"LIVED EXPERIENCES OF YOUNG WOMEN OF THE QUALITY OF OBSTETRIC CARE SERVICES (QOCS) PROVIDED BY MIDWIVES AT MABVUKU BIRTHING CENTRE AND ITS SATELLITES IN HARARE, ZIMBABWE".

BY

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ABSTRACT

The quality of obstetric care services (QOCS) tends to determine young women's choice of where to receive the intended services, yet in lower income countries like Zimbabwe little research on such services is documented. The purpose of this study was to explore the lived experiences of child-bearing age women of the QOCS regarding the QOCS provision in maternity clinics in Harare eastern district and its Satellites in order to understand the degree of their satisfaction with the obstetric care (OC) that they received. Also, to develop a model of care that can fulfil the knowledge and theory gap. Permission was approved by the relevant Research Ethics Committees for protection of the participants. A descriptive phenomenological qualitative approach was used to hear from the perspective of the care users. Data were collected until saturation. Giorgi's technique analysed the data and a Hulton, et. al., (2000/2007) and the Southern Relational Path frameworks were used to guide the study. Semi–structured interview guides were used for the focus group discussions and individual in–depth interview platforms, and notes were written in a research diary and transcriptions were done daily after recording. Thirty-one participants were purposefully recruited from the pre-natal, labour, post-natal records and those who came for post-natal care services after consenting.

Some women were satisfied with the QOCS that they received, citing warm and sensitive reception especially from the male midwives, while others were dissatisfied with the care. They mentioned poor monitoring of deliveries that led to self-deliveries, lack of empathy, rudeness and mistreatment during labour and birthing. Some environmental barriers such as crowdedness in the admissions room, labour, and post-natal rooms were reported. Confusing, inadequate and inconsistent information on family planning drugs, immunizations and breastfeeding concepts were reported. Insensitive cultural and religious values among the care providers were also noted as cause for concern. A model of care that might provide some useful insights that could improve the care and eventually improve QOCS was developed.

The study concludes that women prefer quality obstetric care that constitutes the availability of resources both physical and human, namely trained and competent staff; medicines and sundries; longer clinic stays in order to rest and gain more information on infant care and breastfeeding and adequate space to allow husbands and significant others to accompany them on booking day. Staff need to be warm and empathetic, culturally and religiously sensitive for better maternity care uptake.

KEY WORDS: Quality obstetric care services, qualitative phenomenological approach, lived

experiences, women of child bearing age.

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DECLARATION BY ACADEMIC SUPERVISOR/S

We the supervisors having supervised and read this thesis of Helen Vupenyu Gundani are satisfied that this is the original work of this candidate. We confirm that the work has been completed satisfactorily for presentation and examining.

1. Professor Lovemore Gwanzura

   Signature……

   Date: November 01, 2019

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   Date: November 01, 2019.

Declaration of authenticity

I declare that the research project, “Lived Experiences of young women of the quality of Obstetric Care services provided by midwives at Mabvuku Birthing Centre and its Satellites in Harare, Zimbabwe” is my work and that each source of information has been acknowledged by means of a complete reference. This thesis has not been submitted before for any other research project, degree or examination at any university.

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DEDICATION

For Nyaradzo Chagonda Makoni my beloved mother it's sad you never lived to see me grow into a wonderful mother to my three children and seven grandkids as well as grow to build a success base for myself and also grow to become a keen researcher (RIP)

and

for Lennos Maideyi Makoni my loved and supportive dad. You were indeed a caring father, I owe you tremendous respect for all the care that you extended during those hard times I have lived to do you good I worked hard to become a university lecturer. (RIP)

ACRONYMS

BPFA	BEJING PLATFORM FOR ACTION
EU	EUROPEAN UNION
EMOC	EMERGENCY OBSTETRIC CARE
GBV	GENDER BASED VIOLENCE
NGOs	NON-GOVERNMENTAL ORGANIZATIONS
MOHCC	MINISTRY OF HEALTH CHILD CARE
NSHP	NATIONAL STRATEGIC HEALTH PLAN
RCOG	ROYAL COLLEGE OF GYNAECOLOGISTS
UNCEFDW	UNITED NATIONS ON THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN
UNICEF	UNITED NATIONS CHILDREN'S FUND
UNDP	UNITED NATIONS DEVELOPMENT PROGRAM
UNDFPA	UNITED NATIONS FAMILY PLANNING AGENCY
USAID	UNITED STATES OF AMERICA AID
WHO	WORLD HEALTH ORGANIZATION
WCoZ	WOMEN'S COALITION OF ZIMBABWE
ZDHS	ZIMBABWE DEMOGRAPHIC HEALTH SURVEY
ZINA	ZIMBABWE NURSES ASSOCIATION
ZOWLA	ZIMBABWE ORGANIZATION OF WOMEN LAWYERS

ABREVIATIONS

CEQMCM	**CALABASH OF EXCELENCE IN QUALITY MATERNITY CARE MODEL**
CBAW	**CHILDBEARING WOMEN**
FP	**FAMILY PLANNING**
FPGs	**FAMILY PLANNING DRUGS**
HIV/AIDS	**HUMAN IMMUNO-DEFICIENCY SYNDROME**
HP	**HEALTH PROMOTER**
III	**INDIVIDUAL -INDEPTH INTERVIEWS**
INCM	**INFANT AND NEONATAL CHILD MORTALITY**
MM	**MATERNAL MORTALITY**
MMR	**MATERNAL MORTALITY RATIO**
MNIMM	**MATERNAL NEONATAL INFANTMORBIDITY AND MORTALITY**
MPMM	**MATERNAL AND PERINATAL MORBIDITY AND MORTALITY**
MCSs	**MATERNITY CARE SERVICES**
MC	**MATERNITY CARE**
MICS	**MULTIPLE INDICATOR CLUSTER SURVEY**
MDGS	**MILLENNIUM DEVELOPMENT GOALS**
MHC	**MATERNITY HEALTH CARE**
MNHS	**MATERNITY NATIONAL HEALTH SERVICES**
OC	**OBSTERIC CARE**
ON	**OBSTETRIC NURSING**
PPFA	**PLATFORM FOR ACTION**
PPS	**PUEPERAL SEPSIS**
PRC	**PREGNANCY RELATED COMPLICATIONS**
PT	**PREGNANCY TOXAEMIA**

PMTCT	**PREVENTION OF MOTHER TO CHILD TRANSMISSION**
QOCS	**QUALITY OBSTETRIC CARE SERVICES**
QOC	**QUALITY OBSTETRIC CARE**
QCN	**QUALITY CARE IN NURSING /MIDWIFERY**
OB&GC	**OBSTETRIC AND GYNAECOLOGICAL CARE**
NGO	**NON- GOVERNMENTAL ORGANIZATION**
SBAs	**SKILLED BIRTH ATTENDANTS**
SDGS	**SUSTAINABLE DEVELOPMENT GOALS**
STI	**SEXUALLY TRANSMITTED INFECTIONS**
WCoZ	**WOMEN'S COALITION OF ZIMBABWE**
ZDHS	**ZIMBABWE DEMOGRAPHIC HEALTH SURVEY**

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DEFINITIONS OF KEY TERMS AND CASE DEFINITIONS

Birthing: the process of delivering a baby from the point of full dilatation of the cervix to the point when the baby is out of the uterus to the time a woman is warded to the postnatal care facility up to point of discharge.

Framework: According to Johnson, (1961) is a set of analytic realities to do with a certain phenomenon/variable that give the relationship between them. In this study the framework /model refers to how womanhood per se in view of the care received during prenatal care, birth and postnatal care and there- after as well as the care environment that is the premises building upkeep, the equipment, essential drugs and medical sundries such as gloves, syringes and needles and the socio –economic factors. The Hulton et al., (2007) maternity care framework helped and guided in the data collection process as the primary framework was instrumental in the measuring of the study activities. The Southern Relational Path was used as the secondary framework for its properties with nature, heritage and community since women live together with other human beings, animals and creatures it was found to be appropriate to use since the participants were facing numerous challenges as they sought and accessed OCSs.

Health centre: refers to a local facility in a peripheral setting which in this case is urban registered to offer primary health care includes pregnancy, labour, birthing and postnatal care. Primary health care services provided are prenatal care for timely detection of conditions that require referral. Deliveries are conducted in accordance with the principles of safe motherhood as well as postnatal care.

Health personnel/worker/care provider: refers to health practitioner certified to offer health care that is nurses, midwives, doctors and other health team players and includes non –supportive staff like the cleaners and the guards for instance in this study.

Interdisciplinary team: a team made up of people within member disciplines who work together for the common good by providing maternity care to the patient /client during pregnancy into the perinatal period. In the process these disciplines remain independent of each other in the course of providing the care. For the purpose of this study it is the nurse, midwife, nurse in charge, doctor, health education officer, pharmacist, counsellor and environmental health officer.

Intrapartum care: in this study is used interchangeably with the postnatal period, it is care rendered to a pregnant woman at point and during labour up to the time of delivery.

Maternity Care: care rendered to a pregnant woman from the birth of a baby, delivery of the placenta up to six weeks postnatally. care availed to women in a maternity facility during prenatal care, labour and birthing and postnatally and is used by the researcher interchangeably with obstetric care in this study. It's also, care availed to women in a maternity facility during prenatal care, labour and birthing and postnatally and is used by the researcher interchangeably with obstetric care in this study.

Maternity client: in this study refers to any woman who sought and received MCSs during pregnancy, labour and birthing and postnatally and there -after up to six weeks during year 2016 - 2017 at the time and moment of data collection and was resident in the study sites. The woman needed to be physically and mentally well to articulate her lived experiences fully.

Maternity Health Care Provider: refers to a medical practitioner certified to offer health care to maternity cases during pregnancy, labour and birthing, postnatally and during parenthood.

Maternity care: Midwife: refers to a provider who has graduated from a certified or accredited midwifery training course in the country of practice. S/he is an accountable professional who works in partnership with women to give the necessary care and information during pregnancy, labour and birthing and in the postnatal period to conduct births using midwifery skills. The care

should involve prenatal education and sexual or reproductive health and childcare as a complete package. In this study all the processes and procedures done to the pregnant woman were inquired upon to establish the facts and concerns as narrated by the women to gain insight of what transpires to women as they seek and receive MCS in the maternity care chain.

Model: a model is viewed by most people as any structure that purports to replicate, reproduce, or represent something else. In scientific term a model may be used to define or describe something, to assist with the analysis of a system, to specify relationships and processes, or to present a situation in symbolic terms that may be manipulated to derive predictions. Kaplan states that , "we may say that any system A is a model of system B if the study of A is useful for the understanding of B without regard to any direct or indirect causal connection between A and B"(Kaplan, 1964, p. 263).In this study a six component model was crafted to incorporate the major components of the MCSs as proffered by, (Renfrew et al 2014; Hulton, et al., 2007).

Labour: refers to the beginning of true labour pain with established and well-co-ordinated contractions the moment the cervix is fully effaced and at 4 centimetres dilatation.

Lived birthing experiences: the perceptions, views and observations that young women voluntarily shared according to their own world's view as they went through pregnancy, labour and birthing while in the hands of nurses, midwives, obstetricians at all the levels of care that is health centre, district, and tertiary levels. Also, reflection of the one to one personal attention and constant availability of the nurse –midwife for the woman in labour, (Hunter, 2000, p. 44) was important in this study to capture the lived experiences of the women fully.

Nurse: refers to a provider who has completed training as a medical /surgical nurse and is not part of a certified or accredited midwifery program.

Pre-natal care: care rendered to a pregnant woman from time of booking up to point of labour. It was an important stage of the birth processes as it is the entry point to the care pregnant women receive and was important for the researcher to understand the nature of the care received in general.

Perinatal period from 28 complete weeks of gestation to 7 completed days after birth in our Zimbabwe context.

Pregnancy: forty weeks from the last normal menstrual period to the time the woman goes into labour.

Quality of care: focuses on both the provision of care as well as how clients perceive the care**.**

Quality obstetric care: involves provision of the maximum level of care to all pregnant women and their new-born babies who need the care. This should be done while obtaining the best possible outcome and that which provide satisfaction to the women, their families, relatives and communities as well as the carers themselves, (Pittpott, Campbell and Fillipi, 2002 p278)**.** Hulton, Matthews, Stones, (2000; 2007) describe the care where the human and physical resources, cognition, respect, dignity and equity and emotional support are all in place and conducive for the consumer of the services. In this study the term QOCS is the key term between the OC provided and the way the woman generally sees it as she accesses and receives the care from health care providers.

Referral centre: a district, provincial or quaternary facility usually manned with inter-sectoral mix of health care providers available to offer comprehensive and holistic care to the complicated cases in obstetric, medical /surgical, oncology, paediatric domains.

Skilled Birth Attendant (SBA): refers to a trained health personal who can deliver vaginal births safely.

System: according to the Oxford Dictionary (1982) is anything formed of parts placed together into a regular and connected whole; a set of things considered as a connected whole; a set of bodily organs of like composition or concurring in function: a body of doctrine: a theory of the universe: a full and connected view of some department of knowledge: a plan: a method or a manner of crystallization.

CHAPTER 1

INTRODUCTION

1.1 Background and Rationale

Quality care is elusive and difficult to describe and quantify requiring the need to engage the women who are the key users of obstetric care services OCS. Obstetric is a preferred term because it is inclusive and involves other care providers such as the anaesthetist, paediatrician, physiotherapist, medical doctor, laboratory scientist, on the other hand maternity care refers to the midwife and the patient /client. Currently the thrust of improving the quality of this care has become an important focus in an effort to reduce preventable maternal mortality and morbidity (MMM) among mothers and new -born babies but little research has been conducted in resource restricted urban settings, nationally. Donabedian, alluded that quality is the extent to which actual care is in conformity with present criteria for good care (Donabedian,1966/1988 2005:1743-1748). Quality care is further, dependent on the physical infrastructure, human resources, knowledge, skills and capacity to manage normal and abnormal pregnancies and complications that require prompt, life -saving interventions, (World Health Organization, 2016).

Also, Osariemen, A.G., (2011); Emelumadu, O.F., Onyeonoro, U.U., et al., (2014), demonstrated in their reports that increased availability of service does not always translate to increased access to healthcare. Researches conducted this far indicate that maximizing coverages of essential services is not sufficient to curb MM. What can avert preventable MM is to allow the women of childbearing age expect obstetric care (OC) which in this study is used interchangeably with maternity care (MC) during pregnancy and childbirth utilizing evidence -based practice that is provided in a humane, respectful, supportive environment, (WHO,2016; Homer, CSE., Kennedy,

HP., Matthews, Z., &McFadden, A., 2014; Homer, CSE., Friberg, IK., Ds, MA., 2014; Renfrew, et al 2014). Evidence -based practice dictates that the perceptions of women regarding MC be established through a qualitative study of this kind to hear it from the women. Numerous reports on evidence of experiencing disrespect and mistreatment during childbirth are said to reduce a woman's satisfaction and confidence in the QOC provided, Kuyawski, S., Mbaruku, G., Freedman, LP., et al (2015) and may interfere with her decision to give birth outside a maternity care facility, (Bohren, MA., Vogel, JP., Hunter, EC., et al, 2017;10:e0135621). But little evidence is documented in urban resource restricted settings in Zimbabwe using care users qualitatively. Only one rural study by Mathole, T., Lindmark, G., Majoko, F., Ahlberg, B., (2004) is documented, hence, the need for this inquiry to fill in this knowledge gap.

Furthermore, WHO, (2016) and the mentioned authors envision a world in which pregnant women and their new -borns receive quality MC at most times to ensure wellness. This statement aligned with the two complementary global action agendas: "Strategies, towards the preventable maternal mortality," (Gulmezoglu,MA., Lawrie, TA., (2015) DOI:10.1016); and that "Every new -born: An action plan to end preventable deaths, Hussein, J., Mavalanker, DV., Sharma, SD., et al, (2014) set efforts to reduce MNMM. Additionally, the agendas resonate well with the transformative agenda of the Sustainable Development Goals (SDGs) to reduce MINMM (WHO, 2015) that also includes targets that reduce the global maternal mortality ratio (MMR), which leads to the achievement of access to quality essential healthcare services by 2030, SDGs target 3.1 &3.8, (United Nations, 2015). Also, the near miss concept, (WHO, 2016) is a monitoring tool which countries can use to track maternal neonatal morbidity and mortality (MNMM).

Further, clients' needs are traditionally prescribed from the value judgement of policy makers, health professionals in key positions. These professionals may employ marketing approaches to the services. Rarely do clients and nurses, the care users and care providers of these services have input. Yet there is growing belief that service built on the needs prescribed by health care provides alone is not valid. It is argued therefore, that if the system wishes to provide better OC and wishes to encourage participation (uptake) and reduce fatigue and frustration with care, there is need to be sensitive to the needs of the women and attend to the hardships they may face during pregnancy and childbirth. The study was a vehicle to unravel what women feel about the QMC they received and help to enhance the care from the women's perspective. In other words, this was an exploration of women's perceptions to care with a greater goal to produce knowledge that might help reduce MNMM.

1.1.1 Prevalence of Maternal and new-born mortality

Globally, about 500 000 women died as a result of pregnancy and childbirth complications, and 201 000 (66%) in sub Saharan Africa (SSA) including Zimbabwe die from causes associated with pregnancy and childbirth, (Alkaema, L., Chou, D., Hogan, D., et al, 2015; Nicholas, J., Kassebaun, et al 2015). Higher income countries such as the United States of America (USA), Centre for Disease Control (CDC) reported an increase in maternal deaths from 18.8 deaths per 100 000 births to 23.8 deaths per 100 000 births between 2000 and 2014 most of these deaths are due to preventable causes such as haemorrhage, pre -eclampsia, infections and cardiomyopathy, (Mac Dorman , MF., Declerg, E., Cabral, H., et al, 2016;Troraino, NHW., Icher, PM., 2018). In Zimbabwe, according to the 2014 Multiple Indicator Cluster Survey, MM was reported to be at 614 deaths per 100,000 live births which is significantly lower than the 2010/2011 Zimbabwe Demographic Health Survey (ZDHS) estimates that there are 960 maternal deaths per 100,000 live

births. WHO, UNICEF, UNFPA, World Bank, (2012); Strategic Directions for Nursing and Midwifery Services in Zimbabwe, (2016-2020) reported concerns regarding the high MNIMM. Additionally, UNICEF, (2015) reported that 35 babies in 1000 live births die daily before they reach their first month and 31 stillbirths occur daily in 1000 live births in Zimbabwe. A distinctive feature of the expansion of the midwifery profession is the growing proportion of male midwives (22%) due to new, exam-based selection criteria (Ethiopian midwives' association 2012). This country has relatively understudied challenges of this scale-up which are ensuring the quality of these services and understanding women's readiness to use them.

The definition of the midwife has been established by the International Confederation of Midwives (ICM), as one who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located, in Zimbabwe one is registered by the Nursing Council, which is the regulatory authority; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery. Therefore, midwifery is the expert, educated, and empathetic care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, post- partum, and the early weeks of life (Lancet Series, June 2014).

Also, in lower income countries including Zimbabwe there is little data available to estimate how common is the disrespectful and mistreatment of women during pregnancy and childbirth. However, Ivers, N., Jamtvedt, G., Flottorp, S., et al (2011:CD0059); Mengistu, WG., Warthu, A., Mardhrwe, AA., et al (2017) in their studies reported the importance of such studies to protect

women from abuse while delivering life. Renfrew, et al (2014); Hastings, MP., (2016); Mengisto, WG., Warthu,A., Mardharwe, AA., et al (2017) in their studies emphasized the importance of curbing disrespect and abuse of women during childbirth a current feature in midwifery concepts and practice and the WHO standards, (2016) and the White Ribbon Alliance, (2013). This inquiry might contribute towards the phenomenon of this nature in the country were little is documented from the perspective of the women.

Some of these lower income countries adopted the creation of the Millennium Development Goals (MDGS) 4 & 5 that emphasised on 'Reduction of infant mortality' and 'Improvement of maternal health' through the strengthening of attendance and coverage by women for pregnancy and childbirth for both the mother and the baby, (United Nations, 2015; WHO, 2016). However, these mentioned MCS reforms curb maternal mortality (MM) and focus on increasing the availability of maternity care at the expense of quality. The findings of this study might help to reduce maternal and neonatal morbidity and mortality (MNMM) and possibly improve uptake.

In addition, evidence -based interventions need to be developed and evaluated, so that health systems can effectively be managed. To mention examples, audits and feedbacks have shown to significantly improve professional practice and are critical and important. Only, one rural study by Mathole, et al, (2004) is documented in Zimbabwe, on the QOCS, yet studies of consumer perception (experiences) in relation to behavioural outcomes are on the rise in other African countries and in high income countries such as the United Kingdom, (UK), Sweden, Netherlands to mention a few. The World Health Organization, (WHO) (2015), also encourages and promotes strategies that ensure improved maternal and new -born health in order to match the low MMR reported in Australia, 8.5 in 100 000 births, between 2006 and 2016, (Australia Institute of Health and Welfare, 2016) (AIHW). It was envisaged that this inquiry can set stage for such

interventions to improve maternal care. Further, the inquiry and findings can help nurses /midwives and other healthcare providers understand the elusive concept of QOCS and the theory is useful for practice.

Also, research carried out across (SSA) has concluded that many women desire supportive care during pregnancy and childbirth and future decisions may depend on the QOC received previously , Kyomuhendo, GB., (2003); Chadwick, R., Cooper, D., Harries, J., (2014); Kambala, C., Lohman, J., Mazalale, J et al (2016), mentioned Malawi to have achieved positive client-nurse/midwife relationships through the creation of rapport and therapeutic gestures, for instance greeting patient by name. This was supported by a Tanzanian study that also made reference to therapeutic relations (Larson, E., Vail, D., Mbaruku, GM., Kimweri, A., Freedman, LP., et al, 2015). This inquiry may also contribute to the debate through the findings. In eliciting these perceptions, it could then be possible to provide a model of care that might assist to systematically deliver obstetric care (OC) that satisfactorily addresses the needs of the users, who are women of child -bearing in this study.

The Hulton, L.A., Matthews, Z., Stones, R.W., (2000/2007), framework, highlights the maternal satisfaction that women regard as best for OC. A fundamental aspect on how women experience this care that is significant and crucial was used to guide the study for its strength in highlighting what women in resource restricted settings of India reported as important was found appropriate for this inquiry. Further, the Southern Relational Path, by Lessem, R., Schieffer, A., (2010 /2014/2017) that is centred on nature, environment and community was selected as the secondary framework to guide the study for its strength in social and cultural creativity to establish its influence on aspects of MC accessibility and uptake.

The WHO Quality of care (2014) could have been used but the researcher felt it was centred on reflections of women from 29 different countries whose culture, affiliation can also, vary with the Zimbabwe context. The Renfrew, MJ., Mcfadden, A., Bastos, MH., Campelll, J., et al framework (2014) developed in Australia a developed country that has its own MC culture and orientation could have been used. It emphasizes on skilled care for all including the health of minorities, which was seen to be on a higher level than our health care system. It promotes the strengthening of women's capabilities in the context of respectful relations tailored to their needs, focused on the promotion of normal reproductive, processes that promote emergency treatment of complications and accessibility to this care. In comparison with the Zimbabwe health care system at that time and space which was struggling with inadequate resources to curb high MIMM. The researcher preferred the Hulton's et al (2000) framework for its being developed in resource restricted settings of India. It was appealing and compared favourably to the socio - economic situation of Zimbabwe at the time and space. The detail of these frameworks is in chapter 2.

A qualitative phenomenological approach was used to explore the lived experiences of the women to hear the stories from women who had received OC as opposed to a quantitative approach that might be impersonal and limiting. Further, themes that might emerge from the users' perspective of care received might inform the development of a model of care to cater for any of the needs if indicated. Some researchers such as Fawole A.O, Okunlola M.A, Adekunle A.O., (2008) strongly support client-centred obstetric care (OC) in their studies which seem to support similar views expressed by the other authors in the reviewed literature. But little was known in Zimbabwe, about the (QOC) provided to the women using methods that allow the women to contribute about this care. What is in place is the monitoring of attendance of pre-natal

visits and post-natal visits and their effects on pregnancy and childbirth outcomes. Some researchers in Sociology and Anthropology, have advocated for understanding the meaning that events have for the individual being studied as the core for research practice. They have also postulated that the quantitative thrust was not conclusive in generating new knowledge (Stanley, K., Hyslop, J., 2012; Lessem, R., Schiefer, R., 2010;2014). Hence, the choice of this qualitative approach for this inquiry.

The study settings are in Harare's eastern district, Polyclinic with Satellite feeders which offer both curative and preventive care for communicable and non-communicable diseases, (NCDs) including maternity care. The settings have delivery facilities, prenatal, postnatal and baby care services at first level care to child bearing women. Little -evidence is documented on the perceptions of the women in these settings, creating a knowledge gap that this study could fill and share with others in similar settings.

1.1.2 Socio -cultural and religious values

Midwifery and nursing have for a long time shared the bio -medical assumption that regards itself as a holder of knowledge that devalued the knowledge experienced by women and did not take into account beliefs, practices and context in which they lived. A study by Blutta, ZA., Chopra, M., Aleslson, Bermann, P., et al (2010) provoked reflections on the same theme and led professionals to rethink their practices, making care more humanized. The nursing of pregnant women needs to be integrated into activities that are developed with other professionals in the health care delivery system to facilitate the synchronizing of promotive and preventative activities, (WHO, 2016). This might ensure a multi -professional care that is relevant in the reduction of MNMM, (Tafarrey, S., Kamai, I., Qureshi, A., et al, 2008). It is important for nursing care and culture to walk together in the nursing process to ensure that the popular care permeates

nursing care, (Amin, R., Shah, NM., Becker, S., 2010). Little evidence is documented on this aspect from the women's perspective.

