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Experiences of maternal healthcare delivery in South Africa: Perinatal women's viewpoints

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Abstract

Becoming a mother should be an exciting experience in woman's life. No mother should have to endure adverse encounters. while seeking healthcare in any maternal services facility. this is a phenomenon occurring globally. Delivery of these maternal healthcare services has a bearing on the obstetrical outcomes of mothers from preconception until six weeks after delivery. The study aims to understand the experiences of perinatal women regarding maternal healthcare services in the public hospitals of Gauteng province in South Africa. This study followed an exploratory and descriptive qualitative approach using a purposive sampling method. The study was conducted in three selected public hospitals representing different levels of care namely, district, tertiary provincial, and academic in the Gauteng province. A total of forty-six perinatal women were selected to take part in six focus groups. Data were thematically analysed following the six steps given by Braun and Clarke (2013). Three themes emerged as follows: 1) individual 2) interpersonal reasons and 3) impact of poor complaints procedure on maternal healthcare. The study showed that maternity services rendered to perinatal women in the three selected public hospitals are affected by several factors, such as midwives' attitudes, knowledge and skills, professional ethics, communication, and delayed maternal healthcare. These findings demonstrate an urgent need for practice and policy interventions that go beyond just a routine service but quality and organised maternal healthcare services provided in public hospitals, for improved healthcare outcomes at the point of service. *(Afr J Reprod Health 2024; 28 [8]: 32-44).*

Keywords: experiences, maternal health, perinatal women, service delivery, viewpoints

Résumé

Devenir mère devrait être une expérience passionnante dans la vie d'une femme. Aucune mère ne devrait avoir à subir des rencontres défavorables. tout en recherchant des soins de santé dans un établissement de services maternels. c'est un phénomène qui se produit à l'échelle mondiale. La prestation de ces services de santé maternelle a une incidence sur les résultats obstétricaux des mères depuis la préconception jusqu'à six semaines après l'accouchement. L'étude vise à comprendre les expériences des femmes périnatales concernant les services de santé maternelle dans les hôpitaux publics de la province de Gauteng en Afrique du Sud. Cette étude a suivi une approche qualitative exploratoire et descriptive utilisant une méthode d'échantillonnage raisonné. L'étude a été menée dans trois hôpitaux publics sélectionnés représentant différents niveaux de soins, à savoir le district, le niveau tertiaire provincial et le niveau universitaire de la province de Gauteng. Au total, quarante-six femmes périnatales ont été sélectionnées pour participer à six groupes de discussion. Les données ont été analysées thématiquement selon les six étapes données par Braun et Clarke (2013). Trois thèmes ont émergé : 1) les raisons individuelles, 2) les raisons interpersonnelles et 3) l'impact d'une mauvaise procédure de plainte sur la santé maternelle. L'étude a montré que les services de maternité rendus aux femmes périnatales dans les trois hôpitaux publics sélectionnés sont affectés par plusieurs facteurs, tels que les attitudes, les connaissances et les compétences des sages-femmes, l'éthique professionnelle, la communication et les retards dans les soins maternels. Ces résultats démontrent un besoin urgent d'interventions pratiques et politiques qui vont au-delà d'un simple service de routine, mais aussi de services de santé maternelle organisés et de qualité fournis dans les hôpitaux publics, pour améliorer les résultats des soins de santé au point de service.. *(Afr J Reprod Health 2024; 28 [9]: 32-44).*

Mots-clés: expériences, santé maternelle, femmes périnatales, prestation de services, points de vue

Introduction

The World Health Organization[1] (WHO) maintains that while every pregnancy and birth is different, global maternal mortality remains high across 189 disparate countries. Mothers often face death during pregnancy and childbirth from preventable causes and there is substantial evidence that equates inequalities in access to maternity care facilities with this high mortality rate[2]. Despite great strides being made in the arena of midwifery to improve maternal outcomes, maternal complications and even deaths are still increasing. Thus, reducing maternal deaths has become a challenge in various communities for many years, with numerous developing countries struggling with plans to improve their maternal healthcare shown by the unfulfilled Millennium Development Goals of 2015 (MDGs)[3].

