changed from one visit to the next. The women expected that the dates would be easy to determine and thereafter fixed, but found that they were negotiated and shifted continuously taking into account new information on abdominal size, body parts or ultra sound scan findings. For example one woman was particularly inconvenienced and made anxious as she went for a booked caesar at T. C Newman Hospital, only to be examined by a different doctor, told that "*the baby was still too small*" and sent home for another two weeks. After which time her 4600kg baby was delivered. Many women ultimately stopped believing the staff and resorted to calculating their own dates (which from the researchers' assessment were even less accurate than the shifting ones given by the staff). The

confusion over the dates was often so considerable that it suggested that most women and health providers only had a fairly rough idea of the duration of the pregnancy, as the following extract indicates:

I went to book so late, I was nearly six months already... I went again last month, they said that I [was] not 36 weeks yet (I am now supposed to be 36 weeks) because they do not feel the arms and elbows yet and the baby is very small and the baby is lying bridge...now two weeks ago the doctor examine me and she said I am six months. I really cannot understand why they don't send me for an ultrasound...I am sure that I must get sick in this month [March] at the end of the month or the first week of April...When the doctor examined me she said the baby is due the end of April only...even may be the first week of May...I work it out with my period. The way I worked it out, the baby is definitely due at the end of this month or the first week of April. They work it out for later but I am not going according to them I will go on my own. I will prepare myself .[she had was induced at the end of April - it failed - then she went into labour in mid- May]

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

Advice and problem-solving

The women perceived that 'niceness' was both definitive of and a prerequisite for good communication. One woman from Retreat explained this thus: "*there are some sisters that give you nice advice and they talk nicely with a person...they explain what the problem is etc.*". The women further described communication with the staff as pleasant and satisfactory when the staff

allowed them to ask questions and answered them in a “friendly” and obliging manner, for example a woman attending Retreat MOU described her booking visit and said that she found the “nurse was friendly” because she [the informant] “could ask her if my blood pressure is normal”. She said that she found “you have to ask them. They don’t actually just give [information]... I had to ask how many weeks I was”. Another woman said that she asked the sister about having a scan and was told that if she wanted one she would have to have it privately. She said she was not offended by the answer because it was done politely. In another interview, she also described a doctor at Groote Schuur Hospital as “nice” because “he spoke to me quite long”. Two women expressed satisfaction when nurses acknowledged their concerns and took time to explained symptoms. One of these described phoning the Retreat MOU when she “was experiencing difficulties” and was told that the pain is “normal and is caused by the baby pressing down.” In these positive experiences the women were able to use the information to understand what is happening to their bodies and in this way the staff helped them to allay their fears.

Not every woman had such good experiences of communication, however, some described situations where they were ignored when they asked questions and reported minor ailments. A woman attending Retreat MOU explained that she had not asked the staff about her swollen ankles, about which she was concerned, because “you can tell them, but they do not take note of you”. She had asked them advice twice before for the treatment of heartburn and felt she had been ignored.

Perceptions of poor listening by staff, often resulted in women deliberately deciding not to volunteer information, which the women felt might be relevant to their care. In one, a woman described having a “3 hour test” when it was suspected that she had diabetes. She tried to tell the sister that she had “lots of sweets the night before” but the sister seemed to ignore her. In response, she decided not to tell “them we have sugar in our family ... I thought they must find it out for themselves”.

Scolding

Another barrier to good communication reported by the women interviewed was the practice of “*scolding*” patients, usually in an attempt to correct aspects of their behaviour which the nursing staff perceived as deviant. Many of women mentioned that they knew that if they did not follow the “*rules*”, for example by booking late, being late for or missing appointments or forgetting to bring urine specimens, they would be shouted at or scolded by the nurses. They also described how the staff would often scold a woman particularly loudly so that everyone waiting could hear her misdemeanour and her detection or punishment could be an example to the others. In so doing the waiting women perceived that they were being collectively scolded. A woman gave an example of a sister shouting to women waiting in the corridor at T.C. Newman Hospital:

“remember if you come in here to do the bookings you have to remember the dates of your first children, remember the dates on which you had miscarriages, remember your ages and do not give wrong dates because we are checking all of you here”

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

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

open and now you can't even look at me"

Some women found they were scolded when they contacted Retreat MOU or T.C.Newman Hospital reporting problems. One woman described attending Retreat MOU at 11:00 pm when she had vaginal bleeding. She said she was so *"on her nerves"* and *"confused"* by the bleeding that she forgot to bring her clinic card. She said the staff were *"very rude"* and had told her that she *"wasting their time"* because they had to rewrite her card and did not observe blood in her vagina. She was later given advice by a friend not to get angry (at the nurses) or not to respond to them (to *'swear at the staff'*) lest she compromise her future treatment, but she was also advised not to return to the MOU if the bleeding happened again. Another woman reported rudeness from staff when her friend phoned into Retreat to check what she should do as her waters had broken. She was told *"(She) knows what to do, she does not need to phone the hospital she knows she must come in if her water broke"*. Similarly a woman from Paarl described how she was *"scolded"* when she called the clinic to ask advice about lack of foetal movement. Such experiences may well have discouraged women from seeking advice which could be important for their health and that of their babies.

