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‘I thought they were going to handle me like a queen but they didn’t’: A qualitative study exploring the quality of care provided to women at the time of birth

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ABSTRACT

Objective: To explore experiences of care during labour and birth from the perspectives of both the healthcare provider and women receiving care, to inform recommendations for how the quality of care can be improved and monitored, and, to identify the main aspects of care that are important to women.

Design: A descriptive phenomenological approach. 53 interviews and 10KII as per [table 1](#) took place including in-depth interviews (IDI), focus group discussions (FGD) and key informant interviews (KII) conducted with women, healthcare providers, managers and policy makers. Following verbatim transcription thematic framework analysis was used to describe the lived experience of those interviewed.

Setting: 11 public healthcare facilities providing maternity care in urban Tshwane District, Gauteng Province ($n = 4$) and rural Waterberg District, Limpopo Province ($n = 7$), South Africa.

Participants: Women who had given birth in the preceding 12 weeks (49 women, 7 FGD and 23 IDI); healthcare providers working in the labour wards (33 healthcare providers; nurses, midwives, medical staff, 5 FGD, 18 IDI; managers and policy makers (10 KII).

Findings: Both women and healthcare providers largely feel alone and unsupported. There is mutual distrust between women and healthcare providers exacerbated by word of mouth and the media. A lack of belief in women’s ability to make appropriate choices negates principles of choice and consent. Procedure- rather than patient-centred care is prioritised by healthcare providers. Although healthcare providers know the principles of good quality care, this was not reflected in the care women described as having received. Beliefs and attitudes as well as structural and organisational problems make it difficult to provide good quality care. Caring behaviour and environment as well as companionship are the most important needs highlighted by women. Professional hierarchy is rarely seen as supportive by healthcare providers but when present, good leadership changes the culture and experience of women and care providers. The use of mobile phones to provide feedback regarding care was positively viewed by women.

Conclusion: Clarity regarding what a healthcare facility can (or cannot provide) is important in order to separate practice issues from structural and organisational constraints. Improvements in quality that focus on caring as well as competence should be prioritised. Increased dialogue between healthcare providers and users should be encouraged and prioritised.

Implications for practice: A renewed focus is needed to ensure companionship during labour and birth is facilitated. Training in respectful maternity care needs to prioritise caring behaviour and supportive leadership.

Introduction

A focus on ‘technically competent care’, while essential, will not in itself have enough impact in improving the quality of care and health

outcomes ([de Souza et al., 2014](#); [van den Broek and Graham, 2009](#)). Globally, there is a move towards a more person-centred approach. An approach that ignores the relationships and culture central to care provision is fundamentally flawed. However, this is in real-life terms a

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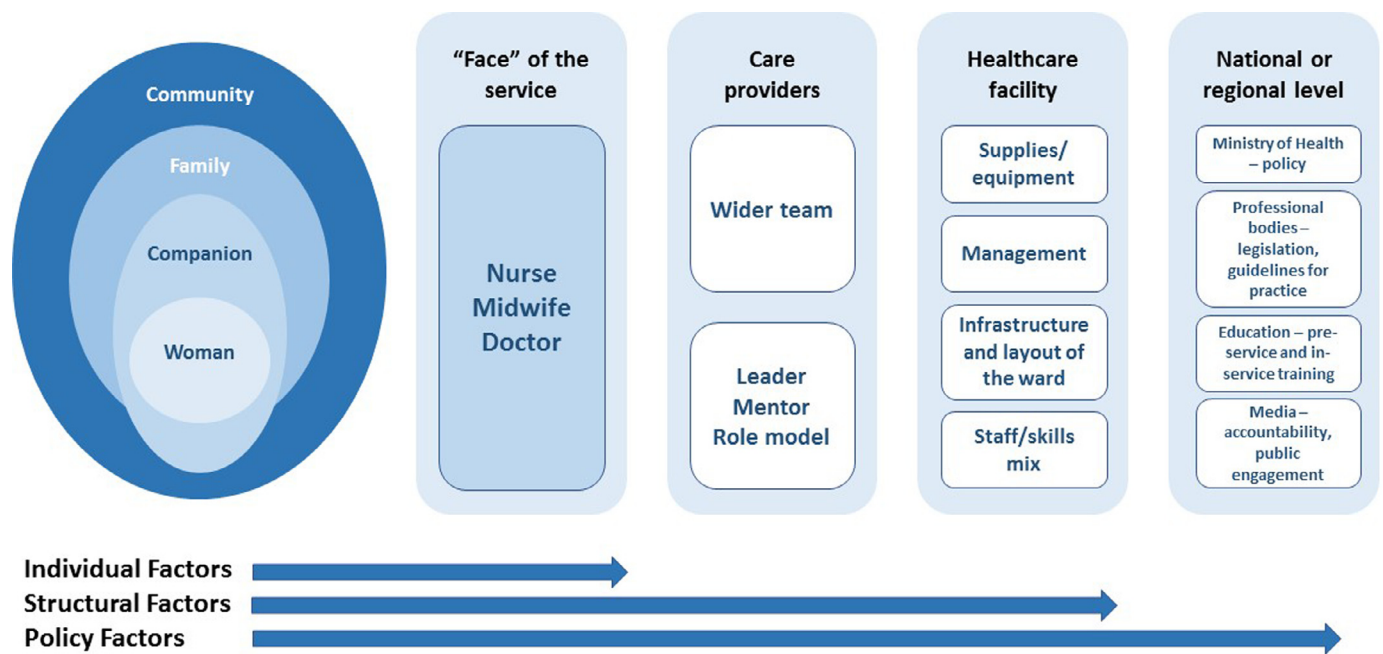