Much has been written by scholars about the provision of healthcare services, including maternal and child healthcare, and the inequalities between privileged and underprivileged communities[4-6]. The health sector, therefore, has a responsibility to bridge any gaps that inhibit access to healthcare, including those social determinants such as unemployment, any of which can negatively contribute to the outcomes of maternal healthcare[7]. The data indicates that around 295,000 women worldwide lost their lives during pregnancy or childbirth in 2017, amounting to roughly 810 women per day succumbing to what are considered preventable causes[2]. This is an unacceptably high number of deaths that could have been prevented. Furthermore, about 90 % of these deaths occur in low-resource settings[2]. The African continent has a high maternal death rate attributed to obstetric complications[8]. Moreover, in sub-Saharan Africa (SSA), five countries have registered more than ten percent of maternal deaths as indirect consequences of AIDS, with South Africa reaching 32%. Sixty-six percent of such cases were recorded in SSA. This suggests that the SSA should increase the number of skilled midwives in many of its countries[9]. A Tanzanian study revealed that improving the working conditions of midwives by increasing the number of skilled personnel and resources could contribute to a reduction in maternal deaths[10]. Out of ninety-nine percent of global maternal mortality, fifty percent of those women who die whilst giving birth are from developing countries[2], in comparison to their counterparts in developed countries. An above-average percentage of these deaths are reported as coming from fragile and humanitarian settings such as the sub-Saharan region. The WHO advocated that more effective management and treatment be employed to improve maternal healthcare[1]. The well-being of mothers during pregnancy and childbirth is a crucial indicator and measurement of maternal healthcare.

South African maternal mortality rates have been as high as in other SSA countries[11], with the data reporting in 2020 that these levels remain high due to social and service delivery factors[12]. Furthermore, South Africa reported maternal deaths of 138 per 100.000 live births attributable to pregnancy-related causes that can be diagnosed, controlled, and treated[12]. This paper, therefore, seeks to explore maternal healthcare to gain a deeper insight into the experiences of perinatal women accessing maternity care in one selected province in South Africa.

Pregnant women in South Africa should receive at least four antenatal care visits and be attended by trained midwives throughout their perinatal period. However, there are challenges in the provision of maternal healthcare services in South Africa. South Africa reported maternal deaths of 1234 and 1507 in 2020 and 2021[13]. Scholarly work has shown a global increase in MMR of above 30% during the pandemic. The rate is due to the impact of direct and indirect COVID-19 Gauteng was the third province with the highest iMMR of 131.52 as per report[13.] Furthermore, it has been revealed that no South African province reached the SGD target of 70 per 100 00 live births[13]. Institutional Maternal Mortality Rate (iMMR) was also high at the hospital level as a result of the effectiveness of the referral policy[13,14]. Hence this study endeavors to explore and unearth the factors leading to many maternal deaths in South Africa and to improve the functioning and the conditions of maternal care in the health facilities.

Research purpose

To understand the experiences of the perinatal women regarding maternal healthcare services in the three selected public hospitals of Gauteng province in South Africa. Hence, the research question designed for this paper was: "What are

your experiences regarding the provision of maternal healthcare in this hospital?

Methods

Research design

This study adopted an exploratory design which used qualitative methods to collect the data. Descriptive narratives were obtained from perinatal women sampled from the three selected public hospitals. In addition, a qualitative approach was considered as best fitting to answer the research question under examination.

Research setting

The study was conducted in three public hospitals in Gauteng province: a regional, a provincial-tertiary, and an academic hospital. All three hospitals are situated within the Ekurhuleni and Tshwane districts. Hence, the district, provincial-tertiary, and academic hospitals are considered the highest level of support and will receive women from facility-based clinical services (PHCs) as the first point of contact[14]. Thus, perinatal women were admitted to the antenatal, and postnatal wards in these facilities as referrals from clinics.

Population and sampling

The population is defined as all the individuals or objects with common defining characteristics[15]. The study population consisted of women referred to the designated hospitals for maternal healthcare services from the referring facilities. The participants who were purposefully selected were regarded as knowledgeable informants. Because the researchers sought information-rich participants from the antenatal and postnatal units for the six focus group discussions[16].

The study employed a maximum variation sampling technique to sample the different levels of hospitals in two selected districts. The researchers wanted to understand how women in different perinatal stages in varying facilities and from different maternity units experienced maternal healthcare services during their hospital stay. The inclusion criteria covered women who had been admitted to maternity units, both antenatal and postnatal wards, and exclusion-protected perinatal women who came for their antenatal and postnatal clinic visits.