The women suggested that the scolding they received from staff took different forms. Some of it, they perceived, was well intended, for example scolding about smoking in pregnancy and booking late, and women suggested that they accepted this and it did not particularly bother them. One woman was very embarrassed about being told to hurry up in the clinic in front of all the other patients but she said she understood as there were so many patients that she too would get exasperated with them and she knew that she also came to the MOU with *"a lot of moods"*. Other forms of scolding were not excused, they were perceived as unpleasant, humiliating and *"rude"*. The latter forms made women feel very *"upset"* and *"angry"* and, particularly when others could hear, it made them feel they were being treated like children. Women reported a number of strategies to avoid being scolded. One woman from Paarl with diabetes attended a private doctor on the Saturday before her antenatal clinic visit to check her urine for sugar in an attempt to defend herself if she was told off for poor control. Another explained, with the confidence of a woman having her third child: *"They have never been ugly with me. Yes, there are people whom they shout at but whenever they come to me they are always friendly. I appreciate it and I make sure that I do not walk out of the 'spoor'. I think I will also become rude if they start to shout at me"*.

Women's knowledge of pregnancy and child birth

The women demonstrated considerable variation in their levels of knowledge about their bodies and pregnancy. Their perceptions of the value of and the need for information in the MOU varied, particularly with their previous experiences of pregnancy. One multi-gravida perceived that at the booking visit talk “*basically they tell you things that you know already*”. Many of the women utilised bio-medical discourse to a considerable extent, for example they spoke of “*cms*” of cervical dilation, “*advancement*” of the baby, methods of inducing labour including breaking waters, and gave explanations of difficulties or things which happened to them which resembled bio-medical explanations. It was often apparent that there were substantial variations between women in the extent to which they understood the bio-medical meanings. The narratives suggested that much of this terminology they had learnt from the midwives explanations of, for example, their progress in labour. Some women had much greater needs for basic information about the processes of pregnancy and child birth than others.

The more educated women tended to have more knowledge and indicated that they had acquired it from reading books and magazine articles about pregnancy and child birth. Others relied mostly on knowledge from previous pregnancies and talking with friends and older women. The younger women who were having their first babies had distinct needs for information. For example, one said that she was very “*scared*” because she “*did not know what was happening ... when pregnant*”. She described trying to speak to friends about the birth and asked them questions such as “*how must I open my legs*” to which she did not receive a response other than being told it is painful. Another woman described how at her first birth she had not known about “*pushing and such things*”.

Older women were said to have given a considerable amount of advice particularly about ‘dos and don’ts’ in pregnancy, and also ‘normal’ ailments in pregnancy and their treatment. Knowledge about medication is discussed later, but other advice given to women included, not to eat too many curries in case the baby becomes jaundiced and one woman was advised not to wean her breast-feeding toddler, lest he die, but wait until he feels the child moving in her stomach, then he will give up the breast himself. Events of the birth were also interpreted through discussions, for example one woman said her baby was blue when he was born and she explained that “*they*” said “*it was because of all the drinks and ice water that I drank during pregnancy*”.

During participant observation the researcher observed the women exchanging information about their pregnancy, the clinic, the staff, and procedures. In this way the woman gained knowledge on common experiences and also received advice on how to deal with symptoms. Peers played an important source of information about what to expect at the clinic and older women in the community also played a role in providing information on health in general although not much is discussed on what exactly happens at childbirth. Sometimes the information given was unhelpful, for example during the last interview with a young woman in T. C Newman she and her partner wanted to know why she “*has not stopped flowing [bleeding] yet*”. She described how she “*got a big fright when I got sick*” because she was told by “*some women*” that she would not be menstruating after the Caesarian.

3.2.4 Health promotion

At Retreat MOU the women were given a group talk during their first antenatal visit which mainly dealt with the clinic’s “*rules*” such as its hours, the after hour facilities including the reasons why a woman might attend after hours service, items to bring when coming for delivery for example sanitary pads, baby clothes, food and money for the public phone. They were also provided with an appointment card which contained information such as when to attend in labour and attending the after-hours facility. Few women reported receiving educational information during the follow-up visits at Retreat MOU, although it was apparent that issues were addressed on a one to one basis during palpation and three mentioned discussing the danger signs of pregnancy in this context.

Some women mentioned that they would have liked to have some other information, including test and measurement results and more explanations, for example of blood tests. Although the experiences of those who did ask generally suggested that women would have been given information had they asked for it, many women wanted further explanations but were not confident and assertive enough to ask the midwives directly. One woman very clearly demonstrated this when she explained how during an antenatal visit she overheard a sister asking and giving advice to another woman in the next cubicle about varicose veins. She described how she was hoping that the sister attending her would ask her similar questions about her own varicose veins which did not happen and she left the clinic without asking the sister.

One of the more knowledgeable women remarked that she found the preparation for labour “*lacking*” and felt that the staff would not “*complain so much about the way women shout or perform when they are giving birth*” if they provided enough information, particularly in the form of reading material. She had bought a book on pregnancy and child birth from the family planning advisor and suggested that the “*MOU staff give each women this book*”. She explained that she had been “*shock*” during her first delivery and felt that many women would feel similarly, it was “*like going into the unknown*”.

At T. C Newman Hospital there were no group health promotion activities. Women were given an information pamphlet at the time of their booking (which covered the signs of labour, danger signs of pregnancy, when to attend for the above and list of items to bring), but for the most part health education, such as it was, was provided individually, integrated into the process of taking the obstetric history. Whilst this could have provided an excellent environment for tailored communication, it did not as there was no privacy. Histories were taken in a room shared by two sisters who talk to their respective patients simultaneously within easy hearing distance of the rest of the women waiting in the corridors. The researcher was able to observe the content of several of these discussions just by sitting in the corridor listening. It was apparent that the interviewing style was interrogational and frequently focused on topics which the women found sensitive such as their economic status or sense responsibility, for example when asking “*who will care for this child?*” and “*how many nappies do you have?*”.