Fig. 1. Factors impacting on experience of care for the individual, structural and policy level.

complex relationship that can be difficult to map out, monitor and, can be challenging to influence (Freedman and Kruk, 2014; Chadwick et al., 2014; Bohren et al., 2015).

It is understood that it is too simplistic to attribute poor quality of care, including mistreatment and lack of respectful care, solely to the healthcare provider (Bowser and Hill, 2010; Bohren et al., 2015). The social, economic and health system barriers healthcare providers experience in their daily working lives can be significant (WHO, 2016; Freedman and Kruk, 2014; O’Donnell et al., 2014). It could be hypothesised that what has most frequently been measured or described, is the absence of quality, rather than quality itself, or, the type of care women would like to receive. Exploring the barriers and opportunities to providing care that is perceived as being of good quality from the perspective of both those providing and those receiving care is essential for meaningful recommendations for monitoring, and, improving the quality of care to be developed (Raven et al., 2012).

The importance of a person-centred approach is highlighted by recent models that provide process measures for monitoring the different aspects of care quality (Freedman and Kruk 2014; Raven et al., 2012). Although Freedman and Kruk’s (2014) model primarily addresses disrespect and abuse, their approach also highlights the interrelationships between the personal experiences of care and the health system. This supports a contextual approach to quality of care with the focus starting with the woman’s perception and experience of quality of care. This is seen as a central rather than a peripheral component of the quality of care. The model of quality of care then extends outwards from the personal to the wider health systems perspective rather than a model that moves from the health system to the personal level (Fig. 1).

In South Africa, with 94.3% of births attended by a skilled birth attendant, predominantly at healthcare facility level, improving the quality of care is seen as a priority (Pattinson, 2014). In addition to improved access to care, it is important that the quality of the care provided is such that care received leads to improved outcomes and also experience of care (de Souza et al., 2014; van den Broek and Graham, 2009). How South Africa addresses this may influence progress in other countries in the process of moving from stage one to stage two in the obstetric transition model. In South Africa, there is a proactive approach to improving the quality of care and addressing mistreatment. Mistreatment of women who have accessed care has long been identified as a serious matter that required attention (Jewkes et al., 1998). Unfortunately, ver-

bal abuse and lack of respect in maternity care is still experienced by women as reported in more recent studies (Chadwick et al., 2014). South Africa has successfully implemented a text-based system ‘MoMConnect’ for both women accessing care, and, nurse-midwives providing care, which has the potential for use to obtain feedback on quality of care (RSA DoH, 2017).