Data collection

Data were collected in a naturalistic environment in the hospitals and was conducted in January and February 2020, thus, the process ran over six weeks. The Institutional Research Ethics Committee in the College of Human Sciences granted permission which was confirmed by the issuance of an ethical clearance certificate followed by an online application to the National Health Research Database (NHRD) and Gauteng Department of Health (GDoH) then the researcher wrote permission letters to the three public hospitals to request permission to collect data. The perinatal women were recruited in the maternity units during their admission. The researcher planned appointments including specific times with the unit managers to avoid interruptions of care. The aim of the study was introduced to the participants to provide them with an overview of the study and build rapport before actual data collection. Firstly, the ground rules were explained, and consent was sought. Informed consent forms were signed by all participants to prove that no one had been coerced into participating and that they agreed to the focus group discussions being audio recorded. All focus group discussions lasted for 90 minutes on average. The focus group guidelines were used to guide the process, as such a research assistant worked with the researchers to capture fieldnotes for the data analysis process. The researcher pre-tested the interview guide at a regional hospital with one focus group discussion with six participants to ensure the feasibility of this qualitative instrument in a real-life setting and the hospital was not included in the main data collection sites. The pretesting assisted the researchers in identifying ambiguous statements and such statements were rephrased. Data collection was conducted until saturation was reached when no new data was emerging from the participants[15].

Data analysis

Data were analysed using the Braun and Clarke Framework[17]. Once data saturation was reached, data analysis started. The six steps of data analysis were followed 1. Familiarising self with data, 2.

Generating initial codes 3. Searching for themes, 4. Reviewing of themes, 5. Defining and naming themes and lastly 6. Producing the report. Data recordings were transcribed verbatim from audio to text. Reading the transcripts and tagging to show the patterns of repeated ideas was then done. An independent coder was appointed to analyze the data independently without being coerced and influenced, who then concurred with all themes, categories, and sub-categories that emerged after minor modifications.

Measures to ensure trustworthiness

Trustworthiness in this study was anchored on the framework of Guba and Lincoln[15]. The following criteria for trustworthiness were adhered to: credibility, transferability, confirmability, dependability, and authenticity. Study credibility was ensured as the researchers extended their time through prolonged engagement with perinatal women during the focus group discussions. Lived truths of the perinatal women and evidence of the audio recordings are available. The reports of the participants extracted from transcripts and the field notes have been kept. Confirmability was grounded in member-checking; by revisiting some of the participants to verify if the statements had been accurately reproduced. Furthermore, dependability was supported through a kept audit trail of the documents of the research so that other scholars interested in equivalent studies on maternal healthcare services can access them. The study used multiple settings; thus, transferability was proven.

Results

Three themes namely: individual, interpersonal reasons and the impact of poor complaints procedures on maternal healthcare became clear from data collection of the focus groups' discussions.

Demographics of the participants

A total of forty-six perinatal women were selected, in groups of seven and eight, to participate in six focus group discussions. Table 1. Three hospitals which represented three different levels of care in two districts were included in this study. Participants were admitted to either the antenatal or postnatal units. Participants' ages ranged between 18 to 48 years. Most of the women were above the age of 30 years, and few of the women were married. Most of the women had secondary education. Most of the women had secondary education, were unemployed and of South African origin.

Table 2 represents the themes as were developed from the data collection of the focus group discussions aided by the guidelines used and analysis which followed the framework of Braun & Clarke[17]. The three distinct themes that emerged from the data collection were captured as individual, and interpersonal reasons and the impact of poor complaints procedures on maternal healthcare. Table 2 above, illustrates themes, categories, and sub-categories concerning maternal healthcare in Gauteng province.

Furthermore, the extracts from the transcripts will be labelled as H – Hospital, P – Participant, AU – Antenatal Unit, and PU – Postnatal Unit all of which are symbolized below:

Theme 1: Individual reasons

The theme is linked to significant individual reasons such as midwife's attitudes, the midwife, and patient profiles during the provision and receipt of healthcare in the maternity wards.

This theme also reflected the opinion of those perinatal women who perceived midwives as having cruel attitudinal behaviours; resulting in them being considered as lacking in passion commitment and time management. These challenges were described as critical and prevented the best possible midwifery care from being made available.

Category 1.1: Midwife attitudes

Midwives' attitude towards their patients in the units was reported as unwelcoming. All participants in the focus group discussions reported elements of arrogance and power displayed by the midwives, words came out vigorously, and this led to the belief that midwives were cold-hearted.