Furthermore, reduction of MM can be realised through the increased utilisation of OCS within the women's socio–economic, status, income, cultural and religious context, (Lubbock, L.N., &Stephenson, RB., 2008:75-84). According to Lewis &Drife, (2001;2004); Lewis, (2007); Centre for Maternal and Child Enquiries, (2011) (CMACE) of the UK accommodating women's views and respecting their ethnic, cultural, social and backgrounds is critical in developing responsive MCS. A disparity between higher income countries and lower income countries in terms of utilisation of pre-natal, labour and birthing and post-natal services are unfairly large in lower income countries where an estimation of about 97% of women of childbearing age receive these services and 53% of these women receive these services from skilled birth attendants (SBAs). World Health Organization, (2007/2012); WHO, UNICEF, UNFPA and World Bank, (2005); (2015/2016) reported the same sentiments in a study on utilisation of MHCS regionally and locally. However, little is investigated in these settings, yet these settings have their own peculiar socio-economic, cultural and religious challenges that can affect utilisation and MCS. The purpose of this study was to explore lived experiences of women of the QOCS provision. The second framework was important because one of the arguments proffered by Lessem &Schiefer, (2010 /2014) is creation of an environment where man, nature, heritage can interact to create harmony for orderly survival in a low -lying community. This could be informed by any emerging needs of the women from their experiences so as to gain more insights on the care provided during pregnancy and childbirth to the women of these resource restricted communities, in Zimbabwe.

1.2 Problem Statement

Women and newborn babies continue to die from conditions related to pregnancy, childbirth and postnatally in Zimbabwe. The Multiple Cluster Survey (2014), reported the Maternal Mortality rate as 614 deaths per 100,000 live births in Zimbabwe and UNICEF (2015) reported that 35 babies in 1000 live births, die daily before they reach their first month and 31 stillbirths occur daily in 1000 live births in Zimbabwe. The expected global maternal mortality ratio according to the SDGs is to be fewer than 70 maternal deaths in 100 000 live births by 2030 (United Nations 2015). Therefore, Zimbabwe requires strategies to reduce the MNIMM. Nationally, little is known about the lived experiences of women who reside in resource restricted high-density urban suburbs, regarding the QOCS they receive. One rural qualitative study was carried out by Mathole, et al, (2004) that looked at pre-natal care only. In the study it was believed that pregnant women were vulnerable to witchcraft during the early period of pregnancy. They concluded that whether in its traditional or new form, prenatal care ignores the experiences and views of women and the way they make sense of pregnancy and the care received. This study explored the lived experiences regarding the quality of obstetric care received with a view to address MNIMM.

Despite the government's effort to adopt the MDGs and the SDGs to curb the MNIMM, women and their babies continue to die especially in SSS countries, including, Zimbabwe, (Alkaemia, et al 2015; Nicholas, et al 2015). According, to WHO, (2009); Human Resources for Health Services Profile, (2009) in Zimbabwe in 2008, 65% of health care services were provided by the public sector. Sadly, the severe social and economic challenges since that time have resulted in an unprecedented deterioration of health care infrastructure, loss of experienced health sector personnel and drastic decline the quality of care given. Additionally, most of the adults in

Zimbabwe are not employed they live on vending and survive on a dollar a day income which is below the poverty datum line, as posited by the Zimbabwe Consumer Council statistics, (2010); Gundani H.V., & Mutowo, J., (2011:15-19). These harsh realities are now a common feature in both lower and higher income countries hence the high MNMM as already referred to earlier on.

Furthermore, from the literature reviewed, it appears there is no systematic framework currently available in most maternity care centres in the city of Harare which can be used to guide and ensure QMC provision. Additionally, at the time of this research study, health care continued to be compromised in the country because of the socio-economic environment that prevailed. The country continued to operate with financial constraints and restricted budgets. Unfortunately, these economic hardships are not peculiar to Zimbabwe alone but it has become a global and regional problem.

Women of childbearing age living in resource restricted urban settings could also have failed to access this care because of the challenges around structure that is dilapidated and unmaintained buildings forcing some clients to seek services outside the catchment area. This could bring unnecessary stress or subject them to verbal or physical abuse which has become a common phenomenon in maternity. Little empirical -evidence is documented on OC in patient -experience exit surveys from the users themselves. The purpose of this study was to explore and understand the lived experiences of women of the QOCS provided by midwives. Aligned to the purpose of this study was the need to develop a model of care to help address any emerging health needs from the experiences of the women which could add knowledge and practice to the nursing /midwifery discipline on the now common feature abuse and disrespect of childbearing women.

1.3 Study Significance

In Zimbabwe, most studies on women and QOCS are conducted in rural areas, Mathole, et al , (2004) and they have contributed to knowledge on the utilisation and provision of prenatal care component, but fell short of putting emphasis on women's experiences of the care they received intrapartum and postpartum. Conducting this study in resource-restricted urban settings might shade some light on how these women view QMC provided to them at all levels of care.

It is hoped the study might provide a reservoir of new knowledge and theory for the Ministry of Health and Child Care, Nursing and Midwifery and the Health Care Providers in both private and public sectors to improve on the quality of care. To academia, the gained new information from the women's experiences extends field of research using the findings from the study and existing literature (Sil al SP., Penn-Kekana, L., Harris, B., et al (2012). Additionally, the findings might add new knowledge regarding women's perceptions of MC to the existing body of knowledge. Also, the women's narrations might incite researchers to re-think about the realities on the MC afforded women to ensure more efficient use of resources to improve outcomes. Lastly, the findings might avail some useful policy and educational insights on the QOCS to policy makers to engineer better management of complications of pregnancy such as puerperal sepsis in similar settings, globally, regionally and locally to reduce MNIMM.

1.4 Research Question

What are the lived experiences of women of the QOCS provided by midwives during pregnancy, childbirth up to ten days postnatally at Mabvuku Polyclinic and its maternity clinic and Satellites in Harare's eastern district.

1.4.1 Sub questions

1. What are the women's perceptions of the provision of QOCS during pregnancy, childbirth and post-natal up to ten days?

2. What are the socio–economic, cultural and religious issues regarding the access of QOCS during pregnancy, childbirth and ten days postnatally?

3. What model of care can best assist in addressing any emerging gaps?

1.5 Research objectives

1.5.1 Main Objective

To explore the experiences (perceptions) of women while seeking and accessing QOCS during the pre-natal, labour and birthing and post-natal period up to ten days.

1.5.2 Specific Objectives

1. To explore the lived experiences (perceptions) of the women regarding QOCS during pregnancy and childbirth up to ten days post-natally.

2. To explore the socio–economic, cultural and religious factors regarding the QOCS during pregnancy and childbirth up to ten days postnatally.

3. To develop a model of care.

CHAPTER 2

LITERATURE REVIEW

2.1 Quality care

Quality obstetric care is therefore, focused on maximising uptake which is in other words, the effective provision of maternal child health services (MCHS). It is the best QOCS rendered to childbearing age women in order to produce a well mother and infant for the development of a healthy nation. At most times this care might be given without the consent of the user simply because that is what is available. Conversely some care given might be very good and could only be received with gratitude by the user. It is through the exploration of the women's lived experiences of the OC that we can get an understanding of perceptions of this care. In eliciting these perceptions, it would then be possible to craft a model of care that might assist to systematically deliver care that satisfactorily addresses the needs of the users who are childbearing women in this study.

In some low -income communities, women are not even aware that they should participate in their own care or let alone talk about the care they receive, instead they submissively wait for the outcome of pregnancy, putting their trust in the attending health care workers. Furthermore, QOC is hence care provided by a knowledgeable, competent and skilled midwife /obstetrician in an enabling environment that has adequate supplies including blood, functional equipment and availability of transport to a birthing centre and to a referral hospital as suggested by WHO, (2010 /2012 /2014). Homer, et al (2012 /2014) perceive it as care where the physical and human resources, cognition, respect, dignity and equity and emotional support are availed to the women during pregnancy and childbirth. Renfrew, et al (2014) describe quality MC as a care that is associated to a health care system -level shift from maternal and newborn care focused on

identifying and management of pathology for minority to skilled care for all. It is also tailored to a protective and helpful care that works to reinforce women's competences in the context of warm and reciprocal relationships that are tailored to meet the women's needs. It also focuses on the promotion of normal reproductive, processes and management of complications and accountability to emergency treatment. This was the focus of this inquiry to add information and close a gap of knowledge that might arise regarding the quality of care, level of abuse and disrespect gleaned from the women's experiences and share with other countries in similar situations, globally and regionally.

Ahmed, S., Byant, LD., Tizto, Z., (2012) also supported approaches that are clientele centred that can facilitate the avoidance of stereo -typing and that can remove the element of guessing the reasons for women's wishes. The use of data collection and triangulation that is the use of the interview guide, focus group discussions (FGDs) and individual in -depth interviews allowed women different platforms to express their views on OC received. The triangulation of methods in qualitative research is a validation tool of the findings. It is the reason why these methods were used to validate and make the findings authentic for study rigor and trustworthiness, (Patton, 1999). This is corroborated by Osariemen, A.G., (2011); and Hutchinson, P.L., Do, M., Algha, S., (2011) in their findings. These, researchers used quantitative methods to assess quality. In noting the limitations of their study, the researchers could have noted the effect of social desirability as it was quite possible for women to withhold experiences that they felt were untoward. Also, Hadjigorgion, et al., (2011) and Kruk et al., (2017) in their studies, used a client–focused method to depict the views of the participants to give them a chance to express themselves fully as they searched for meaningful data on the women's perceptions whose findings would be transferable and thus perceived by the quantitative researchers as a limitation, because they lack the quality

of generalisability according to them. Perceived QOC can be assessed subjectively using the qualitative approach such as participant non–participatory observation, analysis of formal complaints or through an analysis of formal complaints or a participatory inquiry such as a phenomenological inquiry (Morrisey, G., et al 2006; and Gundani, H.V., Zvinavashe, M., Chidara, M.P., Gwanzura, L. (2016) share similar sentiments.

Quality being a sensitive and elusive aspect, might require an approach that can extrapolate information in a manner which can allow participants to talk, hear themselves and express wholeheartedly their experiences. Hence, the choice of a qualitative inquiry which has properties that allow discussions from the heart and mind and encourage participants to have freedom of self-expression and understand the investigator's drive for insight into their experiences as they sought and received OC. Phenomenologists Husserl, E., (1936 /1997), and nurse researchers, Streubert, H.J., & Carpenter, D.R., (2007/2011) promote the use of such an approach for rich data collection for humanistic imperative.

Most Standards of QOC are at most times set by health care managers and care providers. Although, several policies and guidelines to ensure QOC are available, the extent to which they are adhered to is not well known in some low income /middle states with resource limitations in Nigeria, Uganda, Burkino Faso, Zimbabwe included, (Uzochukwu, B.S., Onwujekwe, O.E., Akpala, CO., (2004); Hutchinson, (2011); Emelumadu, et al, (2013). These authorities also reported that several clients in the mentioned settings are not well informed and might be unaware about issues of their health, therefore, often feel that they are not in a good position to influence the type and quality of services they receive even if their expectations are not met. This partly makes QOC elusive. Maternal mortality is an indicator that measures a country's health performance and currently MM, in both well and poorly resourced countries is unacceptably

high, (WHO, UNICEF, UNFPA, World Bank, 2012; Nicholas, et al 2015). Countries such as Brazil and China have reduced MNMM because of aggressively reintroducing midwifery performance to better the care, (Eleore, D., Orsi, E., Bruggemam, OM., et al 2013). This prompted the birth of this inquiry to gain insight on the women's perceptions of care received to include eliciting aspects of dissatisfaction with the care from the heart, so as to enable the filling-in of a knowledge gap in midwifery caring.

Alkaema, et al., (2015) noted that about 830 women die from pregnancy or childbirth complications, daily, worldwide with 201 000 (66%) in SSA (WHO Maternal Mortality, 2015). In the same report, in SSA, a number of countries, Zimbabwe included, halved their levels of MM since 1990 and there has been a significant decline in most countries.

Zimbabwe, a country with a population of 13 million people, affected with a high MM, adopted MDGs at the turn of the century in order to realise a decline in its MNM rate. It has now rallied behind a new target to reduce maternal mortality and has embraced the Sustainable Development Goals 3.1 &3.8. (United Nations, 2015). In order to reduce the one woman out of 48 deliveries incidence in lower income countries at risk of maternal death as compared to 8 in 100 000 deliveries to a pregnant woman in Australia, (AIHW, 2016), Zimbabwe needs to take aggressive action focused on maternal and child health to meet the agenda of health promotion to enhance progress in the reduction of MM and peri–natal mortality (PNM) which could be attributed to various factors, namely, staff attitudes, staff competence, shortage of medical supplies and equipment and staff morale as alluded to by WHO (1996/2010/2014).

2.2 Health care delivery system

Health systems service delivery is a determinant of QOC. These systems are expected to be people oriented and well -integrated with critical health services to reach universal coverage. For this care to be people- centred it needs to be focused and organized around the health needs and expectations of the people and communities not to diseases, (WHO, 2006). Most governments globally and locally endeavour to meet people needs both physically, psychologically, socially and spiritually as they try to protect childbearing women from harm during childbirth as espoused by the White Ribbon Alliance (2011 /2013) in their facilitation of the Respectful Maternal Care Charter. A global consensus statement on a positive vision for respectful maternity care with the following definition of disrespect and abuse and the corresponding rights, (Hastings, 2016), noted that the rights are anchored in the United Nations and other international commitments signed by most governments including Zimbabwe. The abuses are; non-consented care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific attributes, abandonment or denial of care, and detention in facility. This study could be the first to contribute this emergent phenomenon on abuse and disrespect in Zimbabwe and could add to existing knowledge globally and nationally.

The government of Zimbabwe, for instance, put in place a blueprint for Maternal and Child health to ensure supervised home and institutional deliveries; provision of postnatal care; child growth and development monitoring; specific education on care of nutritionally at risk young children 1-4 years, immunizations; child planning and family planning; provision of health education directed at mothers and girls; provision of referral mechanisms to screen complicated or serious cases to get specialized care and compilation of MCHS statistics for program monitoring, (Minister of Health and Child Welfare 2009 -2013). Weaknesses within the delivery

system are revealed in several studies it was important to hear the experiences of the women to add to existing information on QOC where little is documented.

There is a disparity in the provision of care, where in rural settings world-wide most women are attended to by unskilled birth -attendants compared to those from high income-settings (ZIMSTAT &ICF International, 2012). This means that millions of births are not assisted by a midwife, a doctor or a trained nurse (WHO, Maternal Mortality, 2015). WHO standards require OC needs of being safe, effective, timely, efficient, equitable and client -centred to guide care (Tuncalp, et al 2015). The same authorities say the access to a health facility is a hallmark of quality care and is an indicator of equitable distribution of the national resources. Furthermore, better outcomes of maternal and child care are associated with expert practitioners at all health care levels where an enabling environment exists. Staff compliments are therefore critical and need constant monitoring to ensure best care delivery. These standards concur well with the stipulations of the Hulton et al., 2007 model in use for this study.

A study that was conducted in Bethesda in the USA by Bowser & Hill, (2010 /2013) revealed that there is evidence of disrespect and abuse of women during childbirth. In the same light, studies on user perspectives of healthcare services undertaken in Nepal facility based cases by Karkee, et al (2014), revealed that the quality factors pertinent to public hospital clients included attitudes, interpersonal and technical skills of service personnel, and the findings included negative experiences by women seeking maternal health as also supported by Rao, K.D., Peters, D.H., (2017) reported that women responded negatively to the provision of equipment, resources and staff compliments in the health centre. Similar studies that were conducted in Vietnam by Duong in (2004), and in Ghana by D' Ambruso et al, (2008) and in South Africa by Chadwick, R., Cooper, D., Harries, J., (2014) revealed that the women also responded negatively to the provision of

equipment, resources and staff competency aspects that can lead to mistrust in the care being rendered in the health centres. It was the researcher's interest to explore the perceptions of the care users to fill in the identified needs from the findings and possibly share with other countries with similar situations, globally, and regionally.

2.2.1 Resources

A systematic global review by Silal, SP., Penn- Kann, L., Harris, B., et al, (2012); Crissman, HP., Engman, CE., et al (2013) that revealed that resources have an impact on the delivery on the of QOCS, the findings expressed that both the women and the care providers saw staffing constraints as having a bearing on the provision of the care. They further stated that staffing shortage can lead to long waiting times and neglectful poor quality care resulting in providers being overworked, too busy, stretched and paid inappropriately, compromising QOC. Studies conducted in Tanzania by Kruk, M.E., Paczkowski, M., Mbaruku, G., et al., (2009; Kruk, ME., Kujawski, S., Mbaruku, G., et al, (2017: e26-e27); during facility deliveries reported that women can be affected by health care system factors such as a respectful provider attitude, competency to include culture-competency and availability of drugs and medical equipment. In 5 districts of Rural Zimbabwe, a study executed by Dodzo MK, Mhloyi M (2017) to explore some of the reasons why community deliveries are getting more attractive and being preferred by women. The study findings revealed that unskilled birth attendants, whose culture and spiritual beliefs, augur well with women at affordable cost; although Zimbabwe outlawed them, they are still in practice. The use of the Southern Relational Path Lessem &Schieffer, (2010 2014) model in this study would undergird an appreciation of the cultural component of maternity care needs of the women. Quality therefore requires exploration to hear from the users the thrust of this inquiry and add to existing information for improved uptake and quality.

2.2.2 Organisational policies

Jewkes, R., Abrahams, N., Mvo, (2015); Chadwick, R., Cooper, D., Harris, J., (2014) in South African studies point on how women lamented on the lack of a redress or accountability mechanisms to lodge complaints to the provision of care during childbirth. Funding can contribute heavily on the delivery of care as well as regulatory systems may hinder access and affordability, (Akafor, 2015; Egeonwa, 2014; Izugmbra, 2017). It was of interest to establish the views of women in resource limited settings on the impact of policies to speak up about their concerns regarding the care they received in order to improve it. Bohren, et al (2017) in their study alluded to the difficulties women had to express their opinions about the treatment for fear of unfair handling or discrimination. For QC to be ensured, hospitals or clinic managers should put in place mechanisms that allow women to talk about poor care to safeguard quality and better uptake at most times.

Sunhinraset, M., Treleaven, E., Melo, J., et al (2016); Mengistu, et al (2017); Jay, A., Ray, A., (2017); Day, A., Shakya, HB., Chamborkar, D., et al (2017) reported that issues of mistreatment in facility context could lead to low expectations among women to receive high QOC. They further highlighted the importance of understanding the challenges that women may face across the structure, staffing, supply chain and procedural processes that can offer useful interventions to improve the overall provision of QOC. It became imperative to establish the lived experiences of women as they sought and received QOCS through listening to the women's views and allowing them to talk from their hearts and minds for meaningful data. These data could become building blocks in creating a model of care that might systematically address their care needs. Also, it can add knowledge on reasons for poor utilization of health facilities in preference to traditional birth attendants (TBAs).

Furthermore, in a study carried out, by Nyirenda, HT., Mulenga, D., Nyirenda, T., Chok, N., (2018 DOI:4172/2090-7214), in Ndola and Kitwe towns, revealed prominent issues that can lead to ill -treatment. Included were 45% of the women who were not provided comfort /pain relief. Seventy four percent 74% of the women indicated that the service provider did not allow them to assume position of choice during childbirth. Twenty -two 22% of the women' rights to confidentiality and privacy were not adhered to 39% were abandoned or denied care and 65% were left unattended and 28% of the service providers did not respond in any kind way, and 6% were delayed in health facility. These shortcomings have an indictment on QOC and are serious barriers to QOC. This points out on what goes on in MC settings hence the high MM.

Further, a study done by Kikumbai, L.W., Makokha, B.A., Makolwe, et al., (2006) in Rekai district Uganda, a lower income country, revealed that some midwives were perceived as uncouth and unprofessional as they were said to be offensive to women if they reported as an unbooked status, or if they had multiple pregnancies. Maternal health services (MHCS) have done trainings to curb this behaviour but little seems to change. It became necessary to explore women's views about their experiences with OC where little empirical -evidence is documented, with a view to develop a model of care that would address their concerns.

Akafor, et al (2015); Ezeonwa, (2014); Izugumbra, (2017) in their Nigerian studies reported these barriers to QOCS; abuse and mistreatment, funding constraints, shortage of skilled birth attendants (SBAs), poor regulatory systems, poor access and affordability. Zambia, Nigeria and even well -resourced countries such as USA, UK, Sweden are now reporting financial constraints, shortage of skilled birth attendants (SBAs) which can lead to failure to put up effective interventions to correct the staggering high MNMM. Additionally, Asafa, A., &Bekele, D., (2015; doi.10.1186 512978) reported in their Addis Ababa, Ethiopia study on the violation of the

rights to information, informed consent and choice preference of position during labour. This, inquiry sought to establish what obtains on the ground in urban resource restricted settings in Zimbabwe. Therefore, this calls for the need to explore the lived experiences (perceptions) of women where little evidence is documented in an effort to improve QOCS.

2.2.3 Obstetric care practice

In the matrix of providing OC it is critical that the care provided is of an acceptable standard agreed upon minimum standard (agreed upon minimum levels of excellence) so that the best possible outcome is achieved in light of the resources available. Client -centred approaches that can facilitate the avoidance of stereotyping and that can remove the element of guessing the woman's wishes should be the driving force when providing OC. It is also significant that clients are reluctant to criticise their caregivers immediately after receiving the service noted by Collins &O'Collain, (2003). A study conducted by Green, K., Schellenberg, J., Pfeiffer, C., et al., (2012) on the integration of women's views into maternity care research and practice used an exit poll approach, which in simple terms sees women's views only as an outcome and fails to recognise that women have views throughout their maternity experience. Open interactions with the women are important to allow the researcher to hear the client's perceptions, wishes, values and beliefs about the OC provision. This study used an interview guide, FGDs and Individual-Indepth-Interview (III) guides to allow one to discuss the mentioned values which should underpin decision for this particular concept on QOC.

Ahmed, S., Bryant, L.D., Tizto, Z., et al., (2012) also, supported approaches that are client– centred which can in turn facilitate the avoidance of stereotyping and that can remove the element of guessing the reasons for women's wishes. Additionally, Collins & O'Cathain, (2003) are of the opinion that clients are reluctant to criticise their caregivers immediately after receiving services.

In this study the women were interviewed three to ten days after they had received the care in question, making it comfortable for them to express their views and values with ease as they experienced obstetric care without compromising recall. This study which is focused at allowing the participants to talk and express their views on the OC rendered from the pregnancy and childbirth was poised to gather useful information concerning the QOCS given.

In studies conducted in both India, Nepal and Vietnam by Ray, et al (2017); Karkee, et al., (2014); Duong, D., Binns, C.W., Lee, Hipgrave, D.B., (2004), respectively to assess the perceptions of women of maternity services health facility; health care delivery; and interpersonal aspects. Their results concluded that the women observed mistreatment, poor relationships between the women and care -providers, the shortage of equipment and skilled health personnel as they sought OC. The women in India, Guatemala, Dominican Republic and Cambodia were mishandled and exposed to discourteous treatment (Hulton et al., 2007), Guatemala, (Berry, N.S., 2008), Dominican Republic (Foster, J., Burgos, R., Caceres, R., et al., (2010); and Cambodia, (Ith, P., Dawson, A., Homer, C.S.E., 2013). Contrariwise, after delivery, the women reported satisfaction with the quality of care they received.

Staff incompetence can cause harm and can increase the incidence in INCMM if procedures and treatments are not executed according to laid down standards. D'Ambruoso, L., Abbey, M., Hussein, J., (2008); and Hulton, et al., (2000.2007) had findings that pointed to the negative feelings the women had about the care provided to them. One could argue that these respondents were able to bring up the negative treatments they received because they were offered a platform that was conducive and less threatening, so they could say even the bad treatment they received.

Furthermore, failure to provide the expected standard of care could have caused clients to choose alternative health care centres as expressed by (Hutchinson, P.L., Do, M., Algha, S., 2011).

Although some argue that both methods, that is the objective (quantitative) and subjective (qualitative) approaches or by assessing the supply and demand component of the health care services, have potential to produce required knowledge, patient perception of QOC remains the major determinant of uptake of MC. Uzochukwo, et al., (2004) reported the same view in their community satisfaction survey with the quality of maternal and child health services (MCHS) in south east Nigeria. Additionally, Afulani, PA., Kirumbi, L., Lynbon, A ., (2017) in another study that analysed aspects that make or break facility -based childbirth experiences in western Kenya point to relations between the healthcare worker and the client, provision of resources, provider competency, communication that is clear and informative to allow decision making was important.

In other words, a positive client perception of the OC and the nurse/midwife skills can increase utilisation of the delivery and uptake of QOC.

Compromised care can further translate or refer to the structural problems which could exist where facilities could be in dilapidated condition, equipment could be malfunctioning or not available; drugs and medical supplies could be out of stock making treatments very difficult to administer; staff could be demotivated because of shortages and poor working conditions; further personnel could be incompetent because of lack of in-service updates as corroborated by the findings of the Zimbabwean study by Zakeyo, G., (2016).

In the provision of care mishaps can occur. In a study conducted in Accra, Ghana which is a lower income country like Zimbabwe, Tuncalp, O., Were, W.M., MacLennan, C., et al., (2015) reported that women experienced negative treatment from maternity care providers which led to severe maternal complications. Some of the women in the same study reported that the problems they faced involved inappropriate diagnosing and management, for instance a patient presented with vaginal bleeding and was thought to have a pelvic infection but was later found to have an ectopic

pregnancy which is implantation of the ovum in the fallopian tube. This is one of the OC emergencies which had been missed because of knowledge and skills deficiency. Another patient in the same study had a pelvic infection as a consequence of an untreated retained placenta, (Tuncalp, et al., 2015). Additionally, in the same study, a woman who started to have established uterine labour contractions at 36 weeks which were mistaken for Braxton Hicks contractions (false labour contractions), ended up delivering a premature baby when the midwives were not ready for that delivery. Although some of the women felt traumatised by their experiences with HCWs, expressions of thanks were not uncommon among some of them. The afore-mentioned findings point to care provider skill/knowledge deficiency that can interfere with QOC because women might fail to get expert detection and treatment of risk factors such as antepartum and postpartum bleeding.