Wenzel and Jabbal (2016) identify that obtaining feedback from users of healthcare services is only of benefit if linked to an action plan for improvement. Feedback is important in order to be able to identify what needs to change and where to direct resources (Beattie et al., 2014). Tools and methods used to obtain feedback must be easy to use, relevant and provide actionable data. Studies reporting on experiences of maternity care illustrate that often the tools or questionnaires to assess care are lengthy, administered by healthcare providers themselves (which could introduce bias) A mixed-methods approach appears to be the most comprehensive one. For example, using a short, anonymous and easily administered feedback questionnaire and system, enhanced by qualitative studies for triangulation (Wenzel and Jabbal, 2016; LaVela and Gallan, 2014). It is important to identify whether it is experience or satisfaction (or both) that is being measured as these are different aspects of care and require different approaches to measurement.

Furthermore, currently many tools in use are study specific rather than generic (D’Ambruoso et al., 2005; McMahon et al., 2014). Moreover, a trained assessor in the context for example of a research study or an audit, can usually only obtain information from a limited number of women. While this will provide important information about individual women’s experiences, it does not necessarily provide information in a way that can guide change and policy development more widely. There are also limitations associated with this approach in terms of continuous monitoring and quality improvement. To encourage and facilitate monitoring and assessment of quality of care as experienced by women, a set of simple but relevant questions that are easy to use as often as possible and can be self-administered by women would be useful (Finlayson and Downe, 2013; LaVela and Gallan, 2014; Vogel et al., 2015).

There is a complex interrelationship between the factors that determine why a woman may receive care that is not acceptable to and/or not valued by her (Jewkes et al., 1998; Freedman et al., 2014). The aim of this study was to explore the lived experience of maternity care providers as well as women who had received care at the time of birth

Table 1
Study participants.

Participant type	Type of interview (n)			Number of participants			Hospitals (n)
	IDI	FGD	KII	Urban	Rural	Total	
Postnatal mothers	23			11	12	23	6
Healthcare providers working on the labour wards (nurse- midwives, advanced midwives, doctors)	18	7		14	12	26	6
		5		5	13	18	4
Policy makers, clinical leads and managers			10	8	7	11	3
Total	41	12	10	43	49	92	11

IDI = in-depth interview; FGD = focus group discussion; KII – key informant interview.

in a setting where the majority of women receive birth care at a health facility. In addition, we sought to identify barriers and facilitators to providing woman-centred care of high quality in low- to middle-income settings. The study also sought to identify if there were key aspects of care described by women that could be included as part of a monitoring tool to allow women to provide feedback on their experiences of care and on the quality of care received.

Methods

Design

A qualitative descriptive phenomenological study was conducted in the urban Tshwane District in Gauteng Province and the rural Waterberg District in Limpopo Province in South Africa. This method was chosen to allow both interpretation and description of the lived experience of women and care givers participating in facility-based birth (Willis et al., 2016). Guidelines for the conduct and reporting of qualitative research were followed and are summarised below. (O'Brien et al., 2014; Tong et al., 2007)

In-depth interviews (IDIs) and focus group discussions (FGDs) were used to gain both depth and breadth of responses (Sandelowski, 2000). The two female interviewers were experienced midwife researchers, not involved in care provision in the sites chosen. Purposive sampling was used to recruit participants. The first group of participants included women of all risk levels and modes of delivery who had given birth in a public health facility in the 12 weeks preceding the interviews in order to have a wide range of experiences. Excluded from the study were women under 18 years, women who either did not wish to or were unable to consent or who appeared too ill or unwell. A second group included healthcare providers working in a labour ward (including nurse-midwives, advanced midwives and medical doctors). In addition, key informant interviews (KIIs) were conducted with participants with an influential role regarding the care provided within health facilities (healthcare managers and policy makers, clinical leads) (Table 1).

Data collection

Women were invited to take part while they were waiting for appointments. Interviews took place in either English or Sepedi away from the main clinical area in order to preserve privacy, minimise disruption and allow for free discussion. Detailed demographic data regarding education, age or parity was not routinely collected. Key informant interviews were pre-arranged at convenient times for the interviewees at each site. Written consent was sought only once the interviewer was satisfied that the participant understood the purpose of the study, who was conducting it and that participation was optional and could be withdrawn at any time. Data was collected between March and November 2016. A topic guide was developed and used for all KII, IDI and FGDs, which were audio taped. Interviews with the different participant groups

continued until saturation was reached. Examples of main questions include: what comes to mind when you think about the care you received during labour and birth of your last baby? What does it mean to be treated with dignity and respect, were you provided with explanation and reassurance, would you wish to have a companion with you and was this possible? What is your opinion regarding the competence of the staff? What are your experiences of using MomConnect?