Lack of respect

The midwives working in the labor rooms were perceived as being harsher than those in primary

Table 1: Demographic profiles of the participants

Hospital number	Level of care	District	Maternity unit	Focus group	Number of participants
Hospital 1	Regional	Tshwane	Antenatal	1	8
			Postnatal	1	8
Hospital 2	Provincial Tertiary	Ekurhuleni	Antenatal	1	7
			Postnatal	1	8
Hospital 3	Academic	Tshwane	Antenatal	1	8
			Postnatal	1	7
3	3	2	6	6	46

Table 2: Themes, categories, and sub-categories concerning maternal healthcare in Gauteng

Theme	Category	Sub-category
Individual reasons	Midwife attitudes	Lack of respect
		Lack of passion
	Midwife profile	Knowledge and skills of attending midwives.
		Ethical inclusive curriculum
	Women profile	Interactive technology and parenthood
Interpersonal reasons	Communication	Language barriers
		Ethnicity
		Tribalism
3. Impact of poor complaints procedures on maternal healthcare	Delayed maternal healthcare	Lonely birthing
		Compromised maternal healthcare.
		Professional ethics

health facilities. Their responsiveness to the needs of the women was seen as improper and discourteous. The following extracts came from the focus group discussions and are abbreviated as follows:

"I have noticed a lot of lack of respect. Nurses do not have respect for others and their clients. For the mere fact that a midwife would tell a woman who is in labor to shut up and stop making babies, it is a sign of disrespect." (H3; P4; AU).

"The participant quoted what the midwife had said to the fellow woman 'Your sister was here during visiting time, why didn't you ask her to get you water? Poor woman stood up and got herself water to drink." (H3; P2; PU).

Such actions mirrored midwives as not cognisant of women as individuals, their needs, and expectations, and who inevitably experience labor differently. According to most participants, the impolite behaviors also created an unfriendly environment and unwelcoming relations between the midwife and the woman.

"The attitude in this hospital (raising eyebrows) tends to affect the quality of healthcare that we receive in the hospitals. (Perspective from the patient) I do not think I will fall pregnant again while I am in SA. I have two children and I do not think I want to expose myself to this treatment again. I will make sure I use my family planning throughout. I got my first baby in Zimbabwe and never came across this type of treatment." (H2; P4; PU).

Most of the participants echoed many concerns about disrespectful care from the midwives when they interacted with the women in the maternity units. Furthermore, the gender difference of midwives was also cited as playing a major role when seeking healthcare service delivery. They stipulated that male nurses (accoucheurs) are more caring than female nurses:

"We know that by 10:00 pm, they switch off the lights and go to their designated space. I'm so proud of the two male nurses who were on duty last night, they were up the whole night they never slept. Hence, Hence I am saying that male nurses are

better than females. They are more patient-centred than females." (H3; P2; AU).

Lack of passion

This study shown that many of its participants felt that the midwives lacked concern and showed lack of professional commitment to their duties. The following accounts are verbatim quotes from the responses of the participants:

"Last night, there was a lady who was in labor pains. She called for help and one midwife said to her," 'This is not the labor room, quick…walk fast.' Not long ago one woman lost her baby, she had reported her pains, but the midwife did not listen until it was too late." (H3; P7; PU).

Many reiterated that they have lost confidence and trust in midwives and that they experienced feelings of vulnerability while seeking healthcare. Most of the participants showed that they sometimes do not feel safe when seeking care in healthcare facilities:

"I do not even trust them anymore because of the misunderstanding we had. I think they might give me the wrong medicines because of the hatred they have for us." (H1; P2; PU).
Participants stressed that they also felt neglected as some of the midwives were ignorant. They delegated junior staff such as nursing students to respond to the queries raised by the women.

"Some of the sisters will just look at you when you call for help. They will not respond to whatever you have requested her to do for you, they postpone your request or send the student to do it and I think the poor student did not know how to do the task. Such delays compromise the health of our babies. They are not passionate enough even though they are not all the same." (H1; P6; PU).

The study participants concluded that ignorance, unwillingness, and lethargic responsiveness shown by the midwives were also associated with a lack of commitment.

Category 1.2: Midwife profile

All participants agreed that there is immense capacity in the knowledge and skills of midwives. A primary concern that was echoed extensively was the need for them to self-correct their attitudes to improve the delivery of maternal healthcare.