In Zimbabwe, Zakeyo, D., (2016) conducted a comparative study of the quality of maternal health services provision in church mission and government hospitals – the case of Harare Central and Karanda hospitals. Of note the researcher found out that women bypass government hospitals in preference of church mission hospitals where they expect more positive health outcomes for themselves and their new-borns. The quality of maternal health services is said to be better at mission hospitals. Factors mentioned by the participants as constituting quality are the ability of service providers at church mission hospitals to manage complications and availability of skilled local and expatriate doctors; short waiting periods; and availability of essential medicines and equipment. Little is documented on how the women in Zimbabwe's urban resource-restricted areas do perceive the technical expertise of the providers of the OC.

2.2.4 Information processing

Communicating accurate information to clients is essential to quality care. It covers the care providers' communication styles, which advocates the giving of robust and accurate information to avoid ambiguity in the process as postulated by Hulton et al., (2000/2007); Smith, DM., Roberts, (2009). A systematic review by Homer, C.S.E., Kennedy, H.P., Matthews, Z., & et al., (2014) on the QOCS women received noted that compliance to instructions was valued higher than their dissatisfaction with explanations proffered by health workers. Unclear interactions may cause misunderstanding between the client and the provider resulting in a negative outcome. Another systematic review on QMCS revealed that women were often dissatisfied with the explanations from health workers regarding their care and the women believed care providers were not interested in their compliance rather than answering or clarifying proposed procedures, (Homer, et al ,2012/2014); A global health taskforce alliance case study (2008); Koblinsky, M., Moyer, CA., Calvert, LV., (2016). These authors posited that education and culture have been instrumental in strengthening of heath care system, thus, making the use of the Southern Relation Path Lessem &Schieffer, (2010 2014) model ideal for understanding culture competencies in thoughtful experiences of women seeking OC.

A study conducted by Waldenstrom, A., Rudman, A., & Hillingson in (2009) in Sweden also expressed similar findings in that the respondents were not pleased with the providers' way of communicating instructions regarding their treatments. The risk factors were not explained to their understanding which left them with little information to deal with the challenges they met during the intrapartum and post-natal care periods. The study in Nepal quoted earlier, by Karkee et al., (2014) highlighted issues concerning interpersonal relationships and poor communication that could cause barriers to seeking quality obstetric care.

Poor QOC provision has become a health concern because the lack of quality care or its delay can compromise a positive outcome for the mother and her baby. A first timer mother in a study conducted in UK, (1998) narrated that her vital signs were not checked in the first 24 hours. She further stated that the advice received from a male nurse on feeding her baby was done hurriedly. She left the ward not knowing how to position her baby for breastfeeding. The status has since changed, a statistical release survey, (2013), (66%) of the women reported to have received better information and explanations on breastfeeding after birth in England. However, little is known regarding QOCS in resource restricted urban settings, nationally and to develop a model of care to address needs of women which might help to create the desired quality of care.

2.2.5 Respect, dignity, equity and autonomy

Respect, to include dignity, equity and autonomy is seen as a critical component of care that allows women access to their socio cultural-religious needs if a conducive environment is provided. This in turn is believed to help women cope with the burden of the ailments, as well as the aches and pains of pregnancy better, which resonates well with the Southern Relational Path, Lessem &Schieffer, (2010 2014), the study secondary framework that is anchored in the nature, environment and community; and Human Resources Health Profile, (2009). There is no documented evidence for the resource restricted settings in Zimbabwe, hence the interest to explore the women's perspectives. Amin, et al., (2010) found out in their study that within rural areas of Bangladesh, where overall poverty is greater and access to health care more difficult, wealth differentials in utilization remain pronounced. Further, insensitive treatments, poor standards of confidentiality, lack of tactfulness and poor judgements by carers are all elements of poor quality documented by numerous researchers (Finnerman, 1983; Wadersterham, &Moore, 1990; Asafa, A., Bekele, D., (2015); Mengistu et al (2017).

As rudeness of the midwives could have affected the care rendered to the women in Nepal, the following researchers (Clapham, S., Polcharal, D., Bird, C., 2008:197) concur with this outcome noting that care in public hospitals is compromised by a poor nurse-client relationship. In as much as the health-care providers endeavoured to maintain the women's self-respect, it was against the background of catering for large numbers done by fewer nurse/midwives.

Numerous instances have been cited during labour and birthing too, where staff can fail to treat women with respect and dignity. This includes the compliance in maintaining her discretion and self-respect during physical examinations, during pre-natal care, early and late stages of labour and birthing. Also, women's privacy in birthing centres need to be respected at all times, as suggested by WHO, (1996b;2015); and Safe Motherhood Initiatives, Fact Sheet, (1998 /2008 /2012/2013). Insensitive treatment, poor standards of confidentiality, lack of tactfulness and poor moral judgements by health care providers are all elements of poor quality documented by numerous studies. Women's experience of the care was also noted Nyirenda et al (2017); Dey et al (2017) echoed similar findings. It became prudent to explore and hear from the women whether the midwives respected and offered them privacy and dignity while they sought maternal health care during pregnancy.

2.2.6 Emotional support

Women throughout pregnancy, and childbirth require emotional and supportive care which could encompass spouse's presence, demonstrating an effective caring attitude, possible and calming verbal expressions and non–verbal expressions, distraction and use of humour. This could be missing at most times because the care givers have too many activities to carry out leading towards inadequate OC. Also, at risk of being compromised is the information and advice given, instructions on breathing and relaxation, information about routines, procedures and progress. A

global systematic review carried out by Crissman, H.P., Engmann, C.E., Adanu, R.M., et al, (2013); Barrett, SJ., Stark, MA., (2016) revealed that women echoed that staff shortages can hinder the provision of QOC that is empathetic, warm and caring.

Additionally, studies conducted in Ghana, a lower income country by Moyer, C.A., Adongo, P.B., Aborigo, R.A., et al., (2014) revealed that women were mistreated during childbirth. They stated bad language, shouts and beatings. It was appropriate to discover how women of childbearing age in a Zimbabwean context viewed the care they received from midwives. Further, an investigatory study conducted in a village in Rajasthan in India (Hulton et al., 2000) produced anecdotal evidence from in-depth interviews that perceived villagers as dirty and ignorant of modern ways in government hospitals. An analysis is given of a woman and her attendants who were found to feel uncomfortable in the hospital and they also, reported feeling insulted and ignored. Most of the users of OC are mainly women who in reality, play a pivotal role in defining and assessing QOC because they decide whether to go for care based on their opinions, previous experiences with the health system and/or those of people they know. But little is known about women's views in urban resource-restricted settings nationally. Data obtained will help build a model that might systematically address the women's needs.

Support in the form of comfort, reassurance and a mere praise during childbirth is extremely beneficiary. This was also reported by Thonnea, PF., Matsudai, T., Alihonou, E., et al., (2004), in an African multi–centre hospital-based study. These mentioned researches done on MCSs have concentrated more on the component of maternal health quality of care which Hulton et al., (2000) described as institutional to include the professional's performance, perhaps, it would appear there is a need now to hear more from the users' perspective using qualitative inquiry which is seen to be effective. Women and their families often decide the location for childbirth based on their

views, evaluations and experiences with the MCS to a greater extent and Hulton's framework that guided this study highlights on what women consider as QOC.

A study conducted by Mbaruku, (2014) in Kigoma, Rwanda, and a study by Thonnea, et al, (2004) both reported that poor–provider attitudes towards clients influenced the pregnant women's low compliance to a referral hospital and if not managed well had the potential to affect utilisation and uptake to a great extent. Also, a study conducted by Mpembeni et al., (2007) in southern Tanzania determined the skilled care rendered to women during labour as an implication assessment for the MDGs - 3, 4, & 5 targets, where the main focus was to develop strategies to curb MM &NICMM but by 2015, the evaluation year of these MDGs, little progress had been reached and little research had been documented. In the same vein, studies conducted in Zimbabwe by Munjanja et al., 2007 and The Zimbabwe (NIHFA, 2012) in the (MNHS) QOC was singled out as inadequate in birthing centres and family health centres. These studies reported mainly on the (MCNMM) attached to vital services that facilitated the achievement of the country's MDGs 3, 4, 5 and 6 promulgated by the United Nations, (2014). These goals were critical elements in ensuring QOCS as well as the reduction of MNCMM, and pregnancy related complications such as Malaria in pregnancy in women of childbearing age during pregnancy, at birth and after delivery as suggested by the United Nations, (2014). However, by the end of 2015 when the MDGs expired, much work needed to be done, as little research had been done in the country's urban settings to establish the QOCS. Currently the Sustainable Development Goals are the blueprint to achieving a better and more sustainable future for all and maternal health is addressed by Goal number 3.1 & 3.8 (UN Sustainable Development Goals, Agenda 2030).

2.3 Pre-natal Care experiences

Prenatal care or antenatal care is a preventative health care for women of childbearing age to avert any complications. The goal is to provide early bookings and regular follow -up visits for better care to prevent and treat potential pregnancy related complications. It is also focused at the promotion of healthy life-styles that are beneficial to both mother and baby, (Medicine net, 2012). It is time to receive information on pregnancy, biological changes, nutrition, breast care and breastfeeding, family planning, immunisations, screen any medical and obstetric complications, puerperal sepsis, reduce maternal deaths, low -birth weight babies, neonatal infections and other ailments to the baby.

Also, pre-natal care is at most evaluated only through the number of visits. Its content, if evaluated at all, is assessed with a simple checklist of interventions. Its content is potentially limiting the extent to which pre-natal care can address a pregnant woman's general health and well-being. Pre-natal care (PNC) itself leads easily to the concept of wellness as pregnancy is not an illness or disease state; it should rather be seen as an opportunity for nursing interventions that are client empowering to facilitate self–care which can occur through a group talk approach.

A model focused at lower to middle income countries that included only evidence based high – quality interventions delivered through fewer pre-natal care visits than the traditional model which is now known as the Focused Antenatal Care (FANC) was conducted to establish its usability by WHO, (1996b;2015). The protocol included information on standard medical care to be provided to all pregnant women, including guidelines on additional care and treatment for those that needed it. This WHO model facilitated increased access to the pre-natal care, but little is known about the quality of care provided. In a study conducted by Fekede, B., Mariam, A., (2007) in Ethiopia in Jimma town where, high pre-natal care attendances were reported but subsequent visits were

inappropriate in most cases as majority of the pregnant women booked late, around 7-9 months implying that there was reduced first and second trimester care. Improving the QOC was seen as critical by this researcher through giving the women a platform to air their views where little is documented. Further a few indicators have been developed and validated and those that exist are inconsistently measured. Hence, the need to conduct this study to explore the views of the women about the FANC or Goal oriented antenatal care (GOAC) the Zimbabwe term used by Munjanja, S.P., Lindmark, G., Nystrom, L., (1996) in their randomized controlled trial of reduced–visits program of antenatal care in Harare, Zimbabwe. Also, Raan, F., Sing, A., (2006); questioned the effectiveness of antenatal care in the improvement of maternal health which was the focus of this study.

Studies carried out in Oman in the middle-eastern Asia that also looked at the perceptions of pregnant women who had come for antenatal care as reported by McEwen & Wills, (2007); Ghobashi, M., & Khandekar, R., (2008) to establish their views about this care as well as to strengthen the importance of this study where little has been done. The potential benefits of quality pre-natal care and post-natal care go beyond pregnancy and childbirth. With pre-natal care often being the first point of contact women have with the health system it increases access to high–quality and well-coordinated care during this time can encourage future health seeking behaviour. In addition, putting pre-natal and postnatal in the context of the broader reproductive health services is likely to ease access to other services including family planning, detection of gender-based violence (GBV) to reduce MM. Considering the urgency of improving the quality of maternal and new-born health care and the limited documentation in this area this far, their study focused on determining and exploring the factors that influence the provision of pre-natal and post-natal care in terms of improving access and to draw potential generalizable lessons from them. The

experiences reported that might be shared by the participants were seen as a basis for new theory development in the country and could facilitate the production of recommendations for future programs. How the women in this study perceived prenatal care would contribute to the existing knowledge on prenatal care.

2.4 Labour and birthing experiences

Labour- and- birthing is a process of the delivery of the baby, placenta and membranes and the umbilical cord in order to empty the uterus through the vagina out to the outside. Two stages occur in the process the first phase is the cervical dilation up to ten centi-meters. This is the delivery phase or parturition and childbirth, (MD. Shiel, WC, 2012). Information on the third stage of labour management and blood loss is at times not communicated to women in a normal delivery. If it is not done properly it can undermine her confidence, influence her attitude to future childbearing and delay her recovery post-delivery (Carvalheira, A.P., Tonete, V.L., Parada, C.M., (2010); Fraser, Cooper, & Nolte, (2010); Sowastava, A., Avan, BT., Rry, Bangsler, P.,et al (2015). It was also noted that in the labour and birthing period the incidence of high MM still occurs, and the incidence of low birth weight babies can be as high as 30% per 1 000 live births in developing countries which includes Zimbabwe. It is a health challenge because premature births result in complications that can cause high NICMM, which cannot be dissociated with the care of the pregnant mother herself (Piekala, et al., 2014). Hence, the exploration of women's experiences during labour could add on new knowledge on the care offered to them. Reduction of Pregnancy Related Complications through affording the women a platform to express experiences is made possible by producing a model of care from the data collected directed to address their care needs.

Many young women require support from healthcare professionals during pregnancy, labour and birthing and the post-natal period to enable them to go through this process which is a complex

journey that requires accurate information for optimal care for themselves and their babies to reduce complications. Smith, D.M., & Roberts, R., (2009) alluded that women need maximum support as they go through childbirth if their cooperation is recognised. Additionally, studies conducted in Bolivia on maternal seeking behaviour for near–miss morbidity revealed women's views on how social differentiation was embodied in the care rendered to women in a lower social class as reported by Roost, M., Jonsson, C., Liljstrand, J., et al., (2011) in their Netherlands study on immigrants stated that some of the women lacked important knowledge about signs of pregnancy, which could be an indication of susceptibility to complications related to pregnancy. Some felt that they were not in acute danger to seek immediate obstetric/medical attention which can lead to failure to seek help for the complication regardless of the nature and severity; hence the birth of this study using FGDs and individual in-depth interviews for rich data on the phenomenon QOC, as experienced by women was essential.

In addition, Campero, L., Garcia, C., Ortz, O., et al., (1998;2006) reported that Mexican women complained about vaginal examinations being performed with a sense of shame. A first-time mother for instance explained how she experienced such an examination for the first time. This participant's excerpts explained what she went through during the vaginal examination as making her feel strange and she was unhappy that this was not done in privacy, other women watched her open her legs in their presence which was dehumanizing. Others expressed that the examinations were not done gently and caused pain. To them this was a sign of being rough. They even suggested that such procedures should be done when they were not having contractions.

In a study by Patel, B., et al, (1991; 2016) it was indicated that the common image of the hospital delivery was one in which no attendants were allowed near the labouring woman and she was made to lie on a table all by herself. They were not impressed by the way women in labour were

being treated. This further points to the compromise that can occur to women during all stages of pregnancy and childbirth. Also, study findings by Souza, et al., (2009) revealed that, women said, there were fewer care providers for many patients, and they further reiterated that the carers had better put in quality time to clients for optimal outcomes rather than do the procedures hurriedly compromising on quality which can result in complications. It was important to conduct this study to gain insight into the nature of care the participants received during labour and birthing, to get a comprehensive outlook about this care.

Regarding Maternal Morbidity, the shortage of staff mentioned earlier and non-attendance by Skilled Birth Attendants (SBA) have contributed to now the salient feature of Obstetric fistula in Africa and Asia, an ugly consequence of obstructed labour. A study done in Tanzania 2011, by medical students, mentioned that there were about 2,500 to 3,000 new cases of Vesico-vaginal Fistula produced annually with long-time suffering from psychosocial consequences and stigmatization. The women's suffering is not confined to physical discomfort only, but has a negative impact on their emotional well-being. Many of the women with vaginal fistula have had to deal with shame, embarrassment and humiliation in many societies in Africa, where the woman's social status is a lot dependent on her ability to bear children (Hsiung, J., Savbäck, S., & Oneko Olola, 2011). UNFPA country representative said efforts towards ending obstetric fistulas in Zimbabwe started in 2009 with a survey to establish the actual burden of the condition among women. In September 2015, Government in partnership with the UNFPA and Women and Health Alliance (WAHA), conducted its first ever fistula repair camp where 30 women were operated on. (WAHA) representative, whose organization, is conducting the surgeries with assistance from local surgeons said there was no reason for women with obstetric fistulas to continue leaving with the disability. Obstetric fistula is preventable but on top of that it can be

treated. However, in Zimbabwe the actual burden is not known. Hence, the need to explore the women's experiences during pregnancy and childbirth (UNFPA, 2015).

2.5 Post-natal experiences

Postnatal care is given to the mother and her newborn baby immediately after delivery up to six weeks postnally. Normally it is expected to be with no complications if the prenatal and birth phases were done and monitored properly. It becomes a very critical time to identify any deviations in both the mother and baby so as to evaluate and intervene any abnormalities on time to prevent adverse events within two days to reduce MNMM.

The content of post-natal care had not been defined and standardised until recently and there is a dearth of information concerning its implementation. Information on the number of health care visits a woman and her new-born receive are important but fail to describe whether such care can effectively address maternal and perinatal needs. Effective and appropriate post-natal care is viewed to be 'a critical factor' to assist women recover from difficult births, cope with a well or sick baby in the post-natal ward, neonatal unit or at home and a period to adjust to a birth experience which was unanticipated as stated by the (Safe Motherhood, Initiatives 1998; 2006;2014). Although its evaluation is done using attendance figures for weekly and monthly reports, but little is documented from the users' perspective using phenomenology in the study area, hence the need to conduct this qualitative study at the study sites to fill- in that knowledge gap.

The Centre for Maternal and Child Enquiries (2011) stated the factors that exacerbated the MNM in the United Kingdom among women of low social economic status. It became a good basis to study women from a low -income status such as the women in this study. Furthermore, a first timer mother in a study conducted by WHO in the United Kingdom (UK), a higher income country in

(1998) expressed her bad experiences with the care providers where in the first 24 hours in a ward no vital signs were monitored at all. A male nurse was seen to be nasty to one of the patients and drugs were thrown at the patient. She further stated that the advice she received about feeding was done in a hurry and was not clear. As a result, she left the hospital not knowing how to take care of her breasts because nobody demonstrated to her how to position a baby for proper breastfeeding. The identified problem was linked to the shortage of midwives and the lack of breastfeeding dedicated midwives. These excerpts from the UK study participants is an indication of the OC that women can receive while seeking this care which is a worthwhile cause to explore their experiences at the study sites, in resource-restricted urban area in Zimbabwe, since little is documented.

2.6 Socio -economic factors

Socio–economic factors may hinder young women from accessing MC since Zimbabwe is a multi– ethnic country in sub-Saharan Africa whose population on August 2012 was 12 973 808 of which 6 234 931 were males and 6 738 877 were females (ZIMSTAT, 2012). Seven to ten million women and girls all over the world suffer from severe or long-lasting illnesses caused by pregnancy and childbirth complications as reported by WHO, (2012 /2014). And women in depressed communities are generally marginalised and have poor access to information, lack the ability to make decisions concerning their health and sexual reproductive health in particular. Freire (2013); Dodzo &Mhloyi (2017) expressed that poverty can impact in accessing and seeking health care which can be a deterrent to QOC.

Little is documented in the country urban settings, hearing from women themselves how they manage with financial constraints. Also, a study conducted by Izugbara, C.O., & Ngilangwa, D.P., (2010:33) in Kenya depicted that poverty has adverse maternal outcomes during pregnancy,

labour, birth and post-natal. Further, Freire, (2013) in the 'Pedagogy of the oppressed', expressed that poverty can impact on a person's decision-making in the accessing and seeking of health care. In addition, Mabhalaga, N., (2000) in a study on the macro-economic policies and their impact on health in Zimbabwe in the 1980s and 1990s expressed the negative impact this had on the maternal mortality (MM) and poor access to health services for women and children. These studies point out that socio–economic factors might impact on the women's seeking behaviours during pregnancy and childbirth. In study settings, women might have failed to access QOC because of poverty which compares favourably to women that live in similar settings globally and regionally; and nationally as alluded to by Dodzo &Mhloyi (2017).

Other authors, Stenson, A.L., Kapungu, C.T., Geller, S.E., et al, (2010) also assert that reproductive health research in low resource settings create unique and complex challenges, hence the interest to conduct this study. Their qualitative study of 'Giving Birth' – The voices of Women in Tamil, Nadu – India, underscored the importance of understanding the social determinants of health, including reproductive health and quality of life. They suggested the assessment of variables such as physical, psychosocial, socio-cultural, educational and economic, because they have a bearing on the health seeking behaviours of women. The clinical implications advised that the voices of women be listened to and the following could guide clinical care as follows; recognize the importance placed on cultural rituals surrounding birth in southeast Indian women, and honour those rituals that are helpful or harmless; change harmful cultural practices such as infant smoke inhalation by educating women, making changes in their perceptions and attitudes; follow WHO guidelines (2015) for perinatal/neonatal care for achieving quality care in low resource settings was the key to the attainment of Millennium Development Goals 4 and 5 - the quality and safety of healthcare should be monitored; promote initiatives to decrease family

violence; support health policy initiatives encouraging female equity, such as banning dowries and female infanticide; and recognise the importance of food preferences and restrictions and the perceived impact on a woman's health related intake of hot/cold food items and support those preferences where feasible. This study focused on the perceptions of care users to add their responses to current MC debates globally and regionally.

Additionally, in Zimbabwe, the socio–economic challenges between, years 2000-2009 were characterised by hyperinflation and recession that followed land re-distribution which attracted international criticism and sanctions were imposed on the country. The economic crisis had a negative influence on the provision of social and health services which included the MCS delivery, (WHO, 2015; Hastings,2016). Women and children were the most affected group, people lost jobs, women were forced to do cross-border trading and vending to fend for themselves and their families. Although the country's health system received a leverage during the Government of National Unity from 2009-2013 the country was still facing numerous challenges at the time of collecting data because of the weak economy. This economic decline created the deterioration of the infrastructure, shortage of essential drugs and vaccines, medical sundries such as gloves and equipment, and staff attrition because of bad working conditions and poor remuneration, (Maphosa, F., Kiyinga, K., & Chigarande, S.D., 2001). Among all these challenges, the QMC rendered was inevitably affected. This resonates well with what is posited by the Southern Relational Path, Lessem &Schieffer, (2010 /2014) that is centred at the nature, heritage, environment and community where women and their babies live and interact with other communities, service providers as they seek and access OC.

2.7 Cultural and religious people's perspectives

Cultural and religious values underpin the delivery of QOCSs and culture is viewed as being consistent with what one has to know or believe in order to operate in a manner that is acceptable to the members and do so in any role they are in to accept each other for the sake of themselves (Geertz, C., (1973); Chavunduka, 1994; Nussbaun, B., 2003a;2015). Furthermore, culture is also viewed as a complex whole that is referred to as a learned pattern of thought and behaviour, characteristics of a social group which involves religion, kinship, knowledge, beliefs, art, morals and childbearing practices which influence women's uptake of OC (Dodzo &Mhloyi, 2017). The Southern Relational Path, by Lessem &Schieffer, (2010 /2014) the secondary framework used in the study to anchor cultural and social beliefs of women's experiences of MC was seen to be ideal (Brown, H., (1998 /2010). Some of these cultural beliefs tend to make pregnant women delay deciding to seek OC in the event of a complication. Studies conducted in Africa and elsewhere have high-lighted how culture can influence health care seeking processes and have a bearing on the outcome, as noted in a Chiang Mai Northern Thailand study by Liamputtong, P., Yimym, S., Parisunyakul, S., et al., (2005); and Gabrysch, Lema, et al., (2009). Little, however, is documented on the effects of culture and religion on QOC in resource limited urban settings apart from rural studies in Zimbabwe where Mathole et al., (2004) mentioned the role of witchcraft in pregnancy and Dodzo, &Mhloyi, (2017) who said that women preferred delivering in the community aided by TBAs and SBAs because both were adaptive to the cultural and religious maternal care needs of the clientele, which modern health care ignores.

Religious beliefs and healthcare are inter–related, especially within the African context where illnesses have been linked to spiritual effects many years ago. Jesse, D.E., Schoneboom, C., Blanchard, A., (2007) reported similar findings in their analysis on the effect of faith or spirituality

in pregnancy. Since pregnancy and childbirth are associated with religious and traditional beliefs and practices in many African countries as noted by (Ellison, C.G., & Levin, JS., (1998:700-720), nursing and midwifery discourse on spirituality is an important component of care and should not be relegated to the background. Fouka, et al., (2012) also highlighted on the relationship between the Greek Orthodox Church's beliefs influence and women's uptake and meanings of care of OC. Asamoah–Gyadu, K., (2014) reported similar findings in their view on the African Pentecostal/Charismatic Christianity faith. Further, it is an integrated part of the total care provided to clients and their families in all spheres of nursing and midwifery, as reported by Tuncalp, et al., (2012;2015). This study might add insight on this aspect to improve QOC.

In Ghana which is a developing country like Zimbabwe, there are growing religious Pentecostal /Charismatic leaders that pray for pregnant women while some of them give the women religious artefacts such as anointing oil for the same use and all these gestures are meant to ensure a safe delivery, as reported by Tuncalp, et al., (2015). This shows that the role of religion cannot be ignored as it can influence the women's use of MC as failure to accept the women's religious feelings might affect uptake of OC. In another Ghanaian study by Aziato, Odai, & Omeryo, (2016), 13 participants expressed that they used prayer for a successful delivery and prevention of misfortunes or activities of evil spirits that affect the outcome of pregnancy which points to their firm belief in God the Almighty. This assertion was also supported by previous studies, (Takyi, B.K., 2003). Additionally, midwifery has for a long time considered itself as a holder of knowledge that devalues the knowledge experienced by women and does not take into account the beliefs, practices and context in which they live. A study by Blutta, Z.A., Chopra., Aleason, H., et al., (2010) provoked reflections on this theme and led professionals to re-think their practices, making care more humanised. In the context of giving care nurses might fail to recognise women's cultural

and religious values/beliefs which can interfere with the client/patient treatment outcomes. Therefore, the nursing of pregnant women needs to be integrated into activities that are developed with other professionals of the health care team to facilitate the synchronising of the promotive and preventive activities that are holistic for better outcomes. The adoption of phenomenology became ideal for this nature of inquiry to elicit undiluted information on QOC.