Data analysis

Interviews were transcribed verbatim in English and translation was conducted by one of the interviewers. Transcriptions were independently reviewed by two additional researchers to ensure familiarisation with the data and consensus reached over codes for analysis. The interviews were uploaded and coded in NVivo 11 (Mac version). The data was analysed using the thematic framework analysis, a methodology used for analysing data from the perspective of informing health policy (Gale et al., 2013).

Five IDI's were open coded. Thirty-three codes were identified iteratively at this stage and grouped into seven categories; as the first stage of the abstraction of the data. These were: beliefs and attitudes; rapport and communication; human rights; organisational structures; leadership; professional matters; and use of mobile phones for the provision of feedback. This was carried out by the first researcher and independently verified by a second researcher to address potential bias. The coding and categorisation created an analytical framework and was carried out in NVivo which allowed the researcher to contemporaneously collate memos and notes. In addition, a diary kept in the field where contextual factors, observations and assumptions were noted and checked against evidence supported reflexivity. A matrix was developed (in Excel) which allowed clear visualisation and elucidation of the emergent themes (Gale et al., 2013) This then supported interpretation of the data utilising current evidence for triangulation. Reliability was addressed by all data being independently analysed by two other researcher's further reliability of the data was confirmed by member checking the data with the research assistant who undertook many of the interviews in the field. This ensured that findings represented accurately her understanding of the experiences and that they were not influenced by assumptions or bias (Cresswell and Miller, 2000).

Results

Eight main themes emerged from the analysis: (1) women as well as healthcare providers feeling alone, exposed and unsupported; (2) there is mutual distrust between healthcare providers and women who attend for care; (3) there is lack of choice and decision making by women themselves; (4) care is procedure-centred rather than patient-centred care; (5) verbal abuse is normalised; (6) there is dissonance between knowledge and practice; (7) professional hierarchy; with the deductive theme (8) feedback could be provided using mobile phones. Fig. 1 sets out factors relating to the individual, structural and policy levels.

Alone, exposed and unsupported

Feeling alone, exposed and unsupported was the strongest and most prevalent theme and was described by women and healthcare providers in all the healthcare facilities included in this study. For women, it related both to the absence of a healthcare provider as support person as well as to the absence of a (non-professional) companion throughout labour.

[You] want one nurse with you attending to you. That's what I want. (Woman, IDI)

When professional support was provided it was positively received and commented on;

The staff is good and friendly—they are able to talk and reassure you, and laugh. (Woman, FGD)

There were three of them (midwives) sitting around my bed. They were talking to me. Yes, they were a companion to me. (Woman, FGD)

The absence or lack of choice to have a companion was viscerally felt as captured below;

Most of the mothers they go alone through everything, I think that's not nice because I was alone, my boyfriend couldn't come in with me. He wasn't allowed to come in, my mother wasn't allowed to come in, no one. I was alone through everything, awake through birth ... during the procedure but no one with me, even if you go to the maternity ward um to wait to give birth no one is allowed to stand with you. During that time that was terrifying for me, they must allow at least the boyfriend or the husband or someone. That was the important thing to me, not be alone at that time. When my boyfriend couldn't come in, they didn't respect my needs. (Woman, IDI)

Companionship was sometimes negatively perceived by women in rural areas for cultural reasons. This largely appeared to relate to the perception that a companion had to be the (male) partner which was not seen as acceptable. Healthcare providers were aware that they did not provide this because of; lack of patient knowledge of the option, staff shortages, and structural or system challenges. None of the women interviewed in this study had a companion at birth. If offered it was only during the second stage of labour, leaving women feeling alone, isolated and unsupported. Most urban women wanted a companion. However, rural women did not always have such an expectation and lack of transport also acted as a barrier to being able to have a companion at time of labour and/or birth. Rural women more commonly perceived birth as something to be faced alone

If someone wants to be there I will allow him but I won't feel comfortable. I am not used to that kind of life that someone is always there. (Woman, IDI)

Companionship by a midwife was considered acceptable. However, it was noted that the 'working definition' of labour was largely the second stage of labour and/or birth and that companionship was not usually considered for the first phase of labour.