Knowledge and skills of attending midwives.

Perinatal women reported contradictory views about the competence of midwives. Some participants indicated that midwives have the necessary knowledge and clinical skills whilst others projected otherwise. The participants emphasized that midwives are knowledgeable in their own accord and scope of practice. One participant said:

"Surely those who helped me were experts, they knew what they were doing. The midwives' care was amazing because they came back after delivery to follow- up. My birth was not so easy, if they did not have skills anything could have happened to me and my baby. I could have lost my baby." (H2; P8; PU).

However, one participant highlighted those younger midwives displayed a lack of skill and knowledge:
'I also think that the age of the midwives and maturity counts. For example, you find a lot of old midwives in the antenatal clinic. They can give you answers in detail when you ask questions. I just want to put it on record that they are loud, yes, but you leave the clinic satisfied. They are so gentle and enthusiastic even though they are loud. Come to the wards, you get young nurses who do not know their work. I think if they can be rotated, the young one will learn from the older one.' (H2; P3; AU)

Ethical inclusive curriculum

It was established from the participants' feedback that professional ethical aspects were an area of concern in their training that required strengthening. Several of the participating perinatal women gave examples of the midwives' behavior and the actions they saw as being concerning.

"One lady in the labor ward asked a midwife for water to drink. The response from the midwife was, 'Your sister was here during visiting time, why didn't you ask her to get you water? Poor woman stood up and got herself water to drink. Are they not taught Ubuntu and what caring should be like when they train? Please include those things in their training and teach them Ubuntu." (H3; P2; PU).

However, few participants echoed that attitude did not only come from the midwives; there were also perinatal women coming to the maternity units with bad attitudes. One of the participants has this to say: "It is not easy for nurses because you can still get difficult patients, rude patients. Managing difficult patients is frustrating." (H1; P4; PU).

Category 1.3: Women profile

The profile of the woman refers to the types of patients who would typically seek out healthcare services in public hospitals. Additionally, it includes women who are techno-savvy and able to use technology to search for answers to their obstetric issues.

Interactive technology and parenthood

Women reported that they found solace in social media as nurses were reluctant to explain to them planned midwifery care. Lack of explanation to the mothers, limited or no time for individualized health education, and being ignored by the midwives, left mothers with no choice but to use their mobile phones for answers.

"I have been pregnant three times and midwives perceive us as knowledgeable because this is my third baby. When you ask a question… you are taken lightly and ignored. We end up going on Google for answers. Google gives us all the facts and answers that were supposed to be given by the midwife. It replaces the midwives because they do not want to educate us." (H3; P1; AU).

Midwives' role of providing health information to empower new mothers is gradually fading away. One of the participants elaborated on this:

"When you ask a question… you are likely to be taken exceptionally light and ignored." (H3; P1; PU).
Those who are techno-savvy were able to use technology when midwives did not respond to their questions and health education was seen as lacking within the maternity units.

Maternal literacy

Participants associated the way they were treated with their level of education. The disparity between the participants and the midwives was perceived as the main reason women were treated like minors. This is what one participant had to say:
"As a pregnant woman, what we do most of the time …is to beg for healthcare. We are classified as uneducated and poor by the nurses, and we must obey." (H3; P6; AU).

Theme 2: Interpersonal reasons

The above theme focuses on communication between midwives and perinatal women seeking services in public facilities, and how effective communication can enhance understanding. The rapport a person has with his or her clients can have significant impact on the attainment of any overall goals.

Category 2.1: Communication

The interaction between the midwives and their perinatal patients plays a significant role in figuring out the success or failure of maternal healthcare offered by the public hospitals.

Language barriers

Language barriers were found to impede the effectiveness of communication in the units. Some participants reported that foreign women were frustrated and were labelled as rude by midwives because they could not understand the language spoken and had difficulties following instructions due to language barriers. One of the participants said:

"I am from Zimbabwe and have seen the frustrations brought by language, especially with the foreign women because they could not follow the instructions of the midwives." (H3; P8; AU).
Language barriers affect both midwives as well as foreign mothers. Participants also reported that immigrant mothers appeared more vulnerable. They had this to say:

"Communication does not exist at all and if it does…it is not good." (H3; P5; PU).
Most of the concerned participants commented about how constructive communication has become limited between themselves and the midwives.