In the interviews most of the women reported that they experienced these sessions as hostile and formidable encounters. This was not an environment conducive to learning and it resulted in the women becoming fearful and angry at the staff which further discouraged the asking of questions. This was well illustrated by a diabetic woman who was scolded by the sisters about her sugar being high. She perceived that the staff were accusing her of lying when she said she took precautions to decrease the sugar in her diet. She had been very distressed by the encounter and was also offended when they told her “*Oh a person can't tell you people nothing you must look in the Sarie what kind of food to eat*”. She thought they were questioning her literacy and suggesting that she did not read things. During the interview it was apparent that she ate the recommended food but did not cook it in the recommended ways. The sister in the clinic had been unable to detect that this was her particular problem and to explain about the importance of the

method of cooking because she had been scolding rather than discussing.

Women also reported not always being told about the well being of the baby by the doctor examining them during follow-up visits which further discouraged them from asking questions and often the researcher was asked questions of symptoms and the treatment thereof. There was considerable criticism of the doctors at T.C.Newman Hospital both in the clinic and in the wards for not explaining things to patients, and discussing them with colleagues in English which the patients could not understand, without explaining what they were saying.

Smoking

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

A woman attending Retreat MOU illustrated how attitudes and practices towards smoking could change through pregnancy in response to pressure from a variety of sources. At the start of the study she explained that she was “*not really concerned*” about her smoking, even though more than one friend had told her that her baby would be small. She said she had smoked and drunk a lot with the previous pregnancy. On a later occasion she described how she had tried to stop smoking after watching a TV programme in which they discussed “*what smoking can do*”. It frightened her so she decided to stop, but said (laughing) that it did not even last a “*full day*”. In the final interview, she explained that she had made a strong rule that nobody, including herself, was allowed to smoke inside the house because of the baby. She also said she was smoking less as she could not buy “*her brand*” loose, so she was forced to smoke one she didn’t enjoy and so she would “*smoke for a while...then nips it*”. This woman had also altered her drinking practices

whilst pregnant, she avoided “strong liquor” and just had a “dop of beer” instead.

3.3 Responding to problems / symptoms & use of medication

The women described a variety of problems and symptoms experienced during their pregnancies which included heartburn, tiredness, varicose veins, vaginal bleeding, painful legs, lung infection, turning pains, headaches, insomnia and constipation. They responded to these symptoms in different ways depending on their perceptions of the severity of the problem, as well as previous experiences, and either attended the after hours clinic, a pharmacy, a private doctor or followed self-healing practices, which included taking non-prescription medications, indigenous herbs, Cape Dutch remedies and a variety of other non-medicinal products (see Tables 1-4).

Receiving medication was in general an important criterion by which the satisfactoriness of care was judged by most women at both the sites, even though they were aware that they should be cautious about taking medication during pregnancy. Indeed, not being given medication was perceived to be tantamount to not being given care, and this influenced women’s choice of health care provider. An exception was, however, made for iron tablets which were not popular. Many of the women complained about side-effects which resulted in them not taking. These included nausea and constipation. One woman was informed by the sister that her “*iron is enough*” and she should “*not to continue with the tablets*” and had a “*good laugh*” because she has not been taking the iron tablets anyway and said “*I don’t know where the iron comes from*”. There was some confusion about their purpose, as one woman explained that she used *Versterk Druppels* for “*energy*” and so did not need the iron tablets, whilst another, that she did not take them as she was not constipated.

3.3.1 After hours attendance

Only five women spoke of attending the MOU or T.C. Newman Hospital after hours. Three of them had vaginal bleeding, which in one case preceded the birth of a still born baby and in another, a premature birth. One attended for heartburn and was admitted in Retreat with a urine infection and the fifth woman, who had asthma attended T C Newman Hospital at night when she developed a chest infection. She was dissatisfied with her treatment as she was not given the antibiotics which she expected. Eventually she went to her private doctor who immediately gave her these and relieved her tight chest with an asthma “pump”. Most women perceived that only

possible pregnancy complications should be taken to the after hours service.

3.3.2 *Attending private*

As discussed earlier most of the women went to private doctors for pregnancy confirmation and continued to attend them with problems during pregnancy other than complications. One woman explained that she perceived that it was “safer” to do this because the MOU would not provide medication and the doctor would examine her. From the narratives of the Paarl women it was evident that they were very attached to the “farm” doctor who is a GP operating in the “dorp” and referred to him as “good” and someone they could “trust”. This doctor had an arrangement with the farmer who allowed the women and her family to attend while the payment was subtracted from their salaries at the end of the month. This arrangement suited the women because they do not need cash to attend the doctor. Some women reported trying to get advice from a pharmacist before visiting a private doctor.

3.3.3 *Self medication*

Given the emphasis that women placed on receiving medication for healing it is not surprising that self-medication was a common practice of both the rural and urban women. They described a variety of ways in which they treated their minor ailments during and after pregnancy as well as prophylactic treatment for health maintenance for their new born babies. Often they followed the advice of older women. A list of all the substances used and the reasons for use are presented in Tables 1-4.