Yes, they can always bring one person from when they are in active phase; that is when they are about to deliver. (Nurse-Midwife, IDI)

It was evident across facilities that the first stage was often not being counted, with the need for a companion considered to be important only in the second stage. This was, in some cases, attributed to staff constraints and to the structure of the labour room.

It's supposed to be when they are in labour but due to the workload we only have time to go and sit with the woman ... when they are fully dilated. (Advanced Midwife, FGD)

With regard to attitudes and beliefs there was a difference between what women valued and what healthcare providers valued or

thought women valued. Women were most concerned with the healthcare provider taking time, listening in order to develop a relationship through a deeper understanding of the woman by asking questions rather than to elicit 'process' answers. A welcoming nature and a positive, friendly attitude was highly valued. While both women and healthcare providers described the same things, it was more about the feeling and the attitude and emotions invoked that these actions conveyed that was valued by women rather than the process described by healthcare providers.

Feel comfortable, feel safer. People that know what they are doing. (Woman, FGD)

I thought that people should have a heart. I know they are doctors but they need to have a heart. (Woman, IDI)

Many healthcare providers also felt alone and unsupported. They described a lack of consistent 'leading by example'. Managers, policy makers and healthcare providers all valued clinical leadership and recognised that when respected people (professors, lecturers) were onsite then the behaviour was 'the best it could be'. However, healthcare providers did not perceive that they had the support they needed, with senior staff often only visible when something went wrong.

But at the end when I get home, that is the worst thing that you cry alone. That, you know, everybody, they don't see me as a qualified professional, they see me as someone who just went there. Nobody respects me because of what they think of us. (Nurse-Midwife, IDI)

We become this angry midwife. I've seen all those old angry midwives; they don't smile any more, even when you greet them. You can't differentiate if they are happy or sad any more. I feel like they are traumatised or something. They don't get to talk about their experiences. They don't get help. (Nurse-Midwife, FGD)

Yes, you know patients complain always but the [managers] tend to be on the patients' side; they don't hear the side of the midwives ... what really happened. (Nurse-Midwife, IDI)

These quotes illustrate that midwives and nurses may feel 'traumatised' themselves and that the accumulated negative experienced impact on their behaviours. This was contrasted with the experience in two healthcare facilities where supportive leadership was recognised as being in place and where both staff providing care and women receiving care reported that they felt supported.

Mutual distrust

From the women's perspective, distrust developed as a result of word of mouth, the media and their own previous experiences.

Nurses don't trust you. If you feel baby coming out and you tell them, they don't listen. They trust their centimetres. One mother delivered on the floor. (Woman, FGD)

However, healthcare providers distrust related to the media and expectations that could not be met. To overcome distrust and fear, women wanted to be reassured by their healthcare provider. More than just words, it was the intention behind the communication that women felt was important. Both midwives and women themselves were aware of the need for good communication and a caring attitude but the mutual distrust impacted on rapport building. Healthcare providers were threatened by perceived high expectations that they felt was not substantiated:

We are not bad and often women come with the mentality that we are going to get treated bad. And then after they get this care, they are like, 'Wow, I expected to be treated bad'. (Nurse-Midwife, FGD)

Healthcare managers expected caring behaviours from healthcare providers but at times did not themselves express caring when talking

about staff and frequently appeared judgmental. Healthcare leaders and managers who were themselves more clinically active, more supportive and were better able to identify where practical changes could be made.

Lack of choice and decision making

This theme arose from discussion around information sharing and consent. While consent was described as a component of good care this was not substantiated with what was described to occur in every-day practice. It appeared that healthcare providers as well as their managers and policy makers held the common view that women in labour were unable to make the right decisions and needed to be told what to do. With this belief came the negation of the need for consent and choice. This was compounded by an assumption that, in a training institution, you barter choice in return for skilled care. This gave an indication that choice and decision making were considered fundamental rights but that healthcare providers were unable to offer such choice nor that women could refuse or have alternative choices.

Keep on reminding them what they have to do, even when they have had a baby. They make mistakes. (Nurse-Midwife, FGD)

Women wanted to be treated with respect and as an individual.