Ethnicity

Some participants revealed that there is an element of discrimination based on ethnicity and citizenship

or nationality in the maternity units. Below is what some of the participants had to say:
" It is important that other women are respected despite their country of birth or the language they speak. The nationality and ethnic inequalities and tendencies are not just directed to foreign nationals, but even to us, South Africans. If someone is speaking Venda, then the midwife will refuse to speak Venda. They will say here we are speaking the local language." (H2; P2; AU).

"Ethnicity plays a significant role in how we receive maternal healthcare. The wrong thing we did as mothers was to fall pregnant." (H1; P2; PU).

Some participants revealed that this was not just a regional issue but also a global one, and that Africans should learn to embrace each other.

Tribalism

Most participants reported that in the three hospitals, they experienced impolite treatment due to perpetual occurrences of tribalism. The local South African women also experience discrimination, mainly because they speak a different language from the locals spoken in the hospital. These are some of the extracts from the participants:

"Sometimes nurses think that we all understand other Nguni languages. So, it is not only foreigners who are being treated badly, even we, South Africans are exposed to such discrimination. I am a Zulu-speaking person, I cannot hear Sepedi. I am perceived as being difficult, you cannot just assume that a person in (Egoli) Gauteng province can speak Sepedi and I can't, yet I am from South Africa. They are not just attacking foreign people, even us." (H3; P7; PU).

Participants reported that in the three hospitals, they experienced the occurrence of tribalism. These are some of the extracts from the participants:
"Nurses should understand that when a local language is spoken, some of us cannot hear a thing."(H2; P1; AU).

Eventually, the women find it difficult to carry out the instructions as given due to communication barriers brought about by issues of language and ethnic and tribal clashes.

Theme 3: Impact of poor complaints procedure on maternal healthcare

The participants from the focus group discussions were concerned about the ineffective efforts of complaint procedures within the hospitals. Additionally, they said that a lack of proper complaints management tends to impact and undermine the quality of maternal healthcare services.

Category 3.1: Delayed maternal healthcare

This category relates to the quality and timeliness of providing maternal healthcare while the women are admitted to the health facility. Thus, perceived as a serious barrier.

Lonely birthing

The focus group participants gave voice to their fears and concerns about the possibility of having to give birth alone as the midwives tended to disappear to other areas of the maternity units. Additionally, participants reported that they were left unattended mostly at night, without an explanation of their obstetric matters. This is what was reported:

"One lady delivered a baby in the toilets in our full view, and it is not a pleasant experience. Midwives were not willing to help and take care of us, especially at night. Unfortunately, you cannot even report them because they do not put their name tags on." (H3; P3; PU).

It was stated quite categorically that some pregnant women were delivering alone without any midwife or any other healthcare worker in attendance despite having been admitted to a maternity unit. The rationale might be twofold: a shortage of midwives or an increasing number of women delivering in public facilities.

Compromised maternal healthcare.

The participants alluded to the fact that care given to perinatal women is compromised and could contribute to an increase in maternal mortality. Some of the participants reported active and intentionality of delayed and denied care from the midwives. This was what the participants had to say:

"We were so terrified when we witnessed the lady who just gave birth before us. When we scream for help, they think we are screaming for no apparent reason. Until one of the midwives realized that it was indeed true, she was giving birth, that is when she called her colleagues, and they came running." (H3; P2; PU).

Participants suggested that compromised care occurs because of the shortage of midwives and giving care to all the women then becomes difficult.

Professional ethics

Professional ethics refers to the principles, values, and standards of behaviour that govern the conduct of individuals in a particular profession. These ethics provide professional guidance in making decisions, interacting with clients, and carrying out duties in a manner that upholds accountability, honesty, and integrity. Some narratives from the participants have been captured from the focus group discussions, where participants reported the following:

"I was told to stand up and I had vaginal bleeding which messed up the floor. There was nothing that I could do because it was just coming out. I was instructed to clean the floors myself in that state of health, that I was in." (H3; P7; PU).

Participants commented that there is a difference between the nurses working in government and those in private health. The following narratives were captured on that subject:

"Government and private nurses are different; they are not the same. In government, nurses know that they are here forever, and no one will dismiss them despite the behaviors they portray. These behaviours are not happening in the private sector." (H3; P6 ;AU).

Competency in midwifery skills has been directly aligned with the quality of service; however, existing challenges undoubtedly compromised the level of maternal healthcare rendered.