Indigenous Herbs

The indigenous herbs used by the women are described in Table 1 and were locally available herbs known for the treatment of common reproductive health problems. Herbs and Dutch remedies were predominantly used to treat indigenous illnesses, particularly associated with womb ‘dirtiness’ or “baarwind” [winds in the womb], which was perceived to be the cause of the “10 day attack”, a wind from the womb which goes to the head. Womb dirtiness was perceived to be a problem after birth, for which cleansing with herbs was required, “to allow all the old blood and things to come down”, and thus these were used exclusively after the birth. Mothers, grannies, aunts and elderly women in the community were mentioned as the most common sources of information about herb use and were frequently consulted. Often the herbs

were prepared by the older woman after they had been bought or picked from the garden. One woman described how her granny was “*angry*” when she discovered that she had been bleeding continuously for nine months after the birth of her previous baby. The granny had treated her with “*home remedies*” which “*worked immediately*” and caused the passing of “*massive pieces of blood*”. Women were only instructed on their use when they were pregnant for the first time and several mentioned being warned about not buying Dutch remedies or preparing herbs too early because they could be used in witchcraft. Sometimes the Dutch remedies and the herbs were combined.

The Cape Dutch remedies

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

Non-prescription medication and other products

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

to prepare the child for birth. During the narratives of delivery, it was apparent that some were told by nursing staff that they should walk around when in labour for the same reason.

Table 1**INDIGENOUS HERBS**

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

Table 2**CAPE DUTCH REMEDIES**

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

Table 3**NON PRESCRIPTION MEDICATION**

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

Table 4**OTHER PRODUCTS**

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

3.4 Child birth

3.4.1 *Deciding when to go to the clinic*

Women's decisions about attending the MOU or a hospital when in labour (when they "got sick") were influenced by a variety of factors including the time day or day of the week. Those who had given birth before often expressed an unwillingness to spend a long time "walking around" in the facility and so tried hard to stay at home until as near delivery as possible, although transport arrangements did not always permit this. Women near Paarl could call an ambulance to take them to the hospital, whereas those attending Retreat MOU had to arrange their own transport, which could be costly and awkward if needed at night. They often made prior arrangements with a neighbour who owned a car and paid between R20 and R30 for the trip. When labour started in the afternoon or early evening, some women decided to go to the clinic early to avoid the inconvenience of looking for transport in the middle of the night. Similarly, when labour started late at night the women would usually wait out the night at home, instead of waking the driver, and so arrive in advanced labour. One of the women from Paarl had to be admitted as an emergency from home with an antepartum haemorrhage and she remarked positively about the speed of the ambulance service. Husbands and boyfriends were sometimes reported as helping with transport to hospital, but some were described as particularly uncaring and unsupportive, one woman even explained that when she started to get labour pains in the middle of the night she did not bother waking her partner up because "*he won't concern himself with me*", instead she walked over to a neighbour to arrange the transport.

Some women had particular ways of determining the 'right' time to go to the clinic, for example waiting for the pain to be "*3 minutes apart*" or waiting to see "*red mucus*" first. A woman who had given birth previously in the Northern Cape described the involvement of her mother and another older woman in the decision about when she should go to the hospital. She explained "*mamma ... keep a person until the last. They must first smell the blood or your leg must start to shake first*". During the study pregnancy, unfortunately, she had no option but to go in early because of transport difficulties as it was a Friday afternoon.

3.4.2 *Child birth at Retreat MOU*

Of the ten women recruited from the Retreat antenatal clinic, three gave birth at Groote Schuur Hospital, and seven at Retreat. All delivered vaginally. The women varied in the time they

spend in Groote Schuur and Retreat MOU before delivery between three days (with a short break in the middle) and 20 minutes. They all reported being examined on arrival and periodically thereafter until delivery and seemed satisfied with their clinical care, although one complained about the enema. Most of the women described most of the nursing staff who helped them with their deliveries as “nice” or “really nice” and as very “helpful” and all were overall very satisfied with their care. All the women who delivered at Groote Schuur were very satisfied, including a woman who had a second consecutive still-birth there. Most of the women described the first part of their labour when they managed varying degrees of pain and then reaching a point where they felt the urge to push, felt they wanted to defaecate or felt cold and shook. Many described informing the midwives when these feelings developed and being found to be full dilated or to have the head visible, at which point they proceeded to push the baby out (usually described as taking three or four pushes). At Retreat and Groote Schuur the midwives in each case responded to the women when they mentioned these feelings and took steps to prepare for the birth. Some women described having the urge to push at an earlier stage and being told not to do so. In all cases the woman said they pushed anyway, for example one explained “*I pushed four times for this child...I pushed there at the back and I pushed in the toilets as well*”. Many of the women reported being asked by sisters not to give birth until the night shift came on or they came back from lunch, but the women did not mind this as they did not perceive these to be serious requests or instructions.

All but one of the women, however, complained of being scolded at Retreat MOU by staff they came into contact with at some stage. In two cases this occurred in circumstances in which the narratives suggest that the staff may have panicked because they suddenly discovered that a woman was almost ready to deliver. Women who arrived in the first stage in their labour were given a bed in the antenatal ward and encouraged to walk around the corridors. One of these women was found by a sister sitting on a chair outside the labour ward and told her that she felt as if she wanted to push. The sister said she should come into the ward but, the woman reported, “*her manner and her tone of voice was like wild and abrupt*”. The sister also snapped at her when she was delaying in getting into the bed, the patient told her to wait as she had a contraction and the sister responded “*don’t tell me to wait*”. After that her previous sister came back from lunch and helped her deliver “nicely”. A second woman was “*scolded and shouted at*” when she was found having fainted in the passage by staff. The narrative suggests that they

were shouting partly because they wanted her to lie down whereas she wanted to walk but also from their own alarm. She gave birth ten minutes later. One woman complained about the staff who came in the morning after the delivery at Retreat, she said they were “*full of moods*” and were barking at the women, “*come, come, go and wash*” and “*stand up from the beds, come, come*”. She was quite irritated by this. Another patient who complained of being scolded said it was the cleaners who did this as she did not eat her breakfast. One of the women gave an account of her actions in labour which clearly would have exasperated the most patient of midwives, she also complained of staff wanting to “*scold me continuously*” . She was a very vulnerable, inexperienced and immature woman who ultimately delivered safely, responding well to kindness from the male midwife. An informant explained in an interview that a friend of hers who worked at the MOU had told her “*they were not allowed to scold the mothers any more*”. It did appear from the interviews that some women were still being scolded.