According, to Camacho, et al., (2006) culturally congruent care that consists of acts or care decisions that are supportive, enabling or that are facilitative based and designed to fit the cultural values, beliefs and ways of life of a person, a group or an institution can lead towards provision of or support of proper health care. It is important therefore, for nursing care and culture to walk together in the nursing process to ensure that the popular care permeates nursing care as noted by Amin, Shach, N.M., Becker, S., (2010). Consequently, it is being advocated that health care practitioners need to be culturally sensitive to augment the care rendered to women to reduce morbidities and complications. Additionally, cultural relevance is essential when the alternative does no harm to mother and baby as reported by Hulton et al., (2000; 2007) a framework used to guide this study. To cite one example, (Rhodde, 1995), supported the squatting position during delivery. Also, Lawrence, A., Lewis, L., Hofmeyer, GL., (2013: doi.1002 /14651858) advocate for different positions in the first stage of labour to improve mobility for the women and perhaps improve the care. Also, Desseauve, D., Fradet, L.,lacouture, P., Pierre, F., 2017:DOI:10.1016/jejogrb2016.11.006Epub.2016 in their study support the idea of altering positions during childbirth and delivery to easy the process.

2.8 The Hulton, et al., (2000) conceptual framework

The Hulton et al., (2000/2007) maternal satisfaction model was chosen as the primary study framework for the study because it depicts variables that are related to the influence of QOCS

while women receive and access OC during pregnancy and childbirth. It outlines the structure aspects that involve the physical resources, environmental presentation of buildings and the state of the furniture within these buildings, the state of their cleanliness; the human resources aspect that concern the staff competencies, compliments, medical supplies and equipment. These aspects of the framework are congruent to the study concepts namely structure, process features of MC, which are seen to affect the wellness of the women of childbearing age during pregnancy, labour/birthing and post-natal. Then the part to do with the process that is concerned with the promptness of the service delivery, interpersonal behaviour between the care provider and the client, issues of privacy and confidentiality, perception of good care, cognitive and emotional support and the male provider preference; the aspect of access and cost of OC point to what contributes to QOCS. The outcome that is the delivery of the care issues, is seen to have similar aspects on what the women can experience during their contact with the midwives, nurses, doctors and supportive staff during all stages of the pre-natal care, labour/birthing and the post-natal period. In choosing the component of care that deals with the users' perceptions/experiences of care, the Hulton's framework (2000) competently guided the navigation of OCS as experienced by women in this study. The literature on QOCS clearly depicted how the various factors/ variables in Hulton's framework, interrelate around the issues of QOCS and perception of this service by the women during pregnancy and childbirth. The conceptualization of this study was also informed by literature reviewed in this chapter. As adequately demonstrated in this review, the MC during pregnancy and childbirth is influenced by many factors. From literature, a connection does exist between the women, their babies, the health facilities and the care providers.

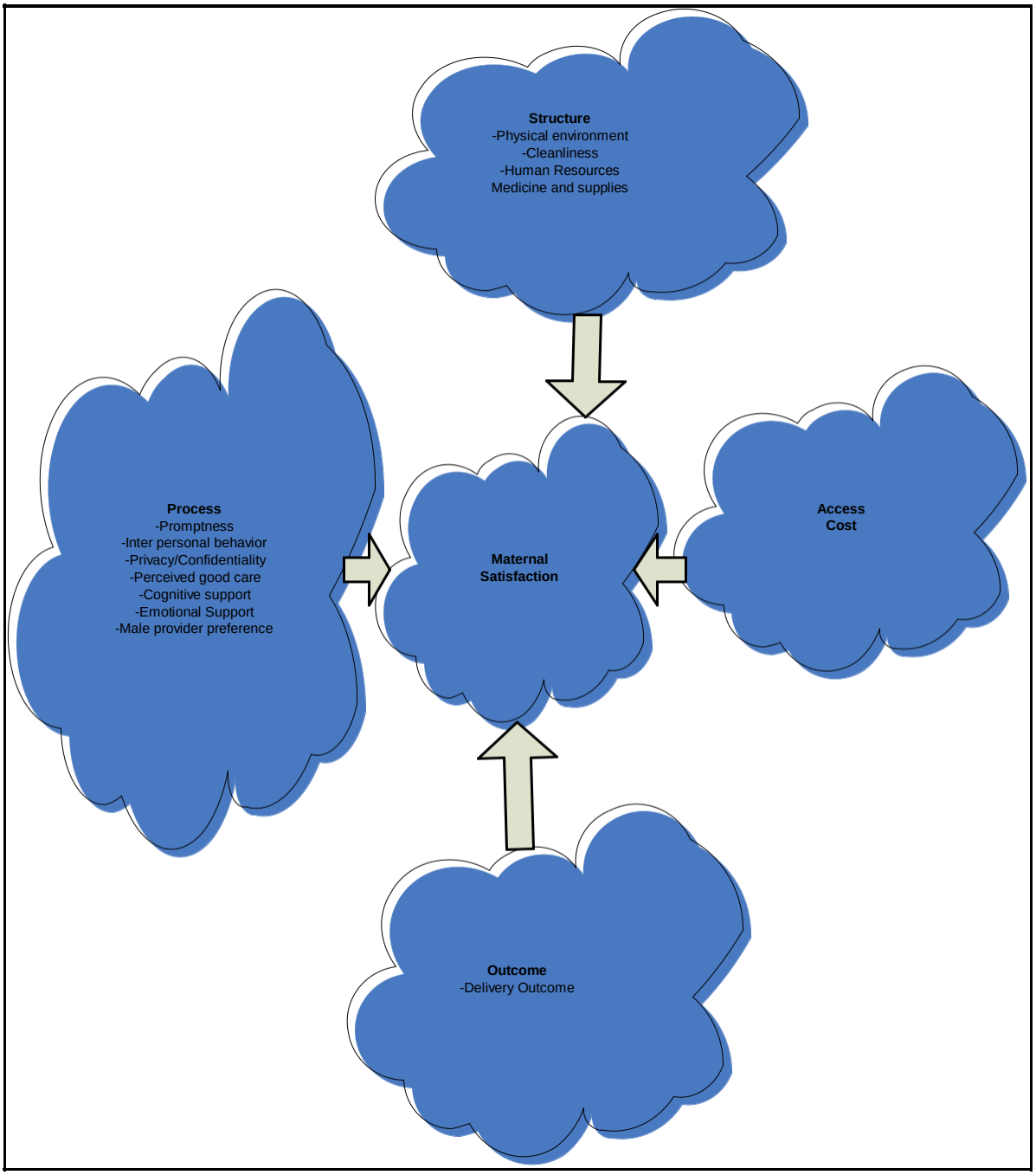
Paudel, YR., et al 2015 study looked at women's satisfaction with maternity care and its correlation with intended future utilization in 13 Nepal districts. They used Hulton et al., (2007) framework.

Respondents in this study showed that women were satisfied with waiting time, information received, improved physical environment and interpersonal communication skills and all these pointed to their intention to return to the health facility.

Morrison, J et al., (2014), in their qualitative study of Disabled women's maternal and newborn healthcare in rural Nepal, used Hulton, et al., (2007) framework to underpin quality care issues and highlighted cost and lack of family support to include resentment by health care workers in attending to the disabled women's health needs.

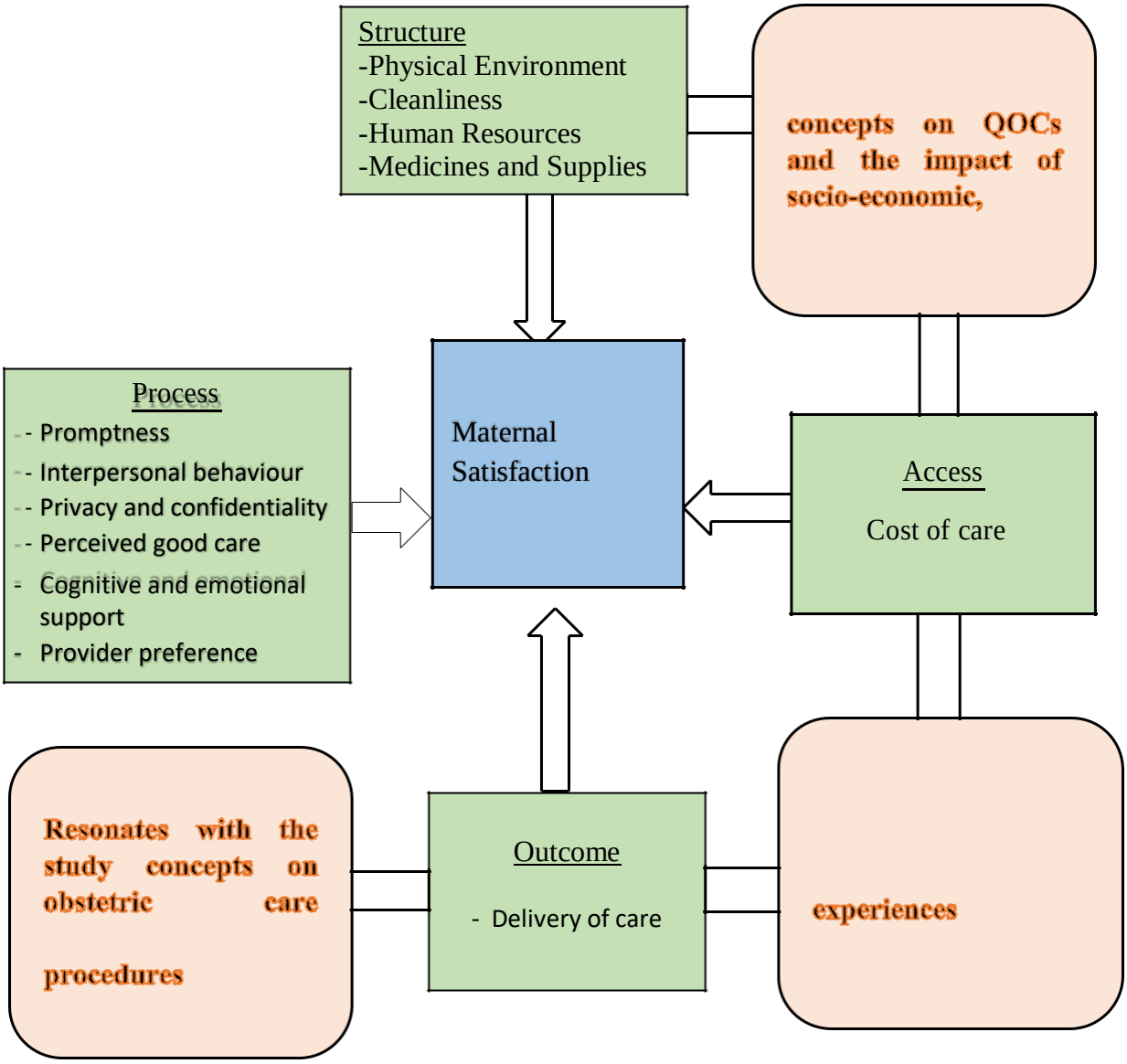
The diagram below is a portrayal of factors that have been mentioned above and studying the MC encompasses an understanding of the different facets of the MC as shown by Hulton's (2007) framework in guiding this study (see Figure 2.1 below).

Figure 2. 1: Illustrates Hulton's conceptual maternal satisfaction



(Adopted from the Srivastava, et al., 2015 maternal satisfaction model).

Figure 2. 2: The Hulton et al., framework and its relationship with the study concepts.



2.10 The Southern Relational Path

The Southern Relational Path, one of the four frameworks popularly used in the integral research as the secondary creative framework which is centred on the relationship between nature, environment and community. Since nature is about the environment where people, (men and women, children), animals and other creatures live and interact with each other for survival, according to Lessen, R., & Schieffer, A., (2014), integral research can lead to social and cultural creativity.

This Southern Relational Path, Lessem &Schieffer, (2010 /2014) is appropriate as it addresses concepts that are not highlighted in the Hulton, et al,. (2000) framework and yet it is linked to the Hulton model (2007) on maternal satisfaction and its connectedness to the study concepts on socio–economic, cultural and religious grounding in that reality is understood through interaction with nature from the inner person exuding to others and to the community, grounded in a particular nature which must be understood by a living system. The Southern Relational Path stands for the living system, grounds it and represents its local identity and its connections to a common course of life, evoking a particular experience that activates the relational feeling from the heart. (Lessen and Schieffer, 2014).

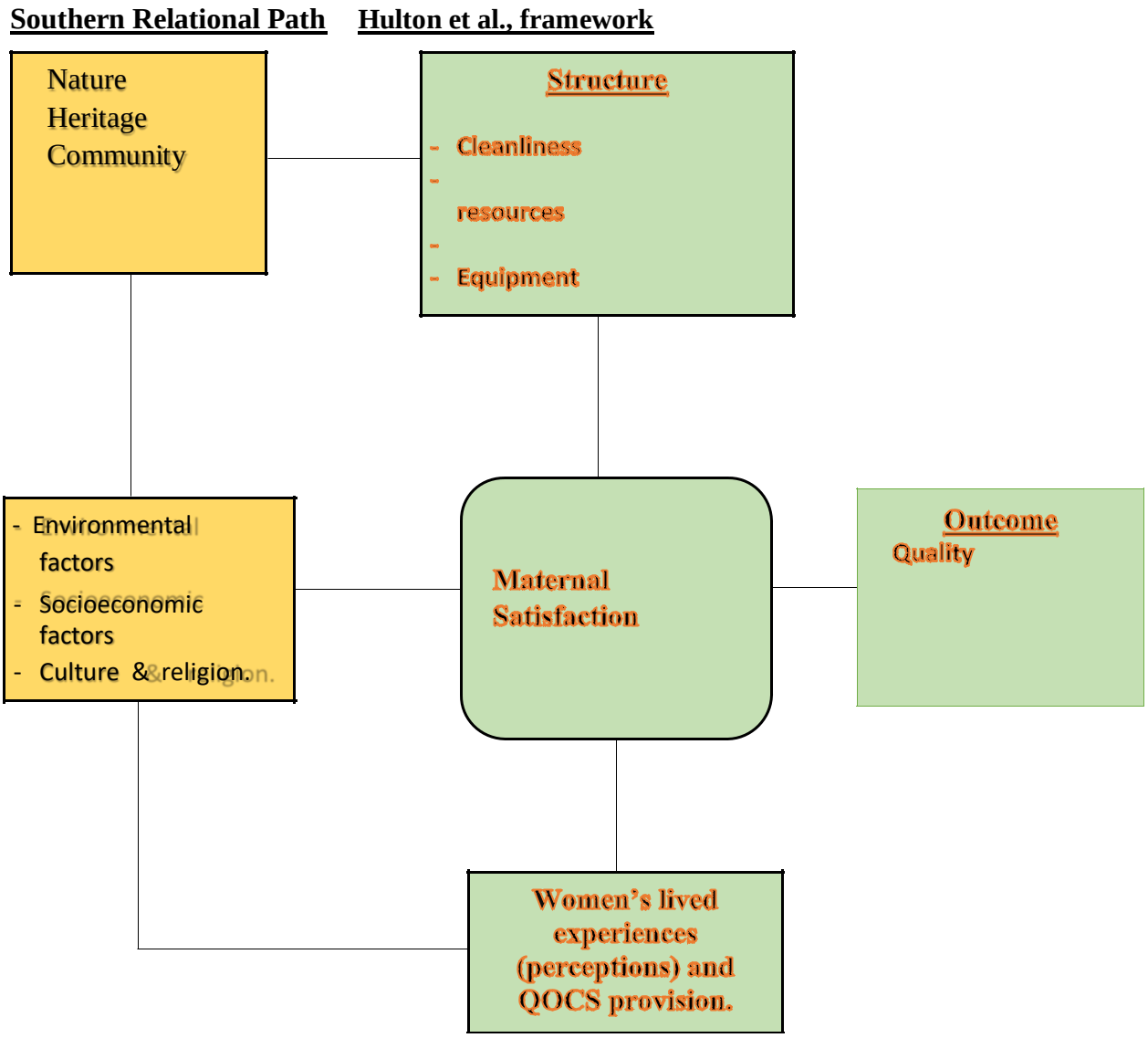
Southern Relational Path is a portion of a grand model, Integrated Worlds "**The Trans4m.**" Trans4m stands for transformative and integrative processes to bring about "all that we can be" – to co-create a world of unity-in-diversity. This was Jointly developed by Ronnie Lessem and Alexander Schieffer over the past decades together with an ever-growing group of co-creators, the approach uniquely interlinks individual, organisational and societal development. Grounded in extensive research into the most transformative theories and successful role models, and direct hands-on experience with partner organisations on the ground on all continents, Integral Worlds

looks at the dynamic interconnectedness and wholeness of living systems. It is designed to effectively address imbalances that fragment and stifle life as well as to support the healthy actualisation of new evolutionary potential. Lessem and Schieffer (2014) seek to form Integral Universities, which propound transformative education (as capacity building and real life problem solving) as programmed knowledge and individual skills; innovative research (scholarship and organisational knowledge creation) which is workplace based problem solving technological and social innovation; activism in community (activating community based learning) that results in a community uplift and community development; and catalysing development (catalysation as a consciousness raising and societal learning) yielding self-awakening; community awakening; societal awakening and world awakening.

This framework was used to help in the creation of the following models in Zimbabwe: The Chinyika Model: A case of an Integral community and Rural Self-sufficiency in Zimbabwe by Chidara MP, Chada S, Lessem and Schieffer 2014; Integral Green Zimbabwe; An African Phoenix Rising by Mamukwa, L, Lessem, R. &Schieffer, A. and other 20 Zimbabwean contributors; and the Calabash of Integral Knowledge Creation/ Trans4m by Elizabeth Mamukwa, the Cooperative Inquiry Group of Turnall and Pundutso – Zimbabwe 2014/2016.

The study might produce a model of care that could systematically assist in highlighting any identified caring needs from nurses /midwives /women' s experiences with OC received. There is a link with the Hulton's et al (2007) model on the maternal satisfaction in that the required knowledge is at an individual level, aspect of social–economic needs when seeking and accessing maternal care and the resultant self and community awakening due to societal learning involving the family, relatives and healthcare providers in the QOCS provided. (See figure 2.3 below).

Figure 2. 3: Congruency between the two frameworks in the aspect of provision of QOCS.



Summary

Previous studies were reviewed, and women's plight while seeking and accessing care was discussed fully, use of the qualitative method was supported fairly. The intention to craft a model of care to improve the care was outlined. The next chapter discusses the methods used to capture and analyse the data, the application of the frameworks in the study.

CHAPTER 3

METHODS AND MATERIALS

3.1 Introduction

A descriptive phenomenological approach was used in this study to explore the lived experiences of the women from their hearts and minds to get a good picture of the QOC provision. Phenomenology, is a science or a process of radical inquiry, where the researcher immerses self in the world of immediately lived experiences that concentrate on illuminating the nature of the "inner self", (Husserl, E. 1938 -1959). Finlay, (2008) analyses it as a study of phenomena, their nature and meanings and focuses on the way things appear to us through experience or in our minds. Husserl was a philosopher, and Giorgi, needed to modify Husserl's method to be useful for psychology (Giorgi, AP., 2009). In this study it is related to midwifery to suit the study thrust. In doing so Giorgi's five -step method provides the systematic process of science while not being reductionist in its treating of persons studied, Broome, RE., (2011). The method is discovery oriented rather than verification oriented and was found suitable because it gave participants an opportunity to share their lived experiences of the QOCS they received. The overall aim of life world research, Dahlberg et al, (2008) is to describe and elucidate the lived world in a way that expands our understanding of human beings and human experience.

Based on Giorgi, (2009) Husserl's descriptive phenomenological philosophy enabled an alternative epistemiology for human science research. Giorgi's steps (2009) modified Husserlian method, are described and explained in the context of doing nursing /midwifery research to understand the lived experiences of participants of the QOCS provision in this instance. These steps allowed the following: 1) assuming the phenomenological attitude, 2) reading the entire written account to gain a sense of the whole, 3) delineating meaning units, 4) transforming the

meaning units into psychologically sensitive statements of their lived meanings and 5) synthesizing a general midwifery structure of the experience based on the constituents of the experience. It is hence the first-person midwifery related perspective that is sought so that an emphatic position is taken that can be accepted by the end –user of the research.

3.2 Descriptive Phenomenological Method

Phenomenology asks: what is this kind of experience like? What does the experience mean? How does the lived world present itself to me? It allows the researcher to engage in active and sustained reflection as one dwells with the data and interrogate them. In summary phenomenology is understanding it existentially, emotively, enactively, embodied, situationally and non –rhetoric; it is a powerful approach, whose text thrives on a certain irrevocable tension between what is unique and what is shared, between the reflective and pre –reflective spheres of life world, (van Manen, 1997; Finlay, 2008). According to Wertz, (2005) phenomenology is a low hovering, in dwelling, meditative philosophy that glories in concreteness of person –world relations and accords lived experience, with all it's inter -dominancy and ambiguity, primacy over the known. It has key tenets which are namely; engage in the process of radical inquiry, immerse self in a life world of immediately lived experiences, concentrate on illuminating the nature of the inner self, focus on the subjective view of experience, locate every unique cultural history as an episode in the larger story and finally go beyond reductive positivism and naïve empiricism, (Lessem &Schieffer, 2014).

According to Husserl, (1977) consciousness synthesizes experience through its internal acts towards objects that are both sensorial and purely of mental origin. This in other words mean, objects that are governed by time, space and causality are called "real" (natural sciences were intended to study the 'real' world) and those that are imaginal, remembered, anticipated, and

hallucinated are called “irreal” because they do not physically exist (Husserl, 1977; Zahavi, 2003). Husserl’s project, (1931/2008) for phenomenology was to develop a method in the form of an eidetic science, (science of possibilities) for midwifery, which would then necessarily include “irreal” objects, in its analysis. In a sense, phenomenology would be a “science” of “possibilities” for human studies in a similar way that geometry is for physics. As there are geometrical concepts that are accepted as theoretically sound, (such as the two –dimensional plane) but that are physically non-existent in our three-dimensional world (Broome, 2011). So far psychological Midwifery -related phenomenology would be the investigation of the consciousness through the examination of its actions upon objects that it takes without positing the origins of the objects. The concept that consciousness takes objects for itself is called intentionality and Husserl (2008/1931) further explained that consciousness is naturally directed to objects, which means that consciousness is always conscious of something beyond itself. Zahavi (2003) explains it this way, “One does not merely love, fear, see or judge, one loves a beloved, fears something fearful, sees an object, and judges a state of affairs. Regardless of whether we are talking of a perception, thought, judgement, fantasy, doubt, expectation or recollection, all of these diverse forms of consciousness are characterised by intending objects and cannot be analysed properly without a look at their objective correlate, that is, the perceived, doubted, expected object.” Consciousness is the means by which we become aware of all sorts of physical, material, biological phenomena but itself is none of these things. It is the medium of access to anything whatsoever that can be experienced in this study, including irreal (non-sensory) phenomena such as ideas or numbers about midwifery, but we have awareness of consciousness itself without appearances. When we reflect on our lived experiences, we become aware of them but not because they appear. Appearances are correlated to things of the world and their manner of being known is different

from the way we know our own lived experiences (Giorgi, A., Giorgi, B., & Morley, J., 2017). In this study what was being explored were the lived experiences of the women of the QOC they received. In the description of intentional acts of consciousness about midwifery activities, one can see that both 'real' and 'irreal' objects of the mind must be considered to understand the whole experience in its natural context, and as it was lived by the participant during pregnancy and childbirth.

The natural context of a social interaction is seen to be an important stimulus on people's behaviour and understanding of their experiences. Contrariwise, experimental-like research done in the 'field' has researchers engineer a situation in the real world but do so without the knowledge of the persons being studied knowing about the research until afterwards (Babbie, 2010), the descriptive phenomenology method provided the lived-context of the participant whilst focusing on the perspective of the women without the use of deception (Giorgi, 2009).

The descriptive phenomenology method also enabled the researcher to keep the voice of the participants in the research without abstracting their viewpoint out through analysis. The subjective perspective of the participants was what was of interest to the researcher (Giorgi & Giorgi, 2003). Thus, it was not only the reactions and behaviours that were included in the data, but also the thoughts, impressions, feelings, interpretations and understanding of the participants' experiences of MC that were analysed. This interaction facilitated the communication of the critical elements of the phenomenon which in this case was the lived experiences of women on the QOC they received. Giorgi, (1997; 2005) noted that the essence of a phenomenon is a fundamental meaning without that a phenomenon would no longer be the phenomenon in question. In the context of this study, the fundamental meaning sought was: 'essence' of, or 'key' to, the experiences of the

women on pregnancy, labour and postnatal care provision and the themes produced enabled the development of a model of care to help address the needs identified to ensure improvement of MC.

3.3 Study design

A descriptive qualitative design is the planning of any systematic research process from the start to the end was used. It can be equated to the builder's foundation work plan and a vehicle for presenting research methods as living entities that require simple classification and can result in the establishment of meaning and solid findings as reported by Giorgi, (1992); Sandelowski, (2010). It is further the basis of an art and science to the production of data. In this study the use of triangulation that gives a research process an in-depth approach into the unravelling of the realities of events when QOCSs were sought by women was done (Burns, N., &Grove, 2005). Focus Group Discussions and in-depth interviews using interview guides were used to achieve triangulation and thus, increase data trustworthiness (Patton, 1999). Additionally, this study was informed by the interpretive phenomenological theory which is based on the understanding that knowledge about humans is not possible without describing the human experiences as they were lived and defined by the women themselves in this study (Husserl, (1932/1965); Mealeu–Ponty (1956); Omery, (1983).