Discussion

This study has discussed the experiences of participants concerning the provision of healthcare services in public facilities. This was summarised under three thematic categories: individual, interpersonal reasons, and the impact of poor complaints procedures on maternal healthcare. The perinatal women indicated that they had concerns when accessing maternal healthcare services in the three public hospitals in Gauteng province.

These findings are consistent with the work of other well-known scholars. This research revealed that midwives had a solid grasp of midwifery care and acknowledged their skills, knowledge and confidence in maternal care[18]. However, some scholars noted that some attitudinal and unpleasant behaviors hinder quality maternal healthcare delivery[19].

The study noted that disrespectful care and abusive language were common in public hospitals when compared to private hospitals despite the recommendations of respectful maternity care and effective communication[2]. These findings are parallel to those of the scholars[20], who reported that disrespect and abuse are perceived as the main reasons that women under-utilize childbirth facilities.

The study participants concluded that accoucheurs cared more for women in the maternity units than midwives as it is stated that accoucheurs listen, respect, and sympathize with women during the labor process[21]. This is further supported by the Kenyan study where female health workers were more disrespectful and abusive than the male health workers in the labor units[23]. Despite that accoucheurs working in midwifery, experienced prejudice, rejection and resistance from perinatal women[23]. Contrary to the study findings, more than 97% of Turkish women preferred female midwives over male midwives as they tended to feel uneasy and shy when being assisted by male counterparts[24].

The results of this study were similar to another study where perinatal women felt neglected whilst they were under hospital care and reported that midwives are not passionate in their work; not only do these perinatal women experience a lack of trust, but they also feel vulnerable in the hands of the midwives[25]. The current findings were consistent with that of the study conducted in Zambia, in which the importance of being with a woman for maternal health services was emphasized[26]. These behavioral traits show a lack of passion and commitment to midwives' professional obligations, which is further supported by the Jordanian study[27]. The perinatal women

labeled the midwives as being cold-hearted and said that they mistreated their patients[28]. Unequal midwife-patient ratios undermine spending quality time with women and lead to compromised maternal healthcare. High nurse-patient ratios are one of the reasons for inadequate quality care[29] met the same results in their study. Sufficient resources are associated with low rates of maternal and neonatal mortality and eventually improved quality care[29]. A further Iranian study by the following scholars[30] revealed equivalent results in that for some time, midwifery education has shown efforts to improve the curriculum in their training. However, a study conducted in Jamaica stated that it is essential for the midwifery curriculum to be inclusive of professional values, to be patient-centered, and for respectful care to be given to strengthen the quality of the maternal healthcare of vulnerable women[31].

The participants indicated that they resorted to available technologies for the answers that could have been answered by the midwives in the facilities. In contrast, a study of Australian midwives felt that mobile phone usage in labor delayed care and affected relationships as it created tension with recording images[32]. Moreover, the current study noted that the same technology can be used to record those negative incidences that occur in maternal healthcare facilities. Nevertheless, women experience a shift in focus as they take time on their mobile gadgets and neglect the safety of their newborns[33].

The study findings described communication between the midwives and the women across the facilities as poor, especially with women from other African countries. The study revealed that communication was impaired due to foreign languages, ethnicity, and tribalistic barriers. However, related results also appeared in a Canadian study in that inadequate language skills were the major factor that reduced access opportunities to maternal healthcare[34].

In another South African study, conducted in the same province as the current study, it was proven that mothers from diverse cultural backgrounds and speaking a foreign language endured poor and unhospitable attitudes, bad communication, and disrespectful care from the midwives[36]. Tribalism in South Africa has been a contentious issue since pre-apartheid, resulting in divisions amongst South Africans due to hatred[5]; the author discussed tribalism in the theological context, which is also pertinent in the healthcare system. The findings show that women delivered their babies alone in the units, while the midwives were occupied elsewhere in the hospital because of varying circumstances such as staff shortages [22]. This then became a traumatic psychological experience for other women; one who had a full view of one giving birth. It has been noted that the audience was fearful of what would happen during their delivery, especially those who had previous intrapartum complications. In this study, women endured treatment exemplified by a lack of professional ethics and integrity, undignified, disrespectful, and uncompassionate care, and abuse from the midwives[29], where they had to clean up the floors should they mistakenly bleed on the floors[37].

This study reported compromised care in the maternity units. Furthermore, it has been reported that midwives are unable to offer quality midwifery care to patients as they were discouraged by the lack of support from the hospital management[10]. Another study also captured the same findings on quality care being compromised by a range of factors such as poor working conditions and inadequate resources, including drugs and equipment[38].