The greatest complaint of almost all the women was the pain of labour. One woman who was induced for hypertension at Groote Schuur was given pain relief and two at Retreat were given an injection. A few women reported asking staff for pain tablets and were encouraged rather to walk around. One described being taught to breathe through her contractions, which she said “*eases the pain for that while*”. None of the other women were given anything. The women also perceived that there was a general lack of sympathy with vocal expressions of distress due to labour pains, as evident in the characterisation (by women as well as staff) of such behaviour as “*performance*” and the frequent complaints that “*lots of women perform because of the pain*” or warnings of women not to “*perform*”. One woman said she heard a midwife shouting at a girl of 18 or 19 who was delivering “*you [didn't] go on like this when the man was on top of you*”. Several of the women indicated that they found this aspect of delivery hard and unfair, as one commented that “*they are there to comfort us but they don't give it*”, none the less the women all participated in criticising women who were noisy in labour.

Most of the women were given a contraceptive injection after delivery in labour ward. There was a suggestion that there was not much choice about contraceptives after the birth. One was sterilised, one apparently ‘missed’ (she did not understand why) and all the others received the 3-month injection. More than one woman thought it was very funny to have been given “*your family planning...just after giving birth*” in the labour ward. Another said “*They ask you when*

you are pregnant - what [family planning] you are going on.... You know that is the attitude they have. ...and in the labour ward they are just as concerned about it - this is the injection that you are going on - yes fine - and then 'schoop' they give it to you just like that".

After they were discharged the Retreat MOU women were expected to attend the clinic every second day with their babies for cord care until the baby's cord "*falls off*". Most of the women perceived this as important. A few, also spoke about the district sister that visited their home after the birth of the baby.

Sterilisation

Several of the women perceived that antenatally some staff members attempted to coerce them into having sterilisations, for example one described how she used her husband as an excuse, saying "*my husband does not want me[to have the sterilisation]*", and later laughed about fooling the staff. Most of the multiparous women said at the first interview that they are planning to have themselves sterilised after the birth of the baby. All but one of these women, however, changed their minds after discussing it with friends and hearing of the "*terrible experiences*" of female relatives. They indicated that they feared additional pain and incapacity after the pain of child birth, not being able to look after the new baby and their other children properly and having a general anaesthetic. One woman complained that the staff advocating sterilisation did not really consider the women's position, "*it is quick for them but they don't know because they do not feel your body*", she felt that she would "*already have lots of pain after the birth and your body is still raw and painful*". One woman was put off as after the birth she shared a ward with a woman who had a sterilisation done and saw her "*curling around with pain*" and soiling herself after the operation. Seeing this and speaking to this woman confirmed that she should cancel her own sterilisation. One woman explained that she would have a sterilisation, but preferred to delay it as she had been told that it is less "*painful*" and "*better*" to have a "*dry sterilisation*" [done a few months after the birth] than to have a "*wet sterilisation*" [immediately after the birth of the baby]. It would seem that women consent to have a sterilisation when they are confronted by the staff to make a decision about family planning during the first booking visit, but develop fear and concerns after talking with other people, which are not addressed by the services.

3.4.3 *Child birth at T.C.Newman Hospital*

Of the five women interviewed who gave birth at T.C.Newman Hospital, three delivered vaginally one had an elective caesarian and one an emergency caesarian. They came to the hospital relatively early in labour (the two having first babies were said to be 2cm when they came in and the other woman was 4cm) and were examined and admitted to the antenatal ward. They all reported being examined regularly and two were transferred to the labour ward to deliver (the other delivered in the antenatal ward bed (see below).

Pain during labour was also a central feature of these women's narratives, with the recurring complaint that nothing was given to them for it and one complained that she was not even given something after the birth for "after birth pains". The nurses told one of the women to walk up and down "to get the baby loose" but she commented that "it doesn't actually help a lot". Another of the women was forced to stay in bed as she was given a drip as "*all her fertile water had run out already*". She found this particularly difficult, and commented "*goodness it was painful, I don't want such pain again*". A third woman also had severe pain but decided "*not to make a noise or perform at all*" but said she just "*rolled around a bit and made some actions*". Explained this saying that "*there were too many of my friends that were also in labour*" and one had said to her "*she wants to hear how I make noise*". She suggested that not complaining of pain was perceived as a sign of strength, a female version of machismo, which would have given her status in her group.