Grounded theory that emanates from sociology or symbolic interactionism could have been a good choice where there is little known about the subject matter with a view to develop a theory, but in this study the researcher was looking to understand the experience of women seeking OC, an area that is well researched internationally but Zimbabwe is confounded by an uncomfortably high MNMM for which ways to address the problem are still being sort. The Phenomenological approach became the ideal choice for the researcher. Quantitative methods could have been used but would only yield impersonal data, be it objective and generalizable but the researcher settled

for Phenomenology that allows for in-depth examination, interpretation, and development of a comprehension that leads to greater self-understanding, a greater moral awareness and an appreciation of the views of women as they sought OC. This approach reinforces the importance of individuals' perception and precision concerning the phenomenon under study (Dowling, (2007); Streubert & Carpenter, (2011).

Furthermore, this approach has an important role to play in the study of human experience, "learning and understanding people's subjective experiences has an obvious and multifaceted importance, with which to explore the lived experiences of women's MC provided by midwifery practical applications as opposed to statistical variables," (Denzin, N.,1998; 2005; Greenwood, 2011) also supported by Becker, (1992); Hasani, et al., (2011). They further, postulated that the second premise of qualitative research is embedded in the view that the everyday world is valuable. It, therefore, became necessary to use phenomenology to extrapolate the experiences, perceptions, opinions and ideas of the women of childbearing age on the QOCS received during pregnancy and childbirth. This was done to fulfil the agenda of this inquiry and paved a way to develop a model of care to address the needs as revealed by the themes emanating from the study.

3.3.1 The country and study sites

Zimbabwe is situated in Southern Africa with an estimated population of 13 million people (ZIMSTATS, 2012). It is a land-locked country, which shares borders with Botswana, Mozambique, South Africa and Zambia. It covers an area of 390, 245 square kilometres, and is divided into 10 provinces and 58 districts. Health centres which cater for these locations Old Mabvuku, Chizhanje and New Mabvuku, Old Tafara and New Tafara and the old Bob and Proton/Caledonia farms within the out skirts of Tafara suburb are now a vast chain of residential houses with poor roads and sub-standard amenities. These factors can reduce women's access to

education, health, recreational facilities, which attracted the birth of this inquiry. The maternity clinic centres and Satellites are housed within the mentioned catchment area, which are all high-density suburbs situated in the eastern district of the capital city of Harare, 22 kilometres from the Causeway Post Office these heath centres were a recruitment outlet for the study. It is a high-density zone with a resource restricted capital base. These health centres offer pregnancy activities that is bookings, follow up visits, growth monitoring of neonates up to five years, family planning services, immunizations, they do deliveries managed by trained midwives that are licenced to deliver quality maternity care and manage normal and abnormal cases using guidelines as laid down in the Emergency Obstetric Care (EMoc) protocol. These facilities have tarmac roads which are unfortunately potholed.

3.3.2 Participants and sample

The accessible population was women of childbearing age residents of the high -density suburbs and their environs, at the time of the study, who had booked and delivered in these health centres. These setting facilities had Skilled Birth Attendants (SBAs) to provide deliveries and they were able to screen and refer complicated cases. This population was accessible to the researcher (Grove et al., 2012).

A sample of 31 participants from females of childbearing age 16 to 40 years old, residents of mentioned health facilities and their environs were selected. Only women who had normal vaginal deliveries were recruited and those who had Caesarean section (C/S) deliveries were excluded as they have their own unique needs which is for another study. A sample of 12 to 15 participants is said to be adequate for a qualitative research as supported by Kuzel (1992). The sample size in a qualitative study is determined by saturation which is when there is redundancy that was reached

when no new information was coming up in the data being collected. Saturation was therefore reached at 31 participants in this study.

3.3.3 Sampling Plan

The accessible population that was studied were women of childbearing age who had come for postnatal care activities and were willing to be studied, who were resident of the high -density suburbs. In this study a purposive sampling technique was used to recruit a total of 31 participants from females of childbearing age who were deliberately at the health care centres at the right time who fell in the mentioned age range. Purposive sampling, is a process of interviewing participants as the research progresses in order to reveal and refine categories (Chenitz, &Swanson, 1986; Glaser, 1992). Participants booked within the study sites' health centres were chosen to participate in this study. Only those that could articulate rich data about their lived experiences of QOCS to ensure collection of valued data for the study were selected (Grove, et al.,2012; Johnson & Christeen, 2008). The sample comprised those participants who were at the maternity clinics between 09.00 hours to 14 hours willing to share their lived experiences and able to speak fluently in the local languages Shona, Ndebele or English about the phenomena. They were offered a chance to be included in the study. The place for the interviews were the identified health centres, those who consented were recruited. Most of those women who were approached in this study participated except three who had booked outside the study zone.

3.3.4 Inclusion criteria

The participants were recruited based on the language one was familiar with, age group, area of residence and only those who had a normal vaginal delivery. Females of childbearing age 16 to 40 years who spoke Shona, Ndebele or English were selected. The different age homogeneity

strengthens group interaction for rich data (Morgan, G., (1996); Kitzinger, (1995); Krueger, S., Casey, M., (2000).

Recruitment was facilitated through collaborations with health care workers (HCW), grass-root health promoters (HP) and the existing community networks. Participants' willingness to be tape– recorded; being residents of Harare Eastern district; and being in good physical and psychological health. Their willingness to consent in accordance with international and national ethics regulations was taken into consideration.

3.3.5 Exclusion Criteria

The participants who had booked outside the study zone were excluded to reduce data pollution. Those that were interviewed during the pilot interview study conducted in 2015 were excluded from the study because they had been exposed to the study. The psychologically challenged and physically unwell women were not included in the study as firstly, the nature of the study required one to be psychologically alert and to be able to articulate one's lived experiences; and secondly, those who were not well were seen as failing to comprehend information and could perhaps not give informed consent. Women who gave birth by caesarean section were not included in the study because they, had unique needs that required a different paper altogether. Participants who fell outside the range of 16 to 40 years of age and could not speak, Shona, Ndebele or English were excluded from the study.

3.3.6 Researcher's entry into the study setting

In order to get access into the study settings, permission was sought from the City of Harare Health Department and the District Nursing officer for the area and the local level nurse-in-charge to follow the laid down protocols that protect research participants from unforeseen harm. One had to produce the letters of permission that were processed by the relevant research ethics committees

for the same purpose. A week prior to the commencement of the study a notification fact letter was dropped to the different community networks such as the schools, creches, churches, traditional leaders, councillors, health promoters to market and explain the research project for easy implementation. Meetings were held with the crucial members of the study sites in the research catchment areas to give them insight on the purpose of the study and to start the recruitment process.

3.3.7 Recruitment of Participants

3.3.7.1 Consenting

Participants to be studied were taken through the consenting process before participating into FDGs and in –depth interviews. The study consent form was read loudly to the participants to make sure the text was clear to them. The researcher also, explicitly informed them about the study purpose, the choice to participate in the research and the right to withdraw without detriment. Participants were assured of their right to fair treatment and were allowed to say their contributions respectfully and professionally. After that the participants were asked for questions or areas of clarification. Subsequently, the participants were asked to provide their voluntary written consent. Further, permission for voluntary audio recording was obtained in writing for the maintenance of confidentiality in the FGDs and image protection after the interviews. Three participants were excluded from participating because they had booked and delivered outside the study catchment area. This was done to reduce extraneous confounders of the data. All participants signed the consent forms and agreed to be tape recorded that being done with their full knowledge and agreement.

3.3.7.2 Justice

Participants' right to fair treatment required that every person received what she was supposed to get at that time and moment. The participants after the interviews, received their service without further delay as per prior arrangement with the attending nurses. Justice also entailed the right to privacy and confidentiality and management of any adverse events.

3.3.7.3 Right to privacy

During interviews, the researcher endeavoured to dialogue with the participants without disturbance. The right to privacy was ensured and through the use of codes and pseudonyms instead of participants' names, anonymity was guaranteed. Interviews were held in the nurse in – charge's offices for maximum privacy and minimum disturbances. Also, names of institutions were used broadly to protect their identity. They had the right to withdraw from a research study at any given time. In this study the participants were not exposed to harm physically, psychologically and spiritually.

3.3.7.4 Confidentiality

Participants in this study were ensured their right to confidentiality so all the information shared was kept in strict secrecy. This was addressed when the researcher agreed that all the recorded information during the interviews would not be shared in any way that would reveal participant's identification. The digital device and transcripts were locked in the senior nurse manager's office for safety. Trustworthiness was emphasized during the FGDs interviews to protect participants' views and image throughout the data collection process.

All the data were kept in a lockable steel cabinet and the forms were kept safely after data analysis for a period of three to five years to cater for any cases of queries or audits by the ethics committees.

3.3.7.5 Recruitment

The research assistant who was a Registered nurse and had collected data for two research projects before was hired to assist in the collection of data in this study. She received training for two days on the study objectives, purpose and methodology of the study to acquaint herself on qualitative research ethos.

The researcher and her assistant screened interested individuals for eligibility over the phone and from the maternity postnatal registers for both the pilot and the main study. Twenty-five women of childbearing age from 16 to 40 years were purposefully selected for the pilot study. For the main study thirty-one participants were invited to participate in FGDs, these group sessions lasted approximately 30 to 50 minutes. Twenty- one eligible participants for the in–depths interviews were selected from those who participated in the FGDs who were found to have rich data about the phenomenon under study. The selected women were briefed about the purpose, the interview process and time and place of the meeting, the session lasted approximately about 20 to 40 minutes.

3.3.8 Interview Guides

Interview guides are tools used to collect data with main topics and prompts which help the researcher to remain focused to the pertinent data to be collected as suggested by Polit & Hungler, (1999 /2012); Burns &Grove, (2012). Open–ended questions as depicted in Appendix A and Attachments 1 &2, were asked the interviewee to get rich data also as supported by (Giorgi, 2009). The interview guide was developed to link the questions to participants' lived experiences of the MC provided. The researcher asked retrospective questions such as, how was it on booking day or delivery day, discharge day to get maternity care from midwives? The guides enabled a face to face interaction to seek spoken answers from participants and were flexible enough to allow the researcher room to get meaning of what emerges during the interview sessions.

The study adopted the use of Hulton et al., (2000 /2007) framework to guide understanding of the women's satisfaction with the MCS provided by midwives and to develop study questions in the Interview guide, with two Attachments; 1 and 11, added merit to the data collection process. Attachment 1 had topics to mention some: expectations of pregnancy, labour and birthing, postnatal care; conception of fear, anxiety, dismay about pregnancy, labour and birthing and child care. Attachment 11 had the interview (questions), the grand question was, "What is the lived experiences of women of the QOCS provided by midwives at the identified maternity clinics in the Eastern district of Harare?" The interview prompts included: How would you describe the first day of the booking visit? -Did you have any expectations on this visit? (If so) can you describe or talk about them? -What was done or said to you by the attending nurse /midwife? (See detail in Appendix A). Further the use of the Southern Relational path, (Lessem &Schieffer, (2010 /2014) which is embedded in community and nature, guided an understanding of how women saw the care provided in the context of their cultural and religious values and beliefs. These questions were asked; What do the church women and pastors say about preparations for pregnancy, labour &birthing and breast feeding? What did the midwives, aunties and elder women say about the use of African *muti* (local language for drug)? What did the midwives say about such things like tree barks or leaves, or the use of elephant dung to help one with labour?

3.3.9 Focus group discussions (FGDs)

According to Lewis, (1985) FGDs permit the researcher to raise questions to the participants for free discussions. The researcher could have used questionnaires and interviews as they are closely linked and are commonly used in quantitative researches. They are regarded to be similar to FGDs and individual in -depth interviews. The later was chosen because it is regarded as a method per excellence of social science, (Oppenhein,1982; Madge, 1967). Focus groups stimulate new ideas,

facilitate creation of a background on a topic of interest and the diagnosing of potential problems in a project under investigation, (Stewart &Shamdasani, 1990). The same authors reported that FGDs are appropriate in a study, as a prelude to other types of research that provide more data.

Additionally, they facilitate collection of huge data in a short space of time. They enable the collection of data that might not have been uncovered in individual in -depth interviews. They also provide data from a group of people much more quickly and at less cost than would be the case if each individual were interviewed separately. Considering that the researcher had no funding it was the ideal approach to gather the required data for the inquiry. No woman was interviewed twice in these FGDs to avoid bias in data collected.

The researcher had 7 groups comprising 3-12 persons who came together to discuss a particular research topic. Group dynamics helped to illuminate the process and facilitated the ease of communication. Further, the group process was helpful in the generation of data insights (Morgan, 1997). The participants were free to talk about their views, they reflected on what other group mates said in view of their own opinions on the care provided to them during pregnancy and childbirth. Those that were burning to continue to give their thoughts were informed that they could still participate in in –depth individual interviews at a later date if it was noted that their contributions were of value to the study. Participants who articulated more on the phenomena were hence identified for participation in the in-depth individual interviews to ensure collection of rich data (Giorgi (2009) Carpenter & Streubert, (2011); Porter, (2013). The use of Interview guide, FGDs and Individual - In-depth - Interviews were used to validate these data and to ensure collection of rich data about the phenomena, (Guba, 1998; Patton, 1999).

3.3.10 Individual- In–depth- Interviewing (III)

An in–depth interview is a conversation with a purpose that provide interesting and prolific stories, data that is abundant in detail and examples, narratives and viewpoints that reveal people's complex feelings and provide an undiluted focus on the individual, which is an important feature in data collection in this inquiry. An interview guide with relevant questions was used and follow -up questions were created to increase more detailed inquiry. The approach was useful because the women were not influenced by their peers as it offered a one to one encounter with the researcher. In depth interviews were conducted from 21 participants who were identified during the FGDs because they could articulate the phenomena well, (Silvermann, D., 2014). Information gathering continued until saturation point was reached, in other words until there was redundancy in the flow of information.

3.3.11 Pilot Interview

A pilot interview was done at Mabvuku hall, and Tafara hall in August 2015 to test and to check on the appropriateness and adequacy of topics in Appendix 1 of the interview guide and the problem questions in Appendix 2 as corroborated by Grove, et al (2012:343); Polit, & Beck, (2012:351). Twenty-five women of childbearing age from 16 to 40 years were purposefully selected and constituted into two groups for the pilot study. One group of fifteen women was made up of women from Mabvuku suburb and the other group of ten women was from Tafara suburb. The women were identified as they came to receive QOCS at maternity centres the Satellite and family health centre. The participants were guided through the FGDs and the in-depth interviews. The interview sessions were for 45 minutes each.

The general response from the women in the two FGDs provided appropriate and adequate information and hence there was no need to make any changes. However, some women in both

groups expressed reservations about the thrust on two aspects in Appendix A, first, the question on ‘what else would you want to tell me?’ was not clear and was changed to ‘what information can you give to the other young women who might like to seek and access QOCS at the health care facilities.’ Second, the researcher was reminded that the prompts pertaining to questions on the aspects of culture and religion were missing. This, therefore, necessitated the addition of these corrections to the interview guide.

These participants were not included in the main study because they were already exposed to the study scope. The data collected from the pilot interview was not used in the write up but instead was used to correct the instrument.

3.4 Data Collection

The raw data for this study is a “naïve description” of their verbatim lived experiences as they accessed and received QOCS during pregnancy and childbirth. For Husserl (1937/2008) “natural cognition begins with experiences and remains within experiences”. Therefore, the naïve description is a first-person account of the experience as it was lived and understood by the participant in one’s everyday common-sense mode of understanding. This is so because no other person can co–experience the subjective–midwifery perspective of any lived–experience with the participant, the best and only “record” of such an experience exists (honestly, only in part) within the memory of the woman who experienced it from the subjective position. Therefore, one captured an audio recording of separate FGDs and in-depth individual interviews with each of the 21 participants about their lived experiences.

To initiate the telling of their experiences, the primary question for the participant was the use of the grand question, ‘what was the lived experiences of seeking OC from midwives?’ This question in its open–ended quality, offered the participants a wide range of perspectives by which they

could verbally describe the experience, as they talked to one another in FGDs and to self in individual in-depth interviews. Follow -up questions were used to probe further into the phenomena of interest. Notes of verbal transition in which it was sensed that more could be said about the phenomenon or that the participants just swayed away from what naturally occurs when people are talking, were noted. The researcher also tape recorded the interviews.

When the participant reached a point that she had shared everything she could have said spontaneously, the researcher then asked follow -up question, 'having spoken about such and such, can you tell the researcher more about that?' (Giorgi, 2003 & Giorgi, 2009). Follow up questions were not purposefully, "leading" in the process of trying to "pull out or extract' particular information of a kind from the participant. This interviewing technique helped one to "re–open the door" to an aspect of the account that was presented but maybe not fully expressed and described by the participant. It was the intention of the researcher to acquire a verbal "re-living of the experience" as expressed by the participant, to the greatest degree to gain rich data about the care rendered."

However, to get an account of the experience based on one's memory and as a report from the participant, comes with a degree of doubt regarding its accuracy. Data collected using a semi – structured interview guide are at most subjected to memory decay, alterations or participant response errors, (Giorgi, 2009). No perfect descriptions are expected, but adequate descriptions were obtainable and were full of wholesome midwifery related meanings concerning the OC provided for analysis (Giorgi, (2003); Giorgi, (2009). More so the interviewing strategy was not intended to "spur" or to "jog" participants into remembering some "hidden details," but rather to help them to just relate as far as they could remember, "what it was like" for them during their experiences. The questioning approach was left open to give participants room to respond broadly

based on the scope, knowledge and experiences in their own words to cite an example “what has it been like to seek and access prenatal care on the first day of booking? Or talk about how the midwife handled you on admission when you fell into labour. “What information were you given about pregnancy, labour and birthing?”

Furthermore, indirect questions were also used to elicit some issues that a participant could have missed to allow for other questions to surface. To mention an example from the study: ‘What do people in the community say about preparation for labour and birthing to hasten it? At times silence was used in between the interviewing process, this helped in summarizing participants’ responses and helped to assess the participants’ line of thought. To cite an example: kindly elaborate what you mean when you say the midwives these days talk more about HIV/AIDS issues?” In the process one needed to take care that it was important to focus also on other aspects in this study to keep on track and in control of the process. Nonetheless, related information that came to the fore on OC activities provided by midwives gave rich data, for instance, issues concerning mothers’ initiation of family planning drugs.

The researcher trusted that the data captured in these interviews were adequate to acquire the most accurate phenomenon regarding the QMC rendered to ensure the exhibition of the most outstanding, personal and critical aspects of their experience as that came from their memories. Through this phenomenological analysis both the expounded and implied meanings of the experiences were accessible for clarification, as reported by Giorgi, (1985). A detailed explanation follows below in the coming paragraphs of the data analysis using Giorgi’s analysis technique.

The naïve descriptions provided by the participants were recorded for later transcription. A digital voice recorder was used to capture the contents of the interviews and transcribed into text for further analysis. All the data were kept in a lockable cabinet to ensure privacy. It was the

transcribed text that was used as the raw data for analysis. As part of the data collection process, all information that could reveal the participants' and other identities, places or things which could make such identities were easily replaced with pseudonyms or any fictitious names to ensure and maintain privacy and confidentiality of the interested parties. This process took place during the transcription process to ensure that only participants and the researcher knew about these stated identities and other private and confidential details.

The trained research assistant participated in the data collection process as she took care and noted- down, in a research diary all the non–verbal cues that took place during these sessions to ensure inclusiveness of data provided (Wall, Glenn, &Pool, 2004). Journal notes taken allowed for better collection and a storage of information of what was seen and heard outside the interview guide that was useful about the phenomenon (Van Manen, 1988:233; Cohen, L., Manion, L., & Morrison, (2007) Malhall, 2003:311). The notes reflected what was seen, heard and experienced by the participants during pregnancy and childbirth concerning quality of OC.

3.5 Data analysis using Giorgi's technique

The researcher used the descriptive phenomenological method adopting a five -step method of data analysis based on some principles of phenomenological philosophy and Giorgi's analysis method (1985/2005:75-82) to achieve scientific rigour. In each step, an explanation of the procedure and its corresponding philosophical concept which supports the purpose and character was done. The data analysis was done after transcribing, making the text become the 'empirical evidence' to be analysed for its psychological implications.

This is a five–step technique of research that holds Husserlian phenomenology as a philosophical foundation, as Husserl was a philosopher of his time. Giorgi, (2009) needed to modify Husserl's

technique to make it useful for nursing /midwifery. The first step of Giorgi is for the researcher to assume the phenomenological attitude, which is different from the natural attitude or everyday way of understanding the world. In the phenomenological attitude, the researcher 'brackets' her everyday knowledge to take a fresh look of the data, putting aside her presuppositions, to include theoretical, cultural or experiential perspectives. The concept of 'bracketing' originates from Husserl's (2008) epoché in which the researcher allows herself to be present to the data without postulating its validity or existence. In this study the researcher allowed herself to 'see' the data as it appeared in itself and in its own context without doubt or belief, therefore, the researcher remained true to the phenomenological slogan, 'back to the things themselves' (Husserl 1901/2001). In addition, the researcher did not postulate the real existence of any object the QMC that is given to consciousness, rather, because it is given to consciousness, the researcher took the object the QOCS as it presented itself without judging its veracity from the objective perspective (Husserl, 2008). Consequently, each object and intentional act on that object by consciousness was included in the analysis because it was there for the participant's consciousness. By bracketing and withholding of existential postulating, the researcher was enabled to see and thus describe what was present for consciousness from the participant's first - person perspective. Therefore, given the foregoing, the researcher assumed the phenomenological attitude and then proceeded to the next step.

In the second step the researcher read the entire "naïve description" to get the logic of the whole experience (Giorgi, 2009; Giorgi & Giorgi, 2003). "Naive descriptions" provided by participants were taken in the natural attitude in the way that one would experience things, in the mode of everyday living from the common - sense point of view. This was done without any critical reflection on the experience. However, the researcher, remained in the phenomenological

attitude that 'put out of action' all common-sense prepositions in order to conduct a critical reflection about participants' experiences of OC so as to describe how it was perceptible by the senses or through immediate experience (Husserl, (2008); Giorgi, (2009). It was in the phenomenological attitude that the researcher presented the data as it was given in this study.

The third step of the data analysis was the demarcation of 'meaning units' within the narrative to allow one to deal with manageable portions (Giorgi, (2009) Giorgi, (2003). The narrative text was read through with a purpose of determining where places of meaning shifted within it. The slogan of experiences in the consciousness has 'landmarks', which in a way is comparable to how beings see the windings, rapids and falls in a river full of water. In the study concept, it refers to how women saw and experienced QOC while accessing and receiving it. Another analogy used by Jones, (1996) is that of a bird's flight that is noted by where it perches more than the actual distances in which it flies. In this study, during the process of reading to get a sense of the whole, subsequent reading was done with the idea of marking where meaning shifts occurred, which were to the researcher like the landmarks' or changes in the flow as allured to the above (Giorgi, 1985). In order to distinguish the meaning units where the researcher marked, the meaning unit demarcations with a forward slash (/) at the cleavage between two meaning units but each meaning unit was identifiable by its numeral label at its beginning point. The numeral identification was expressed in super script. Therefore, the meaning units began with a superscript font numeral identifier and ended with a forward slash. Giorgi, (2009) stated that the how or where the meaning units are delineated is not absolute, however, the same or different meaning units can be among each other, what is important is the results and the quality of the analysis.

The above-mentioned distinguishing of meaning units, was a self–correcting process which the researcher used to recognize those units that were too long or too short in their delineation.

However, it was acceptable to combine or divide meaning units as the researcher got familiar with the data to provide clarity about better places for their distinctions. Generally, the researcher did not have to commit to the initial delineations and battle through them as sacrosanct (Giorgi, 2009).

The fourth step in the data analysis was to transform the meaning units into midwifery related sensitive descriptive expressions of each of them. The researcher took the phenomenon at the psychological level to practice science rather than the transcendental level which is to practice philosophy, (Giorgi, 2009) and further stipulated that the psychological level is an individual experience at personal level rather than mystical (universal, unconditional and independent of experiences) (Koivisto, et al., (2002).

It is in this fourth step, that the first change is made to these data in the analytical process. The meaning units are re- expressed in the third person while remaining faithful to the meanings expressed by the participant. Changing to the third person language does not change the meaning of content but assists the researcher in remaining in the phenomenological attitude by not being empathetically drawn to participant's natural attitude (Giorgi, 2009).

Imaginative variation (Husserl's intellectual procedure to determine the essence of the phenomenal structure of the experience), performed by the researcher enabled changing qualities of the QOCS received that were being analysed so as to determine which qualities were essential and which were accidental (those that were present but not required) (Giorgi, 2009; Giorgi & Giorgi, 2003; Zahavi, 2003; Husserl, 2008). By taking each third person meaning unit individually, the researcher dwelt with it and considered what was being midwifery - expressed through it. A midwifery focused re-expression was transformed in a descriptive manner and placed next to it. These transformations became the midwifery formulations of the essential meanings of each meaning unit. As the researcher remained in the phenomenological attitude,

each transformation described what the meaning unit expressed psychologically into midwifery without any interpretation or postulation about its 'truth.' Therefore, the midwifery transformation only described how the meaning unit was experienced and understood by the participant from her point of view without explaining 'why' it was experienced in the way it was.

The phenomenological attitude of the researcher in the psychological analysis of the data, was what made the results both phenomenological and midwifery. Thus, the general structure of the lived experience, in this case the care rendered, was synthesized from the participants' transformations when taken generally together in a comparative view by the researcher (Giorgi, 2009).

The general structure of the experience is a descriptive paragraph of the lived experience of the QOCS rendered to women prenatally, during labour and postnatally, from a midwifery approach. The fifth step in the analysis is the synthesis of the overall midwifery structure of meaning, from the midwifery constituents of the experience. Unlike the concept of elements, constituents are context dependent, and therefore cannot be independent of each other, and are necessarily part of the whole structure (Giorgi, 1985). The purpose of this procedure is grounded in a phenomenological concept of parts and wholes, which did not originate in phenomenology but was actually developed by the Greek Philosopher, Aristotle. The concept expresses that the value of the whole is greater than the sum of its parts, meaning that the 'whole' of some things or states-of-affairs are irreducible to its parts (Sokolowski, 2008). Parts, in phenomenology, fall into two distinctions called pieces and moments. The difference being that pieces can subsist separately when detached from the whole to which they belong, whereas moments are dependent on the whole and have their essential identities as being a part of its whole, (Sokolowski, 2008). Each constituent, therefore, had to hang together interdependently with the others forming a general 'whole' midwifery structure. In consequent, there were some midwifery aspects of one

or more of individually situated experiences that the researcher found to be a ‘piece’ which was more like an element. Pieces or elements can subsist on their own and therefore would not be constituent (moments) of the general structure (Giorgi, 1985; Sokolowski, 2008). Thus, being identified as a ‘piece’ or accidental quality of the experience did not render the aspect useless, but simply not an essential part of the general structure.