If you have a good sister who asks for permission, it feels good. (Woman, FGD)

A minority of healthcare providers and managers could clearly describe the appropriate care and attitude that reflected what women wanted.

We need to inform them [women] that in everything we do, we need to involve them. In the care, they need to be part of everything; we do because to me it's special. (Advanced Midwife, KII)

This was more evident in the healthcare facilities where staff had received training in respectful care but was only reflected by the women in facilities with visible clinical leadership.

Procedure-centred care rather than patient-centred care

Healthcare providers and their managers appeared to value clinical competence above caring behaviours. This may reflect the necessary focus in recent years on improving technical skills and competence. Care was primarily described in relation to interventions or tasks. Explanations and consent were described by healthcare providers and key informants more as a means of achieving a clinical procedure, rather than a caring behaviour or for building rapport. Lack of staff was frequently cited as a contributory factor. The lack of trained staff was a constant challenge in both urban and rural facilities. While healthcare providers recognised that women wanted more care given, they did not feel able to provide this. Examples of good patient-centred care were given but as an 'outsider looking in', not as part of their own practice.

So, because of that timeframe you know what you must do and you do it. You say, 'I am here to do 1, 2 3'. And you do it and you leave. You don't explain why you want to do it because there is no time for that. You need to attend to someone else. So, I feel I am not giving what I need to or what I would wish [emphasis] to be giving. (Nurse-Midwife, IDI)

Particularly in the urban setting, and often as a result of media messages, some women had high expectations about what care in childbirth could or should be like. However, this was not reflected in their experience.

I thought they were going to handle me like a queen but they didn't [laughter]. [Woman, IDI]

Verbal abuse is normalised

Women were very clear about how they wanted to be spoken to;

I say that, [be]cause I received respect; [be]cause when I entered the door the other sister was next to me and they helped me to the bed and then

they dressed me and 'Please can you just open the legs, nicely, and hold it and just relax. The baby is on its way.' They were so nice. (Woman, IDI)

It means a lot, you know, like when you talk with a polite voice it makes you calm; even if you are feeling pain you understand. (Woman, IDI)

However, even where healthcare providers recognised this, they believed that it was an essential part of care in labour to speak firmly, or as women said, 'to shout'. Women did not think that shouting was justified and wished to be spoken to 'kindly and gently'.

They don't need to shout at you. The shouting part [hesitates]. It's not OK! (Woman, IDI)

They just shout at you. No, 'Do like this. Don't push. You don't have to push 'cause the baby will be hurt' and all that. They were just shouting, so I think the pain was getting worse when they do that! 'Open your legs!' No, they were not nice. (Woman, IDI)

Frequently, this behaviour was normalised and justified in terms of pressure from being busy and short-staffed and as a necessary part of the labour process. There was an acceptance of being impersonal and distancing oneself from the woman's experience.

You were trying to save the baby. You were not necessarily shouting at her but just trying to get her to do the right thing. (Midwife, FGD)

The time of birth was experienced as tense and fraught. There were also examples of verbal abuse.

When you feel pain, they tell you that they are not responsible for your pregnancy. These words have hurt me. (Woman, FGD)

We don't deserve to hear things like 'You opened your legs for the guy, but you don't want to open your legs to take out the baby'. (Woman, FGD)

I was told that if I don't sit properly, I will kill the baby. (Woman, FGD)

In particular, the time of the active second stage appeared to be full of fear, raised voices, and, was often reported to be a negative experience for both women and care providers.

Dissonance between knowledge and practice

In response to questions around the application of human rights, there was widespread responses by both women and healthcare providers of the importance of privacy, the need for food and drink during labour and cleanliness of the healthcare facility and labour ward. Both women and healthcare providers described that minimum requirements for a good working environment were often not met e.g. when clothing was contaminated with no access to barrier aprons, or, when clean linen and soap were not available. System and environmental factors were reported often as being a barrier to good practice, with a direct impact on women's care in terms of safety (e.g. poor infection control), pain management (e.g. lack of suitable drugs), privacy (e.g. lack of space)

Women recalled experiencing pain and discomfort as a direct result of shortages e.g. the catheter available being the wrong size, a lack of sanitary towels causing embarrassment and shame. However, while staff knew this was a supply- or a work-environmental problem, women related these experiences directly to the type of care provided by the midwife. Withholding pain medication or not addressing pain was experienced by some women interviewed in this study. Not just that pain medication was not offered, but that if requested, women were ignored or it was denied as an option. This was a systems failure in some rural facilities, where pain medication could not be administered if a doctor was not available.