The other two women who delivered vaginally were distressed or angered by aspects of their experiences, particularly episodes when the staff shouted at or scolded them. This is illustrated by the following extract from an interview with one of the informants, who was a very shy, quiet and very disempowered young woman:

- N: *So how did the birth go?*
R: *(silence) they were not so nice*
N: *Why do you say that? Give me an example?*
R: *They shout at a person*
N: *What do they shout about?*
R: *If a person makes a mistake or something*
N: *A mistake? Can you give an example?*

R: *If you close your legs or so*

N: *Hmmm what do they say?*

R: *(silence)*

The woman who had described (above) how she tried not to step out of the 'spoor' found during her labour that this was unavoidable. She explained that she was lying in bed with a student midwife sitting with her and she explain how sometime after she had been told she was 7cm she started to get " *a feeling like you want to 'aa'*". She explained " *when I had the 'aa' feeling I knew it was the child that was coming. I could feel my pubic bones opened...when I felt I wanted to 'aa' I started pushing - I pushed as the feeling was telling me*". She narrated:

I told her 'the child is coming' and all she said was 'don't push' and I said to her again 'I am telling you the child is coming' and she ran out to call the sister. She came back and said 'the sister says you must not push', so I said to her 'I can't help it, here its coming'. And she continued to hold my hand and I pressed it as well - so then the head was out - she said 'Oh no' she thought I was lying and I said to her 'the head is out'. It seems she did not want to deal with it so I pulled the sheet from my body and I showed her that the head was out. As she was looking I said to her 'here it comes' and I pressed and the child shot out just like that.

She said that they "scolded" her because there was nobody there to catch her but, she explained, " *I wasn't concern with their scolding...I thought you people can scold all you want to but the pain is all gone*".

The woman from Wellington was quite upbeat in the tone of her narrative of childbirth and indicated that she had perceived herself to be supported by the sister (whom she knew), the doctor and her 'friends', however, she described an episode which happened when she was washing afterwards which another woman was humiliated by the nurse helping her:

There was another woman, her name is Cherilyn, she is a big woman, she is 34 years and she is married already and that is her fourth child - so we met each

other there that day....So when she was done they asked her where is your sanitary pad...so she said she does not have pads. So the sister said to her 'but you know you are finishing at this time and you also know that the hospital does not give you these things. Take that fucking pyjama of yours and tear it up and push it up there in you - I will not give you pads - you know from the paper that you got that you have to bring your own - did you not read the paper or can't you read?' So she said to the sister she can't read and write because she did not go to school. Then the sister said 'Yes you are all fucking stupid when you people had a chance to go to school you did not want to go'.....She just sat there and said nothing

The narrator continued *"with me they did not use my pads they used their own and mine were lying in the bag"* so she went and gave the woman some of her pads, and advised her not to answer back but to *"behave"* herself as *"if you are raw with them they will not help you"*.

After delivering the women described going to wash and having their baby washed and then going to the ward, where *"the baby gets and injection and you get an injection"*. The lack of informed consent around family planning injections was particularly evident when one young woman said she was given an injection but she was unsure why she had it: *"I do not know - I think it is not to get pregnant...I asked my mother when I got home. She said to me you do get it when you finish with the birth - not to get pregnant"*. She also remarked that they had not told her when to return for another injection. The woman who had an elective caesarian also perceived that she was being bullied into agreeing to sterilisation in the clinic by a sister who *"was shouting"* at her about it. She said that she had planned to do it anyway but became so irritated that she responded that *"if this baby isn't normal I am not tying myself"*.

4. DISCUSSION

The lives of the women interviewed in Retreat and Paarl were located within supportive networks of women with whom they shared and discussed many aspects of their pregnancies and received liberal quantities of information, advice and accounts of previous experiences. These networks consisted of peers, older women and relatives and members participated in most of the decisions women made about their health and health care, often including accompanying women to health providers or acquiring herbs or drugs for them. As a consequence, most women had a considerable knowledge of how to look after themselves in pregnancy, what would happen to them with explanations and of the procedures at the MOU or Hospitals. Several of the women supplemented this knowledge through reading books and magazines on pregnancy. As a result of this knowledge most women accepted the procedures of the institutions, for example the need to bring a gown at Paarl, to carry your own urine at the MOU and the fact that you would not be examined on the first MOU visit, even if they did not particularly like them. There was a sense that women perceived that antenatal visits were a necessary part of care in pregnancy and that the procedures formed a necessary part of antenatal care.

The considerable previous knowledge which many women had should have created an environment in which good and full communication between midwife and patient was the rule, health information could be provided and where patients could express their concerns. Unfortunately this did not happen perhaps as often as it could or should have and communication appeared to be particularly poor at T.C.Newman Hospital. At Retreat women were often given explanations of symptoms and advice antenatally but some still complained that they had to ask whether e.g. the blood pressure was normal or when they would deliver. Some still complained that minor ailments which they mentioned were not taken seriously and staff did not always listen to them. At T.C.Newman Hospital the lack of privacy in the consulting area severely impeded patients from asking about sensitive subjects and the interrogational approach to history taking frequently resulted in this interaction becoming fraught with conflict which negated any educational possibilities. The women from farms usually spent the whole day at the T.C.Newman antenatal clinic and there was no evidence of the opportunity of having them present being taken to provide them with general health information. The interviews suggested that many would have benefited from this.

At both Retreat and T.C.Newman, a dominant complaint in many of the interviews from the antenatal period was that of having been scolded and women often described witnessing the scolding of others, which also they found distressing. At T.C.Newman Hospital, the descriptions of the women and the observations of the interviewer in the clinic indicate that in many cases this constituted verbal abuse and was delivered with the intention of punishing or humiliating. This is clearly unacceptable and should be dealt with by the service management through a combination of value clarification workshops to explore the midwives attitudes towards their work and their patients, possibly along the lines of *Health workers for Change* (TDR/GEN/95.2, 1995), and disciplinary action. The scolding reported at Retreat was much milder in nature and was primarily directed at correcting practices which the staff wished to discourage, but patients none the less found it unacceptable. Their reports suggest that it is still important to remind staff that they should not be shouting at patients and should not be rude to them and that managers should look out for and correct such actions.