The constituents were determined by viewing the transformations of all of the participants for convergent meanings. Again, using the imaginative variation (Husserl’s intellectual procedure to determine the essence of the phenomenal structure of the experience), the researcher saw the shared meanings of the participants pertaining to their general consistencies. The researcher applied descriptive words or phrases to the constituents based on their midwifery indisputability, which was not a process of thematizing or creating nominal categories (Giorgi & Giorgi, 2003). The constituent ‘title’ had to be descriptive of its midwifery meaning. These constituents were put together in a descriptive paragraph which was the general descriptive midwifery related structure constituting the structure, the outcome (results) of an analysis. All other ‘pieces’ whether midwifery or not, were set aside for the later or broader discussion with the present literature in dialogue with one another.

The phenomenological concept of presences and absences was an important one to use during the imaginative variation. This is how the explicit data could reveal the existence of the implicit meanings without them being concretely expressed in the data by participants (Giorgi, 2009; Sokolowski, 2008). During the transformations the researcher could not only ‘see’ the explicit data and meanings, but also uncovered the implicit meanings through the imaginative variation and having a ‘sense of the whole’ still in mind from the initial step of the analysis. When synthesizing the general structure, the researcher found that as the structure emerged, some constituents were given implicitly in a similar manner. In this way, the descriptive

phenomenological approach was more comprehensive than mere empirical approaches in the natural attitude (Giorgi, 2009). This is justified through understanding that what is 'present' often implies or indicates an 'absent' quality. An object cannot be viewed circumferentially all at once, we can only view it through the aspect that is facing us, but that doesn't mean that we disregard the fact that there exists an aspect on the other side which is hidden from our view (Sokolowski, 2008). An example is when one sees someone face to face, one also understands the person to necessarily have a back that corresponds to her front and one draws this logical inference from a totality of the other's presence.

Husserl (2008) points out that our experience is self-correcting. The concept of presences and absences is critical and helped when the researcher considered the whole data, as the structure could be visualized, and a determination was done where there was an essential aspect that was 'absent' in one participant's data and was 'present' in the data of the other participants. In consequent, the inter-dependent nature of the 'constituents' when assembled together through imaginative variation, revealed the 'absence' of the constituent among the 'present' other constituents. Thus, at two levels the 'wholes' were considered in the analysis and synthesis of data resulting in the general structure. At the individual level first, the explicit data revealed an implicit quality that was not verbalized by the participant but was an 'absent' essential quality that was logically inferred in the experience. Second, that 'absent' essential quality was also supported by its implicit presence in the data of the other participants that had a similar experience. Consequently, these logical inferences are supported by evidence and not guessing nor wishful thinking to the extent that the veracity of the logical inference, could be critiqued, accepted and refuted upon review by others.

As the expressions from participants provided multiple examples of instances when the 'constituents' were experienced, the grid configuration allowed the researcher to put a note in a

cell of an instance where a constituent was implicitly in the data rather than providing an explicit example. Also, of note, the researcher was further assisted to deal with a structure as and when it emerged. This demonstrated that the researcher was able to classify a kind of experience in a way that it was differently experienced. The differences in the structures that came forth did provide understanding about how and why the psychological experiences were different phenomenologically, where we would ordinarily consider them the 'same' in the natural attitude.

3.5.1 Summary of Giorgi Analysis

The researcher sought the emergence of one general structure of the experience, in a bid to understand the lived experiences of OC rendered. Therefore, any different general structures that emerged from the women was not the failure of the method or the study (Giorgi 1985), it was because the descriptive phenomenological approach is a method in the mode of discovery rather than validation. The phenomenological concepts of parts and wholes were kept intact throughout the study. From the interview, the naïve description was obtained from the participant with as much continuity as possible with the follow up questions designed to get deeper into the aspects that were already given by the participant. The naïve description was read through in its entirety while the researcher was in the phenomenological attitude. The meaning units were delineated but the whole data was left intact. The meaning units were transformed using imaginative variation within the phenomenological attitude and psychological perspective to expound their essential midwifery related meanings. The essential meanings (constituents) were examined for their interdependence as part of the midwifery structure (whole) and described as such. The determination of an essential moment versus an accidental (non-essential) piece of experience, which differentiates the constituent from an element, required the continued use of the imaginative variation, which also enabled the eidetic nature (marked by the extraordinary ability to recall detailed and vivid mental images of visual images) of the data to be brought forth

(Giorgi, 2009). Also used was the phenomenological concept of presences and absences that helped to understand how explicit data could reveal the existence of implicit meanings without them being concretely expressed in the data by participants.

3.6 Ethical Considerations

The purpose of this inquiry was to get deeper understanding of what it was like for the women to seek and access QOCS provided by nurses /midwives and other health team players. This was achieved after the researcher sought permission from relevant research bodies to ensure the research project's integrity from these bodies; the Joint Research Ethics Committee of the College of Health Sciences (JREC), the City of Harare Research Ethics Committee (CHREC) and the Medical Research Council Zimbabwe (MRCZ). These authorities, by granting permission for this research to be conducted, implied that every aspect of the research proposal, the methodology including the tape-recording aspect of the data collection procedures were applied to ensure participants' protection. Participants were allowed to withdraw from the study when and whenever they so wished without restrictions.

The benefit of such an inquiry to the participating women of childbearing age and perhaps the health care fraternity at large was a richer understanding of the personal meaning of the women's experiences that they could not be fully aware of or had come to understand. Giorgi, (2009) points out that when someone says something there is always more meaning in what was said than even the speaker is aware of, in the natural attitude. The natural attitude causes a lot of midwifery aspects of the experience to be taken for granted. It was the researcher's hope that this study could bring out some clarity and new insights regarding the women's experiences of the QOCS rendered to them in the process of childbirth.

Midwifery and Obstetric care disciplines could find some valuable insights for training, policy, or innovations for providing better care for pregnant women during all the phases of pregnancy.

Atuyambe, (2006); Magadi, (2005) obtained and organized valuable information about young women and the consequences of pregnancy and childbirth in their research, the phenomenological approach of this inquiry took the researcher deeper from the natural attitude to the phenomenological level of the young women's perspectives on the obstetric care.

The researcher respected and maintained the participants' voices in the research as much as was possible, since one of the advantages to the descriptive phenomenological approach is that no deception is required to get the data in its real-world context. However, some may critique the approach given that observing behaviour as it naturally occurs could be considered more legitimate than self–reported accounts of the events. Yet, young women's lived experiences were not events that could be predicted well enough to conduct observational research and produce a viewpoint that the natural sciences would value most. Nevertheless, it was the subjective midwifery perspective that the descriptive phenomenological approach pursued, (Giorgi, & Giorgi, 2003). Indeed, self –report methods could suffer similar criticism but have demonstrated over time that they are legitimate ways to gather important data that are not necessarily less valid or reliable than observational or experimental methods.

Additionally, Giorgi, (2009) postulates that falsified memories (through various distortions) are of benefit to midwifery because they divulge more about the childbearing life of the individual due to their personal background. In this study the researcher was most concerned with how the women of childbearing experienced the QOC during the accessing and receiving of care as opposed to creating a distant version of the incident sieved through already existing midwifery theories and terminology. In summary there was neither distortion, deception nor context changes on the women's lived experiences of the care relating to them. Phenomenological midwifery analysis is a mode of discovering the midwifery meanings as they were lived and how they informed our understanding of such experiences on a deeper level. The women could have

provided some new insights about the care that might not yet have been discovered before just because a phenomenological perspective was adopted.

The participants of this study had control over the information and the way it was given. Full and honest descriptions from the participants was sought to their best. However, the researcher recognized the possibility of wilful omissions or distortions in the accounts provided by the participants. No measures were taken to manipulate or control the participants into giving information they did not freely want to share. Clearly, informed consent agreement was secured about the relationship between the participants and the researcher.

The benefits that were acquired from this study were academic part of the requirements to fulfil the completion of this doctoral degree, professional the researcher has served as a nurse manager in a metropolitan health facility and a lecturer in maternal and child health at the College of Health Sciences and for personal advancement and self-actualisation.

Finally, the researcher has witnessed some women die while giving birth or some of their babies dying on them for over 30 years, and that provided sufficient curiosity to want to know more about the issues surrounding the quality of the care women received from nurses/midwives as told by the women themselves, since maternal morbidity and mortality remains untenable. Therefore, the choice of the descriptive phenomenological inquiry was deliberate as it provided a greater understanding about the chosen topic due to its purpose and design, (Giorgi, 1985; 2003; Giorgi, 2009).

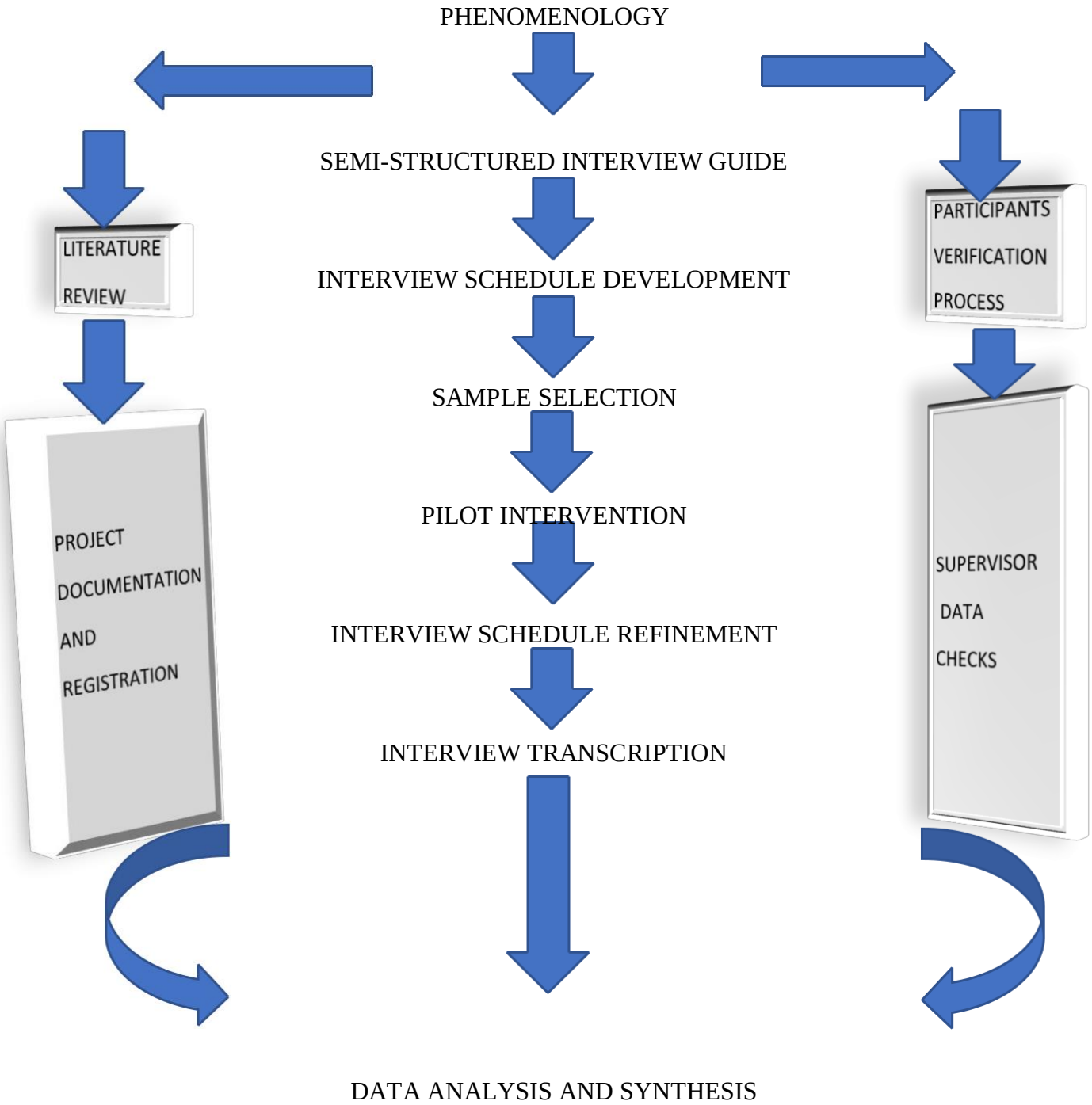
3.6. The Research Audit Trail

In order to gain rigor and depth and to ensure an intellect account of the data collected and analysed, the following steps were undertaken:

1) Purposeful sampling was used to select the participants as it was seen to be a sound sampling strategy that helped the researcher get key themes to be addressed and allowed diversity in a number of aspects.
2) Participants were recruited as they came for postnatal services for themselves and their babies.
3) A thorough literature review was done on current websites to gather the latest information about the phenomenon for scientific rigour.
4) The most valuable sources of the inquiry were the interview guide, FGDs and individual in -depth interviews in this phenomenological study. These tools were developed to help towards the gathering of rich data, depth, nuance and complexity, (Mason, 2002).
5) The tools helped the researcher understand the world of the women that live in resource restricted settings, their point of view, the QOC received, which helped unfold the meaning of their experiences while accessing and receiving OC and to uncover their lived world prior to the scientific explanation, (Kvale, 1996:1; Lincoln, MS., &Guba, 1985).
6) The framing of the questions and the understanding of these data was guided by both study frameworks of Hulton's (2000/2007) and the Southern Relational path of Lessem & Schieffer, (2014).
7) The interview tools helped in the creation of useful and new data on disrespectful and abuse in maternity care, in Zimbabwe to add to a feature that has become a global concern.
8) A pilot interview was done at Mabvuku and Tafara halls to test the feasibility and trustworthiness of the interview guide.
9) The interview guide was then refined to add and correct what did not read well and what was missing for completeness.
10) Data were collected and tape recorded from the women at the study sites.

11) An expert phenomenologist did an inter -rating of the naïve transcriptions to ascertain data authenticity and rigour.
12) Three participants' transcripts were replayed in the presence of the college supervisor to verify the accuracy of the collected data from the participants' point of view.
13) Data were analysed using Giorgi's, (2003 /2009), technique and the last and fifth step of the analysis, informed the process of building the women's perceptions into the various themes to include their socio -cultural elements. The meaningful units, which were developed into parts are referred to as distinct pieces and moments in phenomenology. According to Sokolowski, (2008) pieces are the subthemes that hang together interdependently with others to form constituents that represent the perceptions of women regarding general midwifery practice and also socio -cultural and religious structures. There were 18 subthemes which were later grouped into 8 broad themes namely, 1) perceptions of care, 2) the healthcare performance, 3) communication of information, 4) confusing booking system, 5) concerns regarding the care environment; 6) fear and discrimination, 7) neglect, 8) cultural and religious values and practice. The last two themes were collected from individual in -depth interviews. These major themes emphasize
14) A model of care was developed to assist in dealing with problems that emerged from the findings of the study to ensure QOC and reduce MNIMM (see figure 3.1).

Figure 3. 1: Diagrammatic presentation of the Research Audit Trail



Summary

This chapter covered the research study methodology whose foundation lies in Husserl's philosophy interpretive phenomenology and discussed the study design, (descriptive phenomenological) which is qualitative, the participants and their recruitment, the sample, the inclusion and exclusion criteria, the pilot interview, data collection process, the interview guides, focus group discussions, in-depth individual interviews, data analysis using Giorgi's technique was described in its five- step approach that provide the midwifery thrust. Ethical considerations were discussed. The next chapter covers the presentation of results.

CHAPTER 4

PRESENTATION OF STUDY FINDINGS

4.1. Introduction

In this chapter the research findings from the participants' lived experiences of the quality of obstetric care services are presented and analysed using Giorgi's five step approach grounded in the phenomenological concept for qualitative rigor. The study explored the lived experiences of women of the QOCS provided by midwives during pregnancy and childbirth. It also sought to understand the women's perceptions, views, challenges and joys they encountered while seeking and receiving this care in resource restricted settings and to develop a model of care from identified maternity care needs. The Interview guides, FGDs and individual in -depth interviews had questions that concentrated on the care and information given and received during pregnancy, labour &birthing and postnatally guided by Hulton et.,2000/2007 and Lessem &Scieffer, 2010/2014 frameworks.

Participants' verbatim responses are written in italics. In FGDs and in-depth interviews, pseudonyms were used to preserve participants' anonymity as required by the bodies of research ethics in Zimbabwe and internationally.

4.2 Demographics of participants

Thirty-four participants were selected for this study and three were excluded because they did not meet the inclusion criteria. Thirty-one eligible women within the age range of 16 to 40 years were selected for the FGDs and in –depth interviews. Twelve were single, twenty-one were married and three were widowed. Twenty of the participants had attended secondary education, 8 of participants had attained primary education and three had diploma qualifications. Seventeen were vendors and were self-employed, ten were in gainful employment and four were house-wives.

Twenty-one belonged to a formal religion and ten to other religions. The table below depicts the characteristics of the participants.

Table 4. 1: The characteristics of participants.

Characteristics	Females
Total	31 (n=31)
Age range (years)	
16 -24	21
25 -31	6
32 -37	4
Marital status	
Single	8
Married	19
Widowed	4
Highest level of education	
Primary	8
Secondary	20
Tertiary	3
Employment Status	
Employed (formal employment) Self –employed (vendors)	10 17
Unemployed	4
Religion	
Formal religion	21
Other religions	10

Table 4.1

Table 4. 2: A summary of the themes and experiences and sentiments that gave birth to the themes to guide the study findings.

Summary of the Quality Obstetric Care Services concerns which were abstracted using fifth last of the five steps of Giorgi, (1985) that state the analysis is the synthesis of the general structure born from the midwifery and the socio -cultural midwifery constituents of the lived experiences of the women which differ from concept of elements because they are context dependent. This emphasizes the thrust of the Hulton, et al (2000 /2007) and Lessem &Scieffer, (2010 /2014) frameworks used in this study. From 18 subthemes, eight themes emerged from both the FGDs and face to face individual in–depth interviews.

Theme	Source of data	Characteristics
1. Perceptions of the care	Focus groups (FDGs) and individual in -depth interviews (III).	The shortage of staff /drugs /medical sundries. The user fees, need for better incentives. The need for a labour companion, mother or an aunt. Flexibility in taking oral fluid- sips and mobility in first stage of labour.
2. Health care providers' performance	FGDs &III	The warm reception provided by midwives /nurses especially the male nurses. Ability to use discretion when attending to clients /patients. Some health care providers were knowledgeable. Offering the women a warm bath and tea just after delivery; selective dispensing of iron drugs. Rudeness. Poor performance /incompetence for example, pricking many times on my hands by a student, dispensing of a wrong drug.
3. Rigid Booking system	FGDs &III	Unclear booking system resulting in either not getting the service; Rigid rules and regulations of the service.
4. Communication, cognition and support.	FGDs &III	Overdone education on HIV/AIDS and baby preparation. Inconsistent/confusing or insufficient information on family planning drugs. Inadequate information on pregnancy preparations; signs & symptoms of pregnancy. Disrespectful behavior of the care providers and care users. Little information on immunizations given by the nurses /midwives. Little breast care and breastfeeding information
5. The care - environment constraints.	FGDs &III	Crowdedness in admission area, labor and postnatal wards; inadequate sitting space. Long waiting time for prenatal care on booking day. Dysfunctional toilets.

		Early discharge from the postnatal ward; getting time and space to rest and learn about baby care.
6. Fear and discrimination	FGDs &III	Discrimination because of stature and age; fear of bad treatment and abandonment. Non-payment of fees concerns.
7.Neglect	III	Disillusion and abandonment by boyfriend, in laws, midwives. Bleak future. Psychological and socio-economical concerns. Announcing HIV/AIDS results in the public domain.
8.Cultural values and religious practice	III	Beliefs in use of herbs and leaves to facilitate labour. Midwives not culture sensitive. The power of prayer and religion. Witchcraft beliefs and evil spirits

4.3 Theme 1: Perceptions of the Care.

Focus group discussions and semi–structured interviews revealed that some participants expressed their satisfaction with the physical facilities at a City of Harare health centre. In Hulton's conceptual framework on maternal satisfaction women rate maternity care as good when the care they receive is provided to them is a safe and clean environment which is core to maternal care. Furthermore, human resources, medicines and sundries, according to Hulton's model on which this study is based are critical elements in the provision of QOCS. In this study, the participants reported on the following; inadequate staff, lack of drugs, vaccines and sundries. Also, some of the participants were critical of the services they received when they accessed care from midwives, doctors and the support staff at both local and referral levels. Below are verbatim responses from the participants:

Participants, Mitchelle, Chipo and Tauraihenyu in the FGDs #1 said, *"The sister at a city of Harare birthing centre, I do not know how she does it. The place is now always smart including the toilets. There is new linen, nice bed covers, new and nice cupboards for storing food. Now that they are building a hospital, life will be easier for us because we will have our own hospital. The male*

nurses are really kind and helpful. The one who delivered my baby did everything in a professional manner". (Author translation from Shona).

Furthermore, *"I was pleased with the nurse who gave me a cup of tea after I delivered my baby. This was nice and warm. She brought me a bucket of hot water to wash my body around 4 in the morning, wish every nurse was this warm!!" (Tauraihenyu, 17 years).*

Participant Marvellous, 19 years, in face to face interview reported, *"I was happy with the nurse who used her discretion to give me the fluid medicine that was put up in my arm whatever that is to hasten my contractions. The doctor just did not care. The nurse went ahead, 'let me put up this medicine without fear. The doctor was supposed to order this. I am just going to put up the medicine mother to help the baby. 'Zvifambe mai' ('so that there is progress, mother' - local language). "Furthermore, I was lucky after giving birth at the hospital I was given hot water to wash, I found that to be warm whaa.." by another nurse.*

While participants Tinawo and Maureen, in FGD #2 said that they were not happy with the care in general, stated that, *"If you are told to go to the hospital and you need an ambulance, the ambulance medics will start to sing about the money yet in the meantime this was not planned". "A friend told me she was allowed to pay the money later, but they asked me to pay on the spot. It's not fair. Zvakashata zvekusarura"* local language) ('It is not proper to discriminate).'

Furthermore, participants Tariro, Grace and others, in #4 FGDs reported*: "The guards refused our relatives entry into the clinic they will have accompanied us to offer us help, support and to carry our suitcases and buckets for our washing needs since water is a problem'. 'They tell us our relatives cannot carry our items because women have reported missing items in the past'. 'This is a regulation from the bosses to protect us. 'We now find ourselves pushing and battling with the*

suitcases and the water buckets while in pain'. 'It's just too much for us. 'Something ought to be done".

Participant Tamuka, 21 years, in the individual interview said, *"I wish the nurses could teach us how to do exercises while pregnant like they used to do a long time ago. My sister told me when she had her baby they will go to the other clinic on Wednesday to do these exercises. It will be kind of nice for us and the babies…."*

In addition, participants Sibongile, Vavariro and others in #3 FGDs echoed this about the care they received, "*If you previously gave birth at the referral centre and you now are at 5 cm advance in labour and birthing they will transfer you this is what the midwife said. One wonders what could be happening in their minds. What kind of care is this - ladies? Some of the nurses are something else!!!"*

4.3.1 Subtheme: Shortage of staff and hospital items

Participants Tinawo, Maureen and others in FGDs #2 and Yvonne, 19 years, in a face to face interview expressed that nurses at the local and referral levels at times did not have enough drugs /vaccines /sundries like gloves and syringes to give vaccines, below are participants' excerpts, '*There were no gloves at all at the referral centre on that day and it was an issue to have the fluid medicine in my vein to hasten my contractions. It took them time to find these gloves. Who - ever is supposed to order, find such things, like gloves should do so to make sure we get the help needed. This delay could have caused problems to me and my baby gheee!!!*"

Furthermore, participants Ellen, Tadiwa and others, in the FGDs #5 stated, ***"****Our babies were discharged from hospital without getting BCG the first vaccine to be given to a new born baby. The nurse told us the vaccine was not there. So, the following morning I went to the clinic and I*

was told the vaccine was in stock, but they did not have syringes. I could not understand all this…. Veduwee.! ('Can you imagine' - local language).

Participant Ramwai, 19 years, in the face to face interviews and FGDs said, *"Women at most times give birth to their babies alone. Midwives come to our help late. Proper birth help is therefore not there. We will be in a lot of pain pushing the baby. This leaves one in a lot of wonder sure!"*

Participant Maria, 17 years, in the face to face interview reported that *"Nurses may fail to pick up problems on you because they will be very busy and sad. When I gave birth some of the nurses had been suspended for being in a strike for delayed payment of salaries. Staff money need to be looked into to ensure that nurses work well and happily".*

4.3.2 Subtheme: Dispensing problems

Some participants reported that iron tablets were not dispensed equitably. Some were given these tablets while others were not. The reason for giving these tablets to some and not to others was not clear. Below are participants' excerpts:

Participants Rose, Tamara and Zvavamwe, in FGDs #6 and Berita, 18 years, in the face to face interviews said, "*Vamwe vaipiwa mapiritsi ekuwedzera ropa vamwe vasingapiwi ndakangofunga kuti maripiritsi mashoma kutikwanira", l*ocal language ('Some were given the iron tablets'). The girl before me got but I did not get; I assumed the drugs were in short supply -Local language), *'we did not understand why it was so.'*

4.3.3 Subtheme: Friendly interactions of some of the workers

Some participants expressed that the care providers were friendly and helpful especially the male nurses. Participants Susan and Maureen in FGDs #2 echoed, "*A nurse explained to us how to hold the baby when breastfeeding, put baby's buttock on your folded arm then put one finger up the*

breast nipple and the other fingers below the nipple. This was very helpful, if only this was said during the prenatal time. I only heard about this at discharge..' *and some of the midwives tell us to breathe like puppies hahaaaa!! Wish this was said while we are still carrying the baby it will help us better.*"

And participants Mitchelle, Chipo and Talkmore, 18 years, in FGDs # 1 also reported, *"The sister at a city of Harare birthing centre, I do not know how she does it. The place is now always smart including the toilets. There is new linen, nice bed covers, new and nice cupboards for storing food. Now that they are building a hospital, life will be easier for us because we will have our own hospital. The male nurses are really kind and helpful. The one who delivered my baby did everything in a professional manner".*

4.4 Theme 2: Health care workers performance

Focus group discussions and semi –structured interviews revealed that some midwives were caring during the prenatal, at point of labour and after birth some of them were informative. However, it emerged that some of the participants expressed their dissatisfaction with the nurse /midwife technical expertise as well as the reception they were given by the security guards and ambulance para -medics.