And when you got the pain, they just go away. They lock the door and sit in front of the reception. They were laughing. (Woman, IDI)

Encouraging women to be mobile during labour and/or birth was described. However, in practice, due to both environmental and cultural factors, this was not practiced in the urban settings. According to women and healthcare providers, it was however commonplace in all the rural areas. Lack of confidence in supporting birth in other positions was cited as a reason for discouraging this.

We tend to tell them what position they should be in, to be in for delivery for our own comfort. (Senior Manager, KII)

One of the greatest knowledge practice gaps relates to monitoring in labour. Due to shortages in staff, existing culture and the structure of the healthcare facility, women reported that they attend for birth in the advanced stages of labour so as to be able to spend time with family at home for as long as possible.

Professional hierarchy

Professional hierarchy was evident across all categories.

I think that this needs to be in their training but, at the moment, the doctors are the high and mighty and you can't say a word. (Senior Manager, KII)

However, there were distinct differences across facilities. In those with visible supportive leadership there appeared to be better working relationship and respect and midwives were happier in their role. Advanced midwives were more proud and enthusiastic about the job than more junior midwives. Input from medical doctors appeared to be more for hierarchical reasons than a benefit to patients in some healthcare facilities and could cause delay, as doctors are generally not based on the labour ward and may not 'like maternity' or were the gate keepers of referral. There appeared to be a lack of value or advocacy for midwife-led services both from women and from medical colleagues.

Providing feedback

The majority of women in the urban area used the existing MomConnect service. This is a national initiative in South Africa where all women are registered with a text-based messaging system which relays key health messages throughout pregnancy and the postnatal period and it was known to most healthcare providers (RSA DoH, 2017). The majority of urban women in urban areas said they would be happy to provide feedback on the care they had received through this platform. The key important subthemes identified were: positive reciprocal engagement; improved health literacy; monitoring; and anonymity. In rural areas where phone ownership is lower and there are more language constraints, the use of MomConnect was perceived as more challenging. Healthcare providers felt that, if anonymised, using mobile phones would be an effective way for them to provide and also receive feedback regarding their ability to give the care they wanted to give.

Discussion

Healthcare providers generally have the knowledge regarding what good quality of care is and how this could be better provided. However, organisational and structural challenges such as shortage of staffing, many referred cases and poor referral pathways, shortage of supplies, and, the labour ward lay-out and structure are often barriers which do not enable healthcare providers to implement what they know to be good practice.

This could be interpreted as unintentional mistreatment and it is important that, using a systems approach as described by Freedman et al. (2014), this is differentiated from poor quality of care provided because of personal and group beliefs and attitudes as reflected in other studies. (Jewkes et al., 1998; Chadwick et al., 2014). This is particularly important as personal beliefs and attitude are strong factors when it comes to the 'caring behaviour' most valued by women, both with regard to providing person-centred care for women at the time of birth but

Table 2
Implications for practice.

Candour regarding a facilities ability to structurally meet standards should be encouraged.
A companion in labour should be promoted for all stages of labour, working with communities to raise expectations may be required.
Non-verbal and caring behaviours are very important to women and are best assessed by the woman's experience.
Supportive leadership is a key factor in improving care.
Raising expectations without providing staff with the support or resources to meet them increased distrust.
If women are to have a better experience of good quality care, this needs to be addressed not just through the language of 'respect and rights' but also in such a way that the emotional experience is enhanced and fear reduced.

also with regard to a welcoming and courteous attitude to those who could act as a companion during labour and birth. From this study it appears that attitudes can be improved by visible leadership and a supportive caring culture in the workplace. A number of implications for practice were formulated as a result of this study and are presented in Table 2.