Strengths and limitations of the study

This study has highlighted the experiences of perinatal women regarding the provision of maternal healthcare services and the need to redress the gaps identified, through further research on the phenomenon. Focus group discussions were conducted in the maternity health facilities in Gauteng province where perinatal women were admitted for maternal healthcare. Otherwise, more perinatal women would have been recruited and took part in the data collection. Many perinatal women showed willingness to take part; however, interruptions were experienced in the postnatal units, due to responsibilities related to neonatal care. This study was conducted in the Gauteng province only; thus, the findings may not be generalized to perinatal women in other provinces.

Implications and recommendations

Professional ethics is the key component for improving maternal healthcare in public hospitals.

Despite midwives having been applauded for their knowledge and skills, the emergence of professional and ethical decay has led to women seeking out alternate means of empowering themselves, usually using technology. It is critical to discover more ways in which the issues raised in this study can be improved.

Policy implications should be geared toward prioritizing investments in the training and education of midwives to enhance their communication skills and sensitivity towards perinatal women. Additionally, the formulation of policies to ensure the provision of two-way respectful care from midwives and demand the same respect from the women.

Practice implications, to create a supportive and welcoming environment for women before childbirth through support groups and counseling sessions. This also refers to training on communication skills, regular sessions focusing on effective communication techniques, and culture sensitivity midwifery care. Practices to involve communities to raise awareness about maternal healthcare through dialogues between staff and clients to address the concerns.

By implementing these implications and recommendations, policymakers and midwifery staff can work towards improving maternal healthcare delivery in South Africa and address the concerns raised by the perinatal women in the study.

The study recommends the following

South African regulatory body strengthens the educational and training programmes on intentional and respectful midwifery care to ensure that ethics are prominent at all levels of training. Furthermore, midwifery practitioners should be encouraged to apply ethical practices to their daily routines. Lastly, all stakeholders must work together with the Department of Health to ensure the support of midwives through programmes designed to bridge professional and ethical gaps through seminars, coaching, and training sessions to improve maternal healthcare quality and to improve the attitudes and behaviours of the midwives in public hospitals.

Ethical considerations

The study obtained clearance from the Institutional Research Ethics and Hospital Research Committees. The meetings with participants were secured through the involvement of the unit managers within the hospitals. Basic information about the study was shared with all the women so they understood that their participation was purely voluntary, and further, that they had the right to withdraw their participation at any time without prejudice. The researchers protected the privacy of the perinatal women and the public hospitals in the Gauteng province involved through de-naming. In the cases where an adverse psychological trauma occurs, the researcher would stop the process of the interview and refer the affected participant to the psychologist and/or social worker within the hospital for psychological therapy.

Conclusion

Many women have no alternative but to seek out pregnancy and childbirth healthcare in the maternity units of public hospitals in South Africa due to their socio-economic status. Substantial work is needed in maternal care areas to improve the relational gaps through communication and reduce the disrespectful care that was mentioned by the participants. This work could include various initiatives, improvements, or interventions aimed at enhancing the quality of care provided to the mothers. Furthermore, the relational gaps among healthcare providers and mothers need to be addressed. The relational gap can be improved by fostering stronger communication strategies such as more empathy, and respectful relationships between midwives and mothers; also reimagining training of midwives in implementing policies and creating a culture that promotes respectful treatment of mothers during childbirth and postpartum care. The same goes for the mothers, they should also be guided on good and respectful communication lines. The study aimed to explore and describe the experiences of perinatal women regarding maternal healthcare services in the public hospitals of Gauteng province in South Africa, which has been achieved by answering the research questions. Individual and interpersonal reasons as well as the impact of poor complaints procedures on maternal healthcare have a negative impact on the rendering of maternal healthcare. The challenges that were experienced by the perinatal women while seeking maternal healthcare in public hospitals call for radical responsive action towards the

improvement of professionalism and ethical expectations by the relevant stakeholders.

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Competing interests

The authors (NLN and ONM-N) of this manuscript declare the non-existence of any competing interests other than professional growth.

Authors' contributions

Authors have underwritten the study conception, i.e., proposal development, data collection, and its management and analysis /interpretation of data up to the article draft, and both provided oversight of the paper and critical reading as well as a review of the article up to the final approval of this manuscript.

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