Participants Sibongile and Vavariro in FGD #6 reported on how midwives could fail to follow the laid down referral aspects to ensure maximum OC and proper screening of the cases, they stated: "*If you previously gave birth at the referral centre and you now are at 5cm advance in labour as stated by the midwife they will transfer you. One wonders what could be happening in their minds. What kind of care is this- ladies? Some of these nurses are something else!!!"* (Author's own translation from Shona).

It appeared that some midwives did not have up to date knowledge on some facts regarding midwifery procedures for instance participants Primrose, Ramwai and Tariro in FGD #4 stated that the women were asked to lie on their left lateral side to the end of labour an issue which has been stopped based on new evidence they highlighted, "*The midwives insisted that we sleep on our left side to ensure a good flow of blood until we give birth. This is hard I wish they could let us sleep in any way. Because you are scared to lose the baby, you just do like you are told. It is very tiresome and hard, 'vehama*' ('my friends' - the local language translation by author).

Further, they would not allow the clients sips of water, the same participants said, '*Midwives refused to let us take sips of water you felt so thirsty and sweating a lot*. '*It got tough for sure 'amai woyee!*' ('Mother oh! as an exclamation - local language translation')

Tariro, 22 years, in the face to face interview, also reiterated the same notion on the inadequacy of the midwives' knowledge base she alluded, *"When I booked I was not told when to take the baby for vaccination and BCG is either out of stock or if in stock the syringes are not available. Some nurses told us to get information about these vaccines at the baby clinic. This is very confusing, my child is ten days now, no BCG has been given and am worried and perhaps my child can get sick"*.

She further pointed out to the congested state of the affairs of the maternity facility by stating the following, '*the place was very busy; it was many of you to one nurse; she said, 'she is the only one on duty today so please bear with me."*

4.4.1 Subtheme: Midwives/nurses /doctors' skills

Some participants reported rushed deliveries and vaginal tears occurred and at times midwives failed to make accurate assessments of the labour progress. Some participants stated that they were

given wrong drugs by nurse trainees while others reported being pricked several times by trainee nurses and arms swelled because of the shortcoming in doing procedures. Hulton's model also reported that women expected to be cared for by competent care providers who could make accurate assessments and treatments for maximum outcomes. It is also mentioned in the model that women expect prompt services during all the pregnancy stages. Below are study participants' verbatim responses below support these assertions.

Participant,Tafadzwa, 23 years, in the face to face interviews reported her ordeal with referral centre and said, *"Midwives at the referral level, which is a private hospital, were chatting at the nurses' station most of the time and they asked us to walk to the nurses' room for the checking of our blood pressure, pulse and other things. This was sickening to say the least because one will be in severe pain; something ought to be done….."*

Participant, Tabeth, 23 years, in the individual in-depth interview stated, "*I was transferred to the hospital because I had delayed giving birth to my baby. I was taken to the labour ward area in a wheel -chair and left in there for a while. I screamed for help because I felt something coming down the birth passage. The nurse said you cannot give birth; you have just come in. I sat down on the floor and pushed the baby alone. The doctor came to finish the birth. I had tears which needed repair. He gave me the injection to ease the pain. The doctor only repaired part of the tears. I was left sitting on the bed. The repairing of the passage was finished around eleven the following morning. My husband came to see me about ten o'clock in the morning the next day. He was told I was still in labour ward the nurses were stitching. 'He could not believe his ears'. "He said in disgust, what kind of care is this really!*!!"

Participant Teresa, 16 years, in the face to face interview further said, *"I told the midwife that I feel something pushing down there - the birth passage. The nurse said, 'it can't be. You are only*

a mother of none'. The nurse had to deliver my baby without wearing gloves. I had tears which were repaired under no injection for pain. Perhaps the passage progress estimation was just off".

Also, participant Ramwai, 19 years, in the face to face interview and others in the FGDs stated this, *"Women at most times give birth to their babies alone. Midwives come to our help late. Proper birth help is therefore not there. We will be in a lot of pain pushing the baby. This leaves one in a lot of dismay sure sure."*

She further went on to say, "I saw a woman give birth on her own in the prenatal ward, it was very sad and scary!!"

Participant Getrude, 19 years, in the face to face interviews and others in the FGDs who had reservations with the OC rendered echoed, *"Student nurses should work with a proper nurse. I was pricked many times on my hands by a student who did not know how to take blood. My hand swelled this is not ok uuu*."

In addition, she reported that, *"The doctor had ordered a strong drug (Amoxycillin) for a sore throat for me and a student nurse gave me Panadol instead. Students should work with a trained nurse to avoid such mistakes that can cost life. Sure sure"*

Participant Vavariro, 19 years, in the face to interviews and others in the FGDs had this to say, ***"****When I took my baby for the ten days care the nurse weighed the baby and asked me to put the baby on the bed. I was not happy with the way she examined, she just put her fingers over the nhova (*local language for fontanelle) *and gave the baby back to me and gave me the follow up date chete (*'only' local language). *It was different with the nurse who examined my first baby she took time with the examination, she even made the baby walk. I felt she did not do it right, perhaps it is because she was the only one on duty she was tired. But this is not good sure."*

4.5 Theme 3: Communication of information

According to Hulton's model (2000/2007) women value clear and consistent information which enables them to make informed decisions. In the FGDs and face to face interviews some of the participants expressed the need for adequate information on the health education given. The information on family planning drugs, immunization, breastfeeding and general health education was inconsistent or lacked detail. Other participants complained that HIV /AIDS issues and baby preparation education were overdone at booking and subsequent visits. Verbatim responses below point to the experiences of participants of the QOCSs received regarding communication of information.

4.5.1 Subtheme: Shortfalls in the health education given

Participants Rose, Vavariro and others, in the FGDs #3&6 reported: *"Labour pain is not explained to us in detail that is why women die of pregnancy problems. Little is said about labour itself like the signs and what to do. As a result, some women come to the clinic late, some even deliver at home. What to do when you are having the pains and what can be done to reduce these pains without taking medicine is not said. Nurses assume that we know and at times they get angry that we don't know. Wish they could only explain to us to ease the anger between us and them!!! health care workers"*

Furthermore, participant Tatenda, 17 years, in the face to face interview and others in the FGDs echoed: *"On the first day of booking some nurses/midwives talk more on things that we should prepare for the baby. One wishes to hear nurses talk about important information on signs of pregnancy and discomforts that can come with pregnancy, breast care, breastfeeding issues /concerns to prepare us for the mystery of labour."*

4.5.2 Subtheme: Overdone education on HIV/AIDS and Baby preparation

Participant Shamiso, 17 years, in the face to face interviews and others in the FGDs stated: *"On booking day and subsequent visits* nurs*es now talk more about HIV/AIDS problem, and the bleeding, is just too much. They take blood on the elbow area and a prick on the thumb. You also have to wait patiently for results for a while uhuuu! This has become something out of this world. I tell you the honest truth".*

Other participants in FGDs #5 Queen, Ruvarashe and Tabeth in face to face interviews expressed their dissatisfaction with some of the staff for asking clients to state their HIV/AIDS status in the group, "*One of the midwives failed to maintain a client's rights to privacy and confidentiality. She asked the woman to say her HIV positive blood results in a group umuu! 'kodzero nezvemunhu zvepamwoyo' (*private and personal trust - from the local language*), were not kept. She was later called in. I hope the nurse said sorry. Further, 'Go tell the town clerk to pay employees. We have gone for six months without any pay', said the nurse".*

Also, participants Tamara, Zvavamwe and others in FGDs #7 reiterated, *"On the first day of booking some nurses/midwives talk more on things that we should prepare for the baby. On that list are nappies and not diapers, flannel baby clothes, vests, wrappers, bucket for water, spirit, specific cotton wool packaged by reputable dealers and not to buy cotton wool with red or blue labels. Relevant information on signs of pregnancy, aches and pains that can come with pregnancy, the use of no –drug pain reducers, breast attention, breastfeeding … were not said on the day I booked."*

4.5.3 Subtheme: Inconsistent /insufficient information on family planning

Excerpts from some of the participants on the family planning drugs are outlined below:

Primrose, Susan in FGDs # 1 were instructed to take family planning drugs (FPDs) after delivery and others were instructed to take them when the bleeding had stopped they reported that, "*Nurses told us to only start taking these pills when one was no longer bleeding, or one could start immediately if one so wished. The nurse told us that this would give our bodies time to rest. It's possible one could have fallen pregnant while the baby is still young 'ahaa.' They don't even talk about the use of condoms at all as another protection".*

Participants, Talkmore, 18 years in the face to face interview stated that, "*I was told to only start taking these pills for family planning when I was no longer bleeding, or I could start immediately if I so wished. The nurse told me that this would give my body time to rest. I could have fallen pregnant while my baby is still young 'ahaa'… They don't even talk about the use of condoms at all as another protection."*

4.5.4 Subtheme: Inadequate information on immunizations

Below are participants' verbatim responses on the challenges faced while seeking vaccinations, items such as vaccines, syringes at the health centres:

Some participants Ramwai, Sibongile, and Susan in FGDs #5&6: *"It is disappointing we came very early to get our babies weighed and get vaccines; but the nurse told us that we can only get those services after we get our bloods taken for a research survey that is running in the clinics. 'If you don't accept you are doomed said the nurse'. This is unfair treatment some of us are working, pachisoja chaipo (*local language). *"*this sounds very military".

4.5.5 Subtheme: Inadequate breastfeeding information

Some participants did not get adequate information on exclusive breastfeeding (EBF) to ensure a better outcome since it is the best infant food that prevents jaundice, and dehydration. They further

stated that information on how to position the baby for optimal breastfeeding is not mentioned or if said it is done at discharge which reduces optimal breastfeeding. Below are participants' verbatim responses:

Participants Susan, Chipo and others in FGDs #5&6 reported, *"Some nurses talk of breastfeeding but not in detail, the care for the breasts, the timing to start to feed and the how to hold the baby is not demonstrated to us, a friend taught me she had heard from the hospital nurse she was clear on this. One finger up and the rest of the fingers down the breast it's simple and the whole nipple in the baby's mouth. 'I only heard about feeding at discharge, which was sort of late wish this is said during pregnancy, it will help us better sure'. The nurses were on strike on the day I booked and busy they could not find time to give the detail when we booked. Nurses' wages should be taken seriously to improve the care."*

Furthermore, Shamiso 17 years old, wailed, "The importance of breastfeeding and positioning including early infant feeding was hardly said. If said it was said this is usually done at discharge. First time moms like me need this information. I was discharged not knowing anything about how to breastfeed. I have a mother who is a nurse. She taught me everything."

4.6 Theme 4: A confusing booking system

Focus group discussions and semi-structured interviews revealed that the booking system, user fees, and the method of payment of the fees which were not written anywhere caused problems. Some of the participants, especially, first-time mothers, were shocked to be told by the nurse that they were no longer taking any more clients for the day. According to the Hulton and the Southern Relational path frameworks, women stated that user fees and socio –economic status can hinder women's access to QOCS. Additionally, this can force women to delay in booking for prenatal

care or can make them seek these services from health centres outside their catchment areas or can seek this care from the TBAs, subjecting themselves to substandard QOCSs leading to Neonatal and Maternal Morbidity and Mortality. Below are participants' verbatim responses:

Two angry mothers, Ruvarashe and Queen in the FGDs #3 stated this:

"*You get surprised to hear nurses saying we only take those with appointments. They tell you to wait to see if somebody fails to keep their time. In the mean -time you are advanced in pregnancy because you were trying to put the money for 'sikero' local language* – (prenatal care) *together to get the care. It is really hard, these times!"*

These participants further said, *"The nurse after touching my abdomen said it looks like you are having twins, you need a scan it costs twenty dollars, it is important to have it done. I went back home and came back the following week the nurse insisted that the scan is required. I said I can't find the money and I went back home again without getting any sikero (prenatal care). By the time I found money I was now overdue in my pregnancy, wish there was another way to help us, money is now hard to find for sure!!…"*

Participant Teresa, 18 years, in the face to face interviews also, stated: *"On booking day I was told the day is fully booked for new clients. You can book for the next day or you can wait to fill in for somebody who misses their appointment. One can end up booking late. I booked late because the clinic required the whole amount of twenty- five dollars cash up front. I wish they accepted paying in parts."*

4.7 Theme 6: The concerns regarding the care environment.

Health care centres need to create an environment that allows women and spouses /family access to prenatal care labour and birthing and the postnatal periods including the discharge plans at all

times. This care could reduce negative outcomes. A platform where nurses /midwives can give health education on pregnancy itself, danger of pregnancy comments and emergency treatment, family planning, growth monitoring to meet the women's possible potentials on reproductive health.

4.7.1 Subtheme: Space constraints and housekeeping

Some participants stated the cleanliness of the birth facility, new food cabinets, clean linen and restrooms. However, others were not happy with the crowdedness, long waiting time in the admission area, prenatal, labour and postnatal wards. Some participants were not happy about the early discharge after delivery. In the Hulton's model, maternal satisfaction emphasized the women's quest for decent and clean environments that are well kept and maintained to ensure decency while in health care centres. Below are the participants' responses:

Participants, Ellen, Vavariro, Sibongile in FGDs #3&6 had this to say: **"***Matoireti anofanira kuva nemvura pamakiriniki kuti tisabata utachiwana." (*"Toilets should have running water at health centres so that we do not catch infectious diseases"

4.7.2 Subtheme: The crowdedness in the admission area, labour and prenatal and postnatal wards.

Women reported crowding in the admission area, labour and postnatal wards. The limited space was prohibitive for relatives or partner support as a result some partners were discouraged to attend prenatal care sessions which can interfere with the QOCS. Below are participants' verbatim response*):*

Participants Grace, Rose, Ramwai in the FGDs: #6 "*The prenatal area has little sitting space we can't come with our husbands. The nurses take long on booking day. You come at 07.00 hours in the morning; you spend the whole day by the time the helper nurse takes you round the clinic, show*

you the gate bell, you are just hungry and tired, wish they could just do it another way so that the day is worthy the while sure…sure!"

Additionally, participant Tabeth, 23 years, in the face to face interview expressed*: "Crowding exists in the prenatal care waiting area, long waiting times for prenatal care services. I was at the clinic at 07.00 am to only get done at 16.00 pm. This is just too much waiting time. You will be hungry and tired by then".*

4.7.3 Subtheme: Long waiting time for pre-natal care on booking day.

Some of the participants reported long waiting times and limited sitting space in the prenatal facility on booking day, crowded admission area, labour and postnatal wards. Below are participants' excerpts:

Participants Queen, Grace and others in the #3 FGDs reported: *"The time we took for an appointment with the midwives was just too long and what is disappointing most is that there is no adequate sitting space for all of us pregnant women in the waiting area. It took me from 07.00 hours to about 15 .30 hours to get finished uhuumm… As a result, our partners fail to accompany us because there is little sitting space".*

4.7.4 The short discharge period after birth

Some of the participants were unhappy with the early discharge post–delivery. They strongly felt it was an opportunity for them to rest and to get help and education on baby care. Below are participants' excerpts:

Participants Tinawo and Maureen in the FGDs #2 reported: *"The day we delivered it was many of us some were sleeping on mattresses on the floor and the nurse came around 4.00 pm saying those that live closer the clinic you are going home, you have delivered about six hours ago. We need*

space for other mothers. You will be so tired from labour. You wish they could just bear with us its worse if you are a first- time mother you are overwhelmed with many things the baby and the birth pain uhmm."

Furthermore, participant Shamiso, 17 years, in the face to face interview said, *"I would prefer to stay in the ward for another two days to give my body rest and learn more about baby care."*

4.7.5 Sub -theme entertainment challenges

In this study, some participants complained about the lack of media particularly radio and television at both local and referral centres. Entertainment challenges were echoed by participants in both FGDs and individual in-depth interviews. The Southern Relational Path with its properties in the environment, and people, emphasizes the importance of making environments where humans live to be conducive to allow the inhabitants access to things that reduce stress for them for better standards of living. This is congruent to the essence of this study to provide QOCS for better outcomes. The participants' verbatim responses are presented below:

Participants Tabeth, Tamara, Mazvita and others in #7 FGDs and face to face interviews stated: **'***You get to the hospital labour ward what you hear are mothers screaming with pain and nurses and cleaners talking to each other. It would be good if there was some radio or television to allow us to listen to something or watch football or drama, ('Wenera'* a local film*).'*

Participants Sibongile, Ellen, Vavariro, in the #6 FGDs reported: "*There are charts all over the walls in most of the clinics for us to get information we found this to be helpful. One wishes to listen to a radio or television to watch your favourite film, news or soccer match. I wish the bosses could do something about this"*.

4.8 Theme 6: Fear and Discrimination

Some participants described their sense of fear of ill treatment and discrimination because of their age or non -payment of fees. The Hulton framework on maternal satisfaction stated that emotional and cognitive support makes the women feel wanted and important during pregnancy and childbirth for better results. The participants' verbatim responses are below:

Participants, Mitchelle and Tafadzwa in FGDs #1 stated, *"If you are told to go to the hospital and you need an ambulance, the ambulance medics will start to sing about the money yet in the meantime this was not a planned thing on my part. A friend told me she was allowed to pay later. 'Zvakashata zvekusarura' (*'It's not fair to discriminate' - local language***)**. In addition, participant Teresa, 16 years, in the face to face interviews *echoed, "When I reported at the birthing centre I gave them my maternity care booklet. As soon as the nurse noted that I was 16 years old, she said with a low voice 'uhhuu'. And started to shout, 'why do you engage in adult things instead of doing school? What size of shoe do you wear?' I replied size 4. 'You need to prepare to go to a referral hospital; you can't deliver here. I am calling the ambulance'. In no time I felt like something pushing down the birth passage. She said. 'It is not possible for a first timer mother never, never… You cannot deliver; you are just lying'. In no time I pushed and delivered the baby. The called ambulance had arrived. I was told to prepare to get into the ambulance as it had come for me. 'We had called the ambulance; it cannot go back empty get ready' said the nurse. The ambulance guys were told that the baby had a breathing problem….. The referral hospital nurses were surprised*

with the story. 'Oh, as for that centre (name withheld) -nurses fake referrals' said one of the nurses at the referral hospital. 'This clinic can get an award for bringing unnecessary cases".

Tadiwa, 38 years, in the face to face interview said, *"Nurses at this clinic are something else. Something ought to be done for sure, sureee…..***"** *The nurse said to me, 'As for you! have you not*

heard that as you get old your 'chibereko' ('womb'- local language) *also gets old; you can die from bleeding, poor stretching and shortening of the womb and your husband will marry a 'small house' (another woman), the following day'.*

Grace, 20 years, in the face to face interviews reported, *'I only said to the nurse I am due for my injection. She instead shouted at me." 'You are a problem don't tell me my work.'*

4.9 Theme 7 Neglect

This finding depicts what women go through in closed families in a society such as the suburbs of Mabvuku/Tafara in Zimbabwe where the society is highly patriarchal. Some women echoed their desperate encounters with boy-friends, in–laws and care providers who make the decisions for the women who carry the pregnancy and also give birth to life. Such decisions can hinder or delay the woman from booking early for prenatal care or she may seek help with TBAs compromising obstetric care. This finding points to the component of respect, equity and privacy as reported by the Hulton.et al (2000 /2007) framework. The following are excerpts from some of the participants:

Participant Vavariro, 18 years, in the face to face interviews echoed, *"I was accompanied by my parents when I was now in labour. When we got to the gate my parents were refused entry by the guard. This really puzzled me because I really wanted to be with my mother because she is special to me.!! This reminded me of the booking day when the nurse sent me back home because I did not have enough money. The guard further said, 'as guards we don't carry suitcases or whatever baggage because other women reported missing items like money after getting help.' 'It's now policy we don't carry patients' bags and I repeat your relatives do not help you inside.' I had about three things on me to carry the suitcase and two other bags. 'I was in severe pain and could hardly walk'. 'I struggled to get to the admission room with my 'katundu'* ('this is load'). *I called*

for help. I almost dropped by the door no nurse came to my help. I wish something could be done 'imi woyee.." ('imagine') *'zvakandipedza mafuta'* ('This really dried up my energy')*.*

Further, Zvavamwe, 18 years, in the face to face interview reported, *"I was shouted at during the birth of my child.' 'You need to push hard and to open legs wide, wide, uhhhu.' "I did not like it at all".*

Vavariro, 18 years, in the face to face interview, further added, *"When I was ready to give birth the attending nurse was on the phone talking and laughing." I shouted for help but she continued talking on the phone. She only came when I had delivered my baby alone. 'I had birth passage tears.' She injected me down there the birth passage when I had given birth a while ago it was painful'. She then left me for about forty minutes this nurse was cruel to me. "I wish something could be done to stop this aaah."*

Talkmore, 22 years, in the face to face interview, stated, *"I booked late because of money problems as my mother is a vendor." The little money she gets is not enough for our upkeep, but she tried little by little to save the few dollars to see me book for the pregnancy". The father my baby disappeared when I told him I was pregnant. 'Since that time, I have not heard from him at all. It was only three days ago that I heard somebody saying they met the mother in law", who is said to have said, "go tell her to be strong tomorrow might be better nobody knows". I however, kept praying for something positive to happen. "I have seen it all my God…I hope all goes well with my baby.' It's very difficult though."*

4.10 Theme 8: Cultural and religious value and practice

Some participants in individual in -depth interviews expressed their sentiments about the importance of culture and religion when they sought and accessed QOCS for themselves and their

babies. The Southern Relational Path, a model whose tenets of the relationship between nature, religion and heritage in communities, does influence the pattern of behaviour of people when they seek and access OC. In this study the participants expressed that the midwives were totally against the taking of indigenous medicine during pregnancy to facilitate easy deliveries. The nurses /midwives did not talk about religion as indicated by the participant's responses. Below are the participants' verbatim responses:

Talkmore, 22 years, in the face to face interview said, "*The pastor at church assured us that with the blessing from the Almighty, we will go through pregnancy and birth with ease. We need to pray for a good delivery, through the chasing of evil spirits; he will further say alleluia… one wished to hear something like that from the nurse*."

Maria, 17 years, in the face to face interview stated, *"My mother in –law told me to drink a herb mixture from a tree bark to broaden my birth passage but I did not drink the traditional 'muti' (*'medicine' in the local language) *because the nurse had stressed to us at the 'sikero'* ('prenatal care'- local language) *some of these herbs can harm the baby; she further said, 'you should never, never take them'. I have been around for a while..".*

Summary of the Study Findings

In this chapter the findings were derived from a qualitative design that followed Giorgi's phenomenological, psychological technique for analysis. Themes and subthemes were presented from the FGDs and the responses from individual in-depth interviews were also stated. Some of the responses by the 31 participants were presented in verbatim quotes. The analysis of the narrations of the participants are discussed in Chapter 5.

CHAPTER 5

DISCUSSION OF FINDINGS AND NARRATIONS

5.1 Introduction

The narrations were centered on the 18 subthemes and 8 themes that emerged utilising Giorgi's systematic 5-step analytic approach. The essence of this phenomenological study was to explore and gain insight of the complexities of the participants' experiences as they sought and accessed the QOCS during pregnancy, and childbirth in Harare, Zimbabwe. The participants' accounts illustrated that midwifery aspects of care have equal importance to clinical and infrastructural issues which are the core of the expected maternal care of Hulton, et al, (2000 /2007) for a positive outcome. This enhances the importance and consideration of these characteristics as an integral component of decent QOC. Women described whole -heartedly their perception of the care rendered to them especially by the male nurses as particularly wholesome. To mention some positive points, the cleanliness of the birthing centre especially the new linen and cupboards for putting their food was largely attractive. Bohren, et al (2017, do1.org/101/ijgo.12378), reported similar findings in their study. Quality of obstetric care is a challenge to define and measure, Tulcalp, et, al. (2015), it became necessary to understand how women's experiences of the care they received impacted on uptake of the services, since limited research has been carried out in Zimbabwe's resource -restricted urban settings. Hulton et al 2000 /2007 conducted an evaluation of women's experiences of OC in India and they also reported that the women were poorly engaged in their childbearing care, examinations and procedures were carried out in public places and the providers expected a tip or a bribe for doing their job.

Renfrew et al (2015) advocated for a change in care that works to strengthen women's capabilities in the context of respectful relationships, tailored to their needs, focused on promotion of normal

reproductive processes and where first line management of complications and accessibility to emergency care treatments are provided whenever needed. This study began, not with the needs of professionals nor the health system, but with the needs as described by postnatal women. Women's perceptions of their experiences are important in and of themselves, Renfrew, et al (2014) said, but if systems did not meet their needs, women were less likely to access services and could have rejected them altogether. Hulton, et al 2000/2007 advocate for the importance of health care systems that are focused at offering best practice through suitably skilled manpower, availability of resources and equipment in best working condition at all times to ensure quality.

According to Renfrew, et al, study, women alluded to QOC as good quality if clinical care is good and communication is improved, educative, informative and have respectful care givers as essential aspects of the expected care. The same authors reported that a combination of the mentioned factors was essential to keep the women and their new -born babies safe. Furthermore, poor maternity care services and disrespectful care, negatively compromise the health and wellbeing of women and their children and can lead to fatal incidents of MNMM, globally, regionally and locally.