In terms of feeling 'alone and unsupported', in relation to the language that women used to describe their experiences and expectations of care, the language used often related in particular to the limbic system. Thus, women described feelings and emotions and used words such as; 'safe', 'heart', 'care', 'friendly', 'laugh'. Often competence of healthcare providers was accepted without question and was considered to be in place. In contrast, healthcare providers described care as a more rational logical and procedure-based process and used matching words and language to describe this. Therefore, if women are to have a better experience of good quality care, this needs to be addressed not just through the language of 'respect and rights' but also in such a way that their emotional experience is enhanced and fear reduced. This has the potential to impact not only directly on a woman's experience of care but also on the promotion of 'normal' birth (Dixon et al., 2013).

There is a risk that training workshops to build capacity of healthcare providers can make carers more eloquent (e.g. in their use of respectful care language) but may not change practice per se if the caring behaviours are not valued and implemented. It is also clear that the 'working environment' needs to become a 'caring environment', which includes the needs of the healthcare providers as well as the needs of the women they care for. This reflects the findings of the global consultation on midwives' experiences of providing good quality care (WHO, 2016).

Healthcare providers in this study emphasised that respected clinical leadership, mentoring and role models' support must be in place to bring real change. The role of the midwife as compassionate carer and advocate needs to be promoted as much as the clinical or competency role.

In terms of improving women's experiences of birth, as Chadwick et al. (2014) demonstrated supporting and advocating for companionship in labour and during birth (not being alone) continues to be an unmet priority for women themselves. As this is now well known but not implemented, it should be considered a key measure of quality. It will be necessary to work with communities as well as healthcare providers and leaders of the health system to promote and facilitate the role and responsibilities of a companion for women during labour and at the time of birth.

Although views expressed by women would appear to be an effective 'measure' of care received, this study shows that these views although important, by themselves do not help to identify the underlying reasons for good- or poor-quality care provided. Similarly, the experience of care received as expressed by women may not (taken in isolation) reflect why the care received was experienced as good or poor. This evaluation, therefore, needs to be in conjunction with internal monitoring and audit. Soliciting information of women's experience of care can then be

used to provide effective triangulation with information obtained from staff, system and policy audit. Clinical leaders and managers could be more 'open' and be able to discuss with the community what a hospital can (and cannot) provide in terms of structure, staffing, companionship, equipment and supplies. The public can then more easily separate and understand the healthcare providers' responsibility and ability (or lack thereof) to provide care versus that of the management and government. This may reduce the healthcare providers' experiences of feeling isolated and increase trust between the members of the community and the healthcare providers working in the health system. The media is clearly a tangible influence and could be utilised to better provide information and advocate for positive change rather acting mainly as a critical and negative influence increasing distrust on both sides. With regard to using a mobile phone platform and questionnaire as a method and tool for monitoring the quality of care, this was overwhelmingly perceived as an acceptable way to provide and receive feedback from both women and healthcare providers in urban areas. However, in rural areas where many women do not have a phone and literacy and language were barriers, this is less feasible.

We appreciate there are limitations to this study. The specific findings may not be representative of other settings in Sub Saharan Africa. However, it is likely that the implications for improving quality of care are relevant to most healthcare providers working to provide care during labour and birth regardless of setting per se. Further research is needed to develop and test a short questionnaire with key questions that reflect good quality care from the women's perspective and solicit feedback from women using texts e.g. via the Mom Connect platform. This was not possible within the timeframe and given the limited resources of this study.

Conclusions

Delineating causation and impact according to each of a number of levels of the health system including the; individual, structural and policy level, clarifies where intervention and improvement can be affected. Measuring women's experience rather than expectations may provide valuable information to enable triangulation with data from monitoring and audit of other levels of the health system. This study demonstrated that while there are some variations between urban and rural settings, the main themes identified were applicable across all settings. Women want to feel safe, welcomed, cared for and to have support from healthcare providers and the possibility of a companion during labour and birth whenever they want one.

The attitude of midwives and the way they talk are very important to women and are often perceived as being of greater significance than the content of what is being said given that women who access care believe that healthcare providers are clinically competent. If hospitals are more able to highlight the things they cannot currently provide (e.g. private rooms, space for companions to stay) and explain how they endeavour to improve these shortcomings, it could take some of the 'blame' away from the midwife and improve rapport between women who access care and those who work in and are responsible for the health system. Use of feedback will improve women's and midwives' voice and ownership of service if measured against standards known to be valued by women.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2018.04.007.

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