Most of the women booked early in their second trimester. Often, this was earlier than they thought they were booking as their dates were wrong. The problems with dates caused considerable distress for some women and could have been alleviated in some cases by examination by an experienced midwife on the first visit where there was uncertainty. Women gave a variety of different explanations for why they booked when they did but essentially it seems that most did not think it was necessary to book earlier. One of the barriers to early booking was apparently that women did not feel sure that they were pregnant for the first few months. Most looked for signs other than just absence of menstruation and often this included waiting for foetal movements, which would have occurred only in the second trimester. It is possible, although no one mentioned it, that absence of menstruation is so common in injectable contraceptive-using populations that other additional symptoms assume more importance than they might do otherwise. It is likely that changing booking behaviour would require a combination of providing information on the importance of booking earlier (and agreeing within the service when this should be) and encouraging earlier pregnancy testing. Communicating with farmers about the importance of early booking to their female workers may also be useful. Some women complained that the lack of childcare facilities at Groote Schuur and Retreat made it harder for them to attend. These antenatal clinics should consider allowing women to bring children with them and creating a corner where they could play whilst their mothers are attended

to.

The interviews suggested that there are several areas of health promotion which should be introduced or to which changes should be made, where needed in the clinics. One area was preparation for labour and several patients indicated that the women having their first babies would benefit from more information about what happens in labour and advice about what to do when having pains. The discussions about smoking suggest that most women either already know or are adequately informed (by staff or friends) that they should not smoke when pregnant and that it is also bad for small babies, many want to stop or greatly cut down and many do make changes to their smoking practices. Overall they experienced considerable difficulties in giving up, however, which might have been in some cases overcome had they been told about and encouraged to use, in moderation, nicotine replacement products. Staff should review their smoking cessation advice and consider how to include encouragement to use these products. The third area in which information appeared unsatisfactory was that of contraception. Most of the women suggested that they had not been given much choice of method, did not always know when they were supposed to have their next injection and in T.C.Newman Hospital did not always appear to have given their consent. Contraceptive policy needs to be reviewed to ensure that women are not coerced into accepting a method which may be unsuitable for them. This is particularly important in view of the alarming proportion of unplanned/ (at least initially) unwanted pregnancies in the study. The finding that most women who initially agreed to sterilisation subsequently changed their minds suggests that the information provided initially is not appropriate and may not address women's concerns. We do not know how many women eventually went for a "dry" sterilisation, but clearly if this is women's preference procedures need to be set up so that this is as easy for women as having a "wet" one.

The women's accounts suggest that, with a couple of exceptions, most women were generally happy with their experiences of childbirth. Even though almost all delivering at Retreat and T.C.Newman had some experience of being scolded, the most important staff they came across were "nice" to them and very helpful. It was notable that women perceived they were supported, examined regularly enough and, with the exception of one woman at T.C.Newman, they were taken seriously when they said they felt ready to push. The greatest complaint was of lack of pain relief, although interestingly some women were given it at Retreat MOU. In view of the

early stages at which all the women attended at Paarl and some of the women attended at Retreat it was not clear why so few women were offered pain relief. It was apparent from the interviews that it might have made the experience of child birth more pleasant and would probably have made the work of the staff much easier if more women had been given pain relief.

None of the women indicated that they perceived the MOU or T.C.Newman Hospital to be their first point of call when experiencing ailments in pregnancy, with the exception of the symptoms of vaginal bleeding. This partly stemmed from experience that most midwives were disinterested in women's minor ailments, but also because women were unimpressed by the reluctance of obstetric service providers to dispense medications. The accounts of self-medication by the women indicate that a considerable range of products are taken during pregnancy and after childbirth. Many of the women mentioned that pregnant women should be careful about medication use and it is notable that Versterk Druppels was the only Dutch remedy used during pregnancy, although this was largely because their use, like that of herbs, was for treating indigenous problems, particularly the '10 day attack' and womb dirtiness, which affect women after birth. In view of the evident commonness of their use, it is important that researchers investigating the pharmacological properties and side-effects of indigenous herbs also include Dutch remedies.

The data presented in this report relating to Retreat MOU contrasts considerably with that produced from interviews with women using the Khayelitsha service (Jewkes & Mvo 1997). Although problems with staff patient relationships at Retreat were also reported, they were substantially different in nature and magnitude than those reported at Khayelitsha and solely related to "*scolding*". The particular problems of women delivering alone, perceiving that they were neglected, being verbally humiliated and physical punished which were reported in Khayelitsha did not arise as complaints at Retreat. The interviews suggest that one of the most important differences between the MOUs was that at Retreat there was far greater communication between staff and patients, many of the staff were friendlier and so encouraged communication, there were more personal explanations and discussions, more one-to-one health information was provided, the staff used bio-medical language with patients in a way which empowered them, and staff listened to patients' reports of changes in their bodies, particularly in labour. The women from Retreat had far more bio-medical knowledge than those from

Khayelitsha and the interviews suggest that this was contributed to by the midwives giving full explanations of what was happening. One consequence of the improved communication was that women at Retreat had a much clearer idea of what was happening around them, a much greater level of acceptance that the procedures were necessary and a greater dependence on bio-medical care than the women of Khayelitsha. In some respects these factors made the midwives' work easier, which also helped to reduce tensions and conflict. Retreat MOU is an example of a service which is working reasonably well for women, although there is obviously scope for further improvement, and this clearly indicates that change is possible at Khayelitsha.

5. CONCLUSION

This study has reported on an area of the Cape Town obstetric service (Retreat MOU) where there is a relatively high level of patient satisfaction with care. The findings suggest that this was a well established service which patients had used for previous deliveries, the procedures were familiar to many of them because of previous use or because their extensive networks of advisors (friends and female relatives) had told them about them. The findings suggest that there was fairly considerable communication between staff and patients (particularly more educated ones) and that this was a very important ingredient in the service and helped to create a good atmosphere in the clinic. Despite this, patients still complained of being scolded both in the antenatal clinic and during delivery and there is still considerable scope of improving the health educational aspects in the MOU. T.C.Newman Hospital was identified as having considerable more problems in the organisation of its antenatal clinic and in staff attitudes towards and treatment of patients, and worrying instances of verbal abuse and humiliation were reported and observed. Recommendations are also made for improving health education at T.C.Newman Hospital.

6. RECOMMENDATIONS

We recommend to the management of Retreat MOU that:

1. They reinforce messages to staff that they should not be scolding patients, positively reward those who do not do this and continue to employ practice of management by observation with immediate correction of staff who are heard to shout at or scold patients, backed up ultimately by disciplinary action for those who refuse to change their practices.
2. Staff be encouraged, if necessary through the provision of further training, to increase the amount of information given to patients during examinations, particularly reassurance of normality, and that staff be made aware of the finding that patients usually want more information than they ask for and may be shy to ask for this. Staff should also encourage women to read more on pregnancy and child birth and provide them with information on how to access information such as the use of the local library.
3. Information sessions should be tailored to the needs of the women. Special primigravida clinics should be held once a month with extra information and education based on their perceived needs. A conducted tour of the labour ward should be offered to all the primigravidas.
4. A video on normal delivery should be made to be used as an educational tool
5. The Friends of Retreat MOU should be encouraged to play a bigger role in the education of the women.
6. Large photos of the MOU staff and their names be placed on a poster in the clinic for patients to identify staff.
7. Staff be encouraged to provide more support when patients complain of minor ailments, even if there is not very much which can be done about them.

8. Women should be given an estimate of the EDD on their first visit.
9. Women be informed that if they struggle to arrange child care on the day of the clinic visit they be allowed to bring the child/ren to the clinic. This however should not be encouraged explicitly.
10. Policies on pain relief such as the availability of known effective drugs should be reviewed and many more women should be offered it.
11. Health promotion should be reviewed in the clinic so that information about what to expect in labour and child birth can be provided for primigravidas. Smoking cessation advice should be reviewed.
12. Women should be encouraged to bring a birthing companion and be told that this person can be a woman.
13. Enemas should not be given as a routine during labour.
14. Contraceptive information and arrangements should be reviewed, particular those for sterilisation, to ensure that women are given a genuine choice, that their previous problems (which often led to pregnancy) are taken into account in the advice given and that sterilisation at an interval after birth can be arranged and women who seem keen to be sterilised are encouraged to take up this option. At the same time women who choose sterilisation should have their choice discussed throughout the pregnancy to be able to discuss and address new fears.
15. Ways of encouraging women to confirm their pregnancies earlier be investigated.

We Recommend to the Provincial Health Department

- 1 The Department provide funds to develop health promotion material

We recommend to the management of the obstetric service at T C Newman Hospital that:

1. Values Clarification workshops be held to redefine midwives' professional roles in ways which respect patients' autonomy, dignity and knowledge and does not include a duty or right to judge or attempt to correct patients.
2. Staff be informed of management's determination to eradicate verbal abuse of patients from the obstetric services and that management take appropriate action to indicate that they are serious.
3. Closer management of antenatal clinics and labour ward be instituted in order to identify bad practice and staff be encouraged to report colleagues who they hear abuse patients. Such staff must be protected from possible victimisation.
4. The organisation of the antenatal clinic be reviewed so that staff can interview patients in private.
5. The provision of health education to the women from the farms who wait considerable periods of time in the antenatal clinic for their transport be investigated, particularly the use of videos.
6. Staff be encouraged, if necessary through the provision of training in communication, to increase the amount of information given to patients during examinations, particularly reassurance of normality, and that staff be made aware of the finding that patients usually want more information than they ask for and may be shy to ask for this. Staff also be encouraged to improve their listening skills.
7. Staff be encouraged to provide more support when patients complain of minor ailments, even if there is not very much which can be done about them.
8. Policies on pain relief should be reviewed and many more women should be offered it.

9. Health promotion should be reviewed in the clinic so that much more information is given, particularly about what to expect in labour and child birth for primigravidas. Smoking cessation advice should be reviewed.
10. Contraceptive information and arrangements should be reviewed, particular those for sterilisation, to ensure that women are given a genuine choice, that their previous problems (which often led to pregnancy) are taken into account in the advice given and that sterilisation at an interval after birth can be arranged and women who seem keen to be sterilised are encouraged to take up this option.
11. Managers should ensure that staff do not give contraceptive injections to women without informed consent.
12. Ways of encouraging women to confirm their pregnancies earlier be investigated.

References

Jewkes R, Abrahams N, Mvo Z (1997) Study of health care seeking practices of pregnant women in Cape Town. Report One: midwives' perceptions of their working environment. MRC Technical Report, Medical Research Council, Tygerberg.

Jewkes R, Abrahams N, Mvo Z (1997) Study of health care seeking practices of pregnant women in Cape Town. Report two: women's use and perceptions of Khayelitsha midwife obstetric unit. MRC Technical Report: Cape Town.

TDR/GEN/95.2 (1995) Health Workers For Change. A manual to improve quality of care. Women's Health Project, Johannesburg and UNDP/World Bank/WHO Special programme for Research and Training in Tropical Diseases(TDR), Geneva.