5.2 Discussion of Text

The participants in this study expressed their acceptance of QOCS given during pregnancy and childbirth, where some of them praised the cleanliness of the facility, made note of the new cupboards and linen and the friendly reception afforded to them especially by the male nurses as stated in the above paragraph. This resonated well with Hulton's conceptual maternal care model. However, some of the participants expressed dissatisfaction with the care received citing bad attitudes, refusal to have a labour companion such as a mother or an aunt to ease their delivery experience process. Some participants reported that HIV/AIDS activities were overdone. The

nurses talked the whole morning about the condition, they had numerous registers to fill, they needed to bleed the new clients to get their sero–status and to give them their results after a long education talk on client management. This activity devoured the nurses' time on the Prevention of Mother to Child Transmission (PMTCT) program. For the reason that the PMTCT program is cumbersome in nature, a client's confidentiality was compromised, perhaps the care providers got overwhelmed with things to do on booking days. As a result, the clients ended up not listening to what the midwife /nurse was talking about in the educational talks regarding pregnancy's different stages leading to the mothers, perhaps, failing to assimilate useful information disseminated by nurses/midwives. This perception is contradictory to a study carried out by Kershan, et al., (2009) where care providers saw it as an opportunity to reach out to clients on HIV/AIDS prevention concepts.

Participants; Queen, Ruvarashe and Tabeth's excerpts in FGDs #5 and individual in –depth interviews alluded to the challenge that it might be helpful to cut down on the excessive registering documentations that was time consuming and interfered with QOCS rendered.

In this study it was reported that the staff were caring and professional, but others echoed elements of dissatisfaction with the quality of care they received during pregnancy, and child birth. Participants expressed the sensitivity of health workers as they accessed OC, specifically those who said midwives lacked empathy, and that they were rude and uncaring and putting clients to risk of infection caused by repeated arm pricks as they failed to locate blood veins. This was supported by findings in a study conducted in Nigeria and Uganda where women's perceived poor quality of care in a health facility, to be a critical barrier to utilization of services, (Idris et al., 2013). The findings in north -western Nigeria concluded that 23.7% of the women interviewed did not deliver in a health facility as they cited negative provider attitudes as a primary reason for not

using the services and 52.0% of the women suggested that improvement in provider attitudes was necessary to increase demand for clinic -based deliveries, (Idris et al 2013; Kyaddondo, et al 2017).

Both voices of warm reception singling out the male nurse midwives as being warmer and those that said nurses were not caring and lacked certain competencies concurred with Kruk, et al (2018); Shaifiei, T., Small, R., MacLacan, H., (2012); Tetui, M., Ekirape, EK., et al (2012) who also reported similar sentiments in their studies on women's views and experiences on maternity health care provision. Characteristically, Duong, D., Binns, CW., Lee, AH., Hipgrave, DB., (2004:447-452); Aitken, JM., (1994 /2009); Parker, S., McKinnon, L., & Krusker, S., et al (2014) also noted that clients rated pertinent factors such as attitudes, interpersonal and technical skills of service personnel as key to quality maternity care services. This speaks to the Hulton's et al, 2000 /2007 framework for QMC.

Some participants in this study appreciated the caring of midwives as they said they were offered a warm bath and a warm cup of tea post-delivery and stated that they were very happy. The caring received appeared to have cemented a good client-midwife relationship, supported by respectable administration and professional care. It becomes critical for midwives to uphold to professionalism at all times to ensure care and safety during pregnancy and childbirth. Contrariwise, poor attitudes and low esteem can derail QOCS provided to women during the prenatal, labour and birthing and post-natal period as asserted by Rahmani, et, al, (2013) in their qualitative study among health care receivers and health care providers in Afghanistan. Furthermore, providing women with a connected approach in caring ensures a positive wellness for both the mother and baby. Findings in a study conducted by Green, JM., (2012) suggested that it is important to demonstrate that it is a reproductive right that women like to be treated as individuals and with respect.

Participants reported long waiting periods in accessing care and if not booked they would wait for the chance created by a booked client who failed to turn up. The type of waiting experienced by the women in the study produced hunger and dehydration, which made them have a negative perception of the care they received. In the literature review, studies carried out by Novick, G., (2013); Hooper, P., de Bernish, L., Campbell, J., et al., (2014) revealed that some of the women participants were treated with respect and reported comprehensive, individualised care; while, other women experienced long waits and rushed visits and perceived prenatal care as mechanistic or harsh. Affording the women optimal care allows them to receive the best of maternal care, which is a strong stand point of the Hulton's (2000 /2007) model of maternity care. This also can reduce some shortcomings that may arise and cause pregnancy related complications to both the mother and baby, in helping to reduce both maternal and neonatal morbidity and mortality.

In this study, some participants reported that midwives got to them when they had already delivered and some sustained tears, with further delays in having those tears sutured causing them to experience a lot of pain, whilst some saw other women deliver their babies on their own on floor beds in the pre-natal wards. Robinson, JH., Callister, LC., Berry, JA., et al (2008); Tuncalp et al., (2015) reiterated that a safe delivery ensured a healthy live mother and baby. If women are not treated with respect and fail to receive individualized care they are forced to seek QOCS elsewhere, or they may be discouraged completely from seeking Skilled Birth Attendant care. Satisfaction being a nebulous concept, other participants in this study stated that the care providers were caring and approachable which helped them in understanding useful information they were given during childbirth. In this instance health care workers provided acceptable care, which allowed for the development of trust between them. Hulton, et al., (2007); Renfrew, et al., (2015) reported similar

findings that restates the significance of nurse/midwife and other health care team players' support throughout the pregnancy and childbirth for a positive outcome.

In this study participants pointed out that one of them received a wrong drug for a sore throat. This drug was administered by a trainee nurse from one of the training institutions in Harare. Students when on internship need a lot of supervision when administering oral medications and injectable drugs to prevent errors that can harm the patient. Kanotra, et al (2008) reported similar challenges among the participants in their study. It is envisaged that student nurses who are given this responsibility will have had their competencies in drug administration assessed even as they possess the recommended knowledge of pharmacology.

In this study some participants stated that nurses/midwives were short staffed hence the delays they suffered in not being attended to promptly. Other participants reported the crowdedness of the admission area with sitting space problems, yet some said that they were received warmly by the maternity care providers, while others were happy with the clean environment, clean equipment including toilets. However, some participants were unhappy with the shortage of drugs like iron tablets, medical sundries to include gloves and vaccines. Mabvuku health Centre and its Satellites experienced shortages of qualified staff because of the brain drain to greener pastures, shortages of water, drugs and medical sundries. The shortages had a negative effect on the QOCS provided by midwives. The importance of the availability of resources is scored highly for the provision of quality care, Donabedian (1980/2005) classifies resources under the structure indicator for measuring quality care. While Hulton, et al., (2000) considers resources as critical for maternal satisfaction, Jacobson, (2009); asserts that QOCS are basically the availability at a health centre of physical and human resources, cognition, respect, dignity and equity, and emotional support to clients. A systematic global review by Crissman, et al., (2013); Rahmani, et al, (2013) revealed

that the impact of the lack of resources greatly affects the delivery of QOCS. Higher MM is attributed to a variety of issues such as poor QOC, inadequate resources, poor infrastructure and inaccessibility to care is also echoed in a study by (Minerva et al., 2017). In this study, participants mentioned that nurses/midwives were few and as a result some clients were turned away without being served, the participants also said they were agitated and were overwhelmed and as a result the procedures were compromised for instance women giving birth unattended. Such experiences could have easily led to negative pregnancy outcomes.

The women's needs, views, values and experiences, as the key users of MCHS, should be considered as a useful component to the improvement of their health. It is vital to give women a platform to express themselves regarding their preferences and care values for efficient and effective QOC, more so, as the global communities are moving towards a, "Survive, Thrive and Transform" healthcare agenda to pursue the Sustainable Development Goals, (UN, 2016; WHO, 2016). This was the thrust of this study to unveil the experiences of women as they accessed OC and subsequently suggest solutions to avert MINMM globally, regionally and locally. Also resonates well with the study concepts and frameworks for better outcomes.

In concurrence with the importance of the human resource, another study conducted by Souza, et al., (2009) revealed that at times there were fewer of the care givers and that compromised the women's wellness throughout the care processes and could easily have resulted in complications such as unmonitored medical conditions of pre-eclampsia, and anaemia. These complications could subject the patient to eclampsia, causing maternal and infant mortality. Munjanja et al., (2007) also reported that medical conditions such as, anaemia, and diabetes can make women susceptible to maternal morbidity and mortality. Milltenburg, AS., van der Eem, E., Nyanza, EC., van Pelll, S, Ndaki, P., et al, (2017 10.1371/journal pone 0186279) also reiterated in their

Tanzanian study that ANC performance was marred by insufficient resources, poor performance in history taking and attention for clients' wellbeing. Furthermore, it is reported that the human resource shortages have an impact on the improvement of financial risk reduction for clients and patients, (Praita, N., Greing, F., Walsh, et al 2004; Chirwa, et al., 2013; WHO standards 2016). Human and physical resources are critical in the provision of QOC. The shortage of Skilled Birth Attendance also contributes to maternal morbidity in the form of women developing Obstetric fistula (Vesico-vaginal Fistula and Recto-Vaginal Fistula) as a complication of obstructed labour, a sequalae of unmonitored labour. A study done in Tanzania 2011, by medical students, as cited in the literature review, mentioned that there were about 2,500 to 3,000 new cases of Vesico-vaginal Fistula produced annually with long-time suffering from psychosocial consequences and stigmatization. Bashah, DT., Worku, AG., & Mengistu, MY., (2018), in their study stated that Obstetric Fistula causes life-long disabilities and poor quality of life and that in the developed world it is now very rare and indeed faded away 100 years ago following enhanced obstetric care while it remains the prevalent cause of maternal morbidity in the developing world. In consequent, the suffering of the woman with an obstetric formula lives with her and what she endures is best described by her, for many have been rejected, separated and forgotten whilst they are still alive. Their participation in community activities is shunned and the smell of urine and/or feaces live with them. It is in light of such devastating morbidity that this study would produce a model to help address emerging issues emanating from the experiences of women in the resource-restricted urban sites in Harare East. A model of care that has roots in the socio - cultural and religious bearing as propounded by Lessem& Sceiffer (2010/2014) Southern Relational Path, to improve the delivery of care to the women was developed.

In this study some participants booked late because they did not have the money partly because of the economic meltdown. This could be a true reflection of the impact of socio –economic power on the utilization of MCS. This decline of the economy called for the promotion of economic growth for better living standards, (Chimhou, Myengwa & Feresu, (2010; WHO, 2016). To mention some deficiencies cited in the study, babies failed to get their initial vaccinations which could compromise their developmental growth and protection. Resource availability has a role to play in the QOCS provided as it improves the uptake of services. Maternity care managers at all levels need to ensure that both human and physical resources are available at all times. This was well coined by participants Susan and Chipo in FGDs #2.

Some participants, however, were unhappy about the unavailability of drugs and medical sundries such as gloves and syringes. These factors are critical for the Emergency Obstetric Care program which focusses on the efficient running of MCS to reduce maternal and neonatal morbidity and mortality at all levels, Kruk, et al, (2009;2018) concurs. In addition, Saizonou, J., Godin, I., Ouendo, EM., et al, (2006) in their study on the 'near miss patients' views on the EMoC in Benin referral hospitals, also noted the importance of offering women due care during all the stages of pregnancy and childbirth. Nagahama, E.E.I., & Santiago, S.M., (2008) in their Brazilian study reiterated similar sentiments regarding EMoC. Brazil and China are now rated among middle income countries that are doing well in reducing MNIMM through the introduction of well, funded midwifery programs. Maternity care systems should therefore craft flexible policies regarding the booking and user fees that do not prohibit the access of QOC at all the stages of pregnancy and childbirth. Prioritization of resources at the allocation stage by management could mitigate the shortage of resources and ensure that staff needs are met for a better maternity delivery care all the times. To guarantee sustainable finances for maternal and perinatal health, countries could

accelerate progress through evidence, advocacy and accountability, (Koblinsky, M., Moyer, CA., Calvert, L., Campell, J., 2016: DOI.10.1016/s0140-6736(16)331333-2.).

In this study participants in both FGDs and individual in -depth interviews raised pertinent issues regarding a few demotivated nurses who were on duty because others were on an Industrial Action and gloves were in short supply. This could have affected their performance and impacted negatively on the care provided. This is indicated in the verbatim response by Maria, 17 years: *"Nurses may fail to pick up problems on you because they will be very busy and sad. When I gave birth some of the nurses had been suspended for being in a strike for delayed payment of salaries. Staff money need to be looked into to ensure that nurses work well and happily".* Prohibitive processes/procedures that can negatively impact on client care are embedded in human and physical resources issues, practice realities and negative attitudes on the part of staff. The human resource issues in the QOCS involved lack of midwives/nurses and provision of care; the poor interaction of the two parties (midwife/nurse/supportive staff and the client); inadequate supplies of drugs and medical sundries; inadequate space; and policy pertaining to booking system and user fees. Furthermore, the manpower shortage can result in an overworked staff at the shop floor, which can get too busy, stretched and sad, as noted by Wahn, EH., Nissen, H., Ahlberg, BM., (2005); Mselle, et al., (2013); Kruk, et al (2018). A study conducted in Vietnam by Duong, et al., in (2004) revealed similar sentiments where the women responded negatively on the provision of equipment, resources and staff incompetence in health centres. In the same light, Baillie, (2009) in a case study on patient wellness, expressed similar sentiments on how a lack of resources or shortage of essential medical sundries and supplies interfered with the QOCS. Also, Crissmann et al, 2013; Bekke, 2013 in a systematic global review stated that lack of resources which included staff shortage have a negative impact on the delivery of MC. It is suggested that staff conditions

of service and benefits need to be given special priority. To abate job demotivation and burnout, conditions of service and benefits and pay salaries need prompt attention for sanity of staff at all the time. Management requires an innovative leadership that priorities resource allocation that will meet both the client and staff needs for a better MC delivery at all times. These findings address the set objectives 1 and 2 of the study.

Some participants in both FGDs and the individual in -depth interviews expressed negative sentiments about the distribution of some essential drugs and medical sundries. A participant was segregated in the issuing of an iron tablet and the other client delayed having an injectable drug, oxytocin, administered because gloves were out of stock. Zakeyo, (2016) in her comparative study between Harare Hospital and Karanda mission hospitals in Zimbabwe, participants echoed that the later had better supplies of medicines, medical sundries and equipment. This challenge in the provision of QOCS could be avoided if priority for the foreign currency allocation was considered for health products ahead of other budget allocations.

In this study some participants were dissatisfied with the behaviour, knowledge, skills and practice of some of the nurses /midwives and supportive staff. They were also dissatisfied with the care and the midwives' competencies when conducting their duties during the prenatal, labour and birthing and post-natal periods. The women, as reported, suffered undue pain during deliveries as some sustained tears, some delivered babies by themselves because the midwives perhaps did wrong assessments of the birth progress. The women carried their suitcases and baggage whilst they were in pain. They were required to pay user fees up front and their pleas to do part payments of these fees were not entertained. Also, they were asked to lie on their left lateral side regardless to how they felt until delivery which was uncomfortable and painful. While labour was in progress, additionally, they were not allowed to even take sips of water when thirsty and vaginal tears were

sutured without any local anaesthesia which was very painful. One participant was asked to state her HIV/AIDS status in front of others which was quite humiliating. Some were denied treatment before they had bloods taken for an HIV/AIDS research project that was running concurrently with this study. Afulani, et al, (2017); Dzomeku, et al (2018) reported similar determinants and drivers of QOC during childbirth. It becomes critical at all times to have care providers that are competent and skilled to offer the best practice to limit shortcomings when delivering OC. The Hulton et al., (2007) model of maternal satisfaction stated that the positive physical and human factors can influence the utilisation and uptake of these services.

Nurses and midwives too, are expected at all times to provide holistic care to the women during pre – conceptual period, prenatal care, labour and birthing and postnatally to ensure a positive outcome. Holistic care could improve the seeking and accessing behaviours, which in turn, can attract pleasant and improvement of MC uptake, which can arguably facilitate on provision of QOCS. Furthermore, nursing and midwifery as disciplines should at any opportunity availed endeavour to provide pregnancy related concepts to both young men and women in early adulthood to help them understand their needs as human beings in their entirety so that an attitude of being concerned about others is instilled in them (Muhlanga, et al, 2016). In addition, D' Ambruoso, et al., (2008) in their study, noted that a lack of supportive care, including a perception that the care provided was mechanical or lacked comfort or courtesy was registered. They made women feel unsupported and not sufficiently cared for that they did not receive the time and attention from health care workers. The same authors further reported that despite receiving technically sound care, their experiences were marred by lack of emotional support and their experiences were therefore incongruous with their expectations. Another study conducted by Campero et al., (1998/2006) in Mexico, revealed that women complained bitterly about the way the vaginal

examinations were done. The care providers induced shame in their clients as the women were examined in front of their mates which was humiliating. These examinations were done while the women were having painful and strong contractions and the women suggested that this could be done gently to ease the labour process. It is being suggested that health care providers also need to receive adequate support in order for them to feel valued which can in turn make them more motivated to provide higher quality care, as suggested by Prudhan, et al., (2011); Larson et al (2015). Also, Tobianos, G., (2015); Muhlanga, M., et al., (2016) in their concept analysis alluded to the importance of upholding the nursing practice for client satisfaction and wellness and Nawaneelttan, K., & Dhamalingan, A., (2002) in an Indian study, emphasized the same that midwives/nurses need to maintain the callings of their training to ensure best practice. Additionally, they might benefit from workshops and lectures tailor made to maternity current issues such as respect and dignity of human beings and their rights so as to empower them against staff induced gender -based violence. Asafar, &Bekele (2015:33); Mengistu, et al (2017 /18) reported abuse and mistreatment and poor regulatory systems in their study on violation of rights to information, informed consent and choice /preference of position during childbirth. Their findings showed that 39.3% were without attention during labour, 14.1% in health centres and 63.6% in hospital, 78.6% objectively faced disrespect and abuse. Furthermore, Hunter, B., Berg, M., Lundgren, I., et al., (2008); Rosen, HE., Lynam, P.F., Carr, C., et al, (2015) in their studies noted that aspects of care, which are, a caring and sensitive attendant, are highly valued by most women in many countries and contexts for maximum utilization of QOCS rendered. The study by Kruk, et al., (2014/2018); concur that a positive client perception of the doctor's and nurse's skills can increase utilisation of the maternity delivery services. Additionally, Rosen, et al., (2015:306:1-11) in their study findings also outlined similar sentiments and noted that aspects of care are highly

valued by most women in many countries and contexts. Blutta, et al., (2010) provoked health professionals to re-think about their practice to ensure that the care they offer is humanized for an optimal care for both the mother and baby. Miltenburg, et al (2017) in their study express similar sentiments. The development of a model of care that is guided in nature and environment as promulgated by Lessem& Sceiffer (2010/2014) Southern Relational Path model, may have an impact for the health centres in Harare as a noble initiative that could improve the QOC provided to the women of childbearing age for improved care.

Excerpts from participant, Vavariro, 18 years, in the face to face interview, echoes the challenges that women face during pregnancy and childbirth and these responses concur with the study findings of a qualitative analysis of consumer evaluations of maternity care in Queensland Australia, by McKinnon, et al., (2014) which found that the midwives lacked empathy and were rude or showed uncaring behaviour. Studies also conducted by Patel, (1991;2015) Souza et al., (2009); also shared similar sentiments on how clients could be discouraged from accessing and seeking OC if the services and the carers did not afford them pleasant OC at every stage of pregnancy up to the postnatal period.

Some of the participants in this study, were unhappy about the assessments done by midwives which were at times not accurate, others were forced to lie on the left lateral side most of the time, yet some sustained vaginal tears and relatives could not accompany them into the birthing centre especially at night. They further stated that midwives refused them to take any food in early labour even sips of water, Hatamaleh, H., Shaban, I.A., Homer, C., (2013; Vedam, S., Stolll, K., Martin, K., Rubashkin, N., Patridge, S., et al, 2017) concur with these sentiments. Vaginal tears can make women susceptible to puerperal sepsis (PPS) or maternal sepsis has become a number one cause of MM. In a study conducted by Bonet, M., Souza, JP., Abalos, E., Fawole, B., et al (2018)

doi.10.1186 /s12978-017) 11% women had died of PSS. Ngozi et al, 2017/2018, share similar sentiments in their study. It has become a significant contributor of maternal deaths globally. This calls for effective prevention, early identification and adequate management of maternal and neonatal infections and proper management of women during childbirth to prevent this global menace. The experiences of women in this study have therefore, affirmed the existence of this underlying scourge which can exacerbate the current maternal deaths.

Further, Michels, (2015) asserted that loss of autonomy left women frustrated with what the midwives were doing to them as they were not allowed to talk about their misgiving. Also, Pitchforth, et al., (2010:1739 -1748) in their assessment and understanding of quality of care in labour had the similar findings from their study in Gondor, Ethiopia. If labour and birthing are not well monitored the maternal and neonatal morbidity and mortality will remain high, (Homer et al., 2014; Chikadaya, H., Madziyire, MG., Munjanja, SP., (2018). In concurrence, Waldenstrom, et al, (2009) in a Swedish study on the intrapartum and postpartum care regarding women's opinions, stated that midwives should screen all the possible risk factors on the labouring woman to exclude anything sinister that can impede progress by proper use of the parto–gram at all the times. Forssen, A.K., (2012) reported that a lifelong bad and fearful experience can be instilled in the women which can affect their booking status for pre-natal care that in turn can have a negative impact on the mother and her baby. Ray et al (2017); Day et al (2017); Dzomuko, (2018), share similar notions regarding childbearing women's quest for quality care throughout the process of carrying pregnancy to childbirth.

Further, some participants reported that the information they received was inadequate or confusing and lacked detail. Findings in the Hulton's maternal satisfaction model purports that women consider information that is adequate and consistent to be sufficient to help them

understand and make informed decisions. Information on family planning drugs (FPDs) was confusing on issues of when to initiate the drug; information on immunizations schedule was confusing; some nurses referred the mothers to the family health service clinics for the vaccine; and availability of either the vaccine itself or the syringes always was problematic; inadequate preparation for breastfeeding initiation and implementation; and breast care was not emphasized on day of booking even on subsequent visits, at times it was mentioned on discharge, which was late for effective and exclusive best breastfeeding practice. This was reinforced and reported in the Sibindi, et al., (2015) study on exclusive breastfeeding as the best infant nutrition in the first six months to prevent dehydration and jaundice.

In addition, the confusing and inadequate information on vaccination could affect the protection of the babies against the immunizable diseases. Hulton, et al (2000 /2007) states that communication, therefore, between the care provider and the client should be clear, factual and precise. The interaction should not be interfered with by some hostile happenings or stressors at the work environment and this if well instituted may help to facilitate both the diagnosis and treatment process preferences as suggested by Renfrew et al., (2014) in their maternal satisfaction analysis. Also, WHO, (2002) reported that late initiation of the first breast feed within 1 hour of delivery makes a lot of difference to the health of neonates. Nurses /midwives should, therefore, emphasize this to the mothers who opt for Exclusive Breast Feeding for effectiveness Mugadza, G., Zvinavashe, M., Gumbo, F.Z., Haruzivishe, C. (2017) revealed similar findings.

The relationship between the two parties, mother and the care giver should be characterized by privacy, confidentiality, informed decision making, concern, empathy, honesty, tact and sensitivity, (Fenwick, 2009; Hall, et al., 2009; Blutter, C., 2017 http/dw.com/p2pQ1s). The woman must reciprocate the therapeutic advances proffered by the care-giver for better participation in the

care. Also, client health education enhances a positive outcome and empowers the clients to make informed decisions concerning their health as noted by McEwen & Wills, (2007). It is also reported that women need clear communication, as a poor relationship between them has a bearing on pregnancy and childbirth outcomes, as noted by, Okufar, CB., & Razzito, R.R., (1994 /2015); Heatley, et al., (2015).

In addition, Safe Motherhood, (2006;2012;2014) concurs with the notion that communication is important in the transmission of information with clients /patients. Afulani, et al (2017) in their study also emphasize the need for clear instructions and what is said to women to ensure better understanding between the two parties. It is being suggested that MCHCP managers need to develop open communication systems that can ensure that women understand and are able to make informed decisions throughout pregnancy and childbirth. This can facilitate the clarification of the not so clear communication issues that at times uses the medical jargon and improve the connectedness and links between the provider –client matrix complexities as they seek and access QOCS. This link could also encourage empathy and help reduce GBV, mistreatment and disrespect which have become a feared feature in maternity care as shared by researches done globally, regionally and now locally. This also points to the endeavour of this study to address objective 1&2 and reiterates the Hulton, et al (2000 /2007) framework for better care during childbirth.

In this study some participants expressed that a booking system exists, but it is not known by the care users. When they got to the health centre they were told to book for the next appointment or were asked to wait to fill in for somebody who missed her appointment. This was not known by the clients and ceased to serve its purpose. Clients were frustrated when they were given messages at the centre, which they felt they should have known in advance. The presence of suggestion boxes which clients could use to deposit their suggestions could, perhaps, be of great assistance.

For the suggestion boxes to be functional and effective, there should be set deadlines on when to open and provide feedback to both of the interested parties. An evaluation however, is required to validate its usefulness. Women lamented that inability to express their opinions about the treatments and services rendered to them during birth was because they were afraid of receiving unfair treatment and discrimination. As mentioned by Fonn & Philpott, 1995; and Greedy, et al., 2002 a lack of a mechanism to inform and to facilitate dialogue between client and provider can interfere with provision of MC. A lack of a redress mechanism for lodging complaints was found to be a missing link in the provision of care during childbirth, (Forin, 1995; Izugumbra, 2017). Also, McMahon, S.A., George, AS., Chebet, J.J., et al., (2014); Vogel et al., (2015) grieved that inability to express one's opinion removes the right to freedom of expression. Nurses/midwives and other health care team players should at all times allow the women to speak their minds, as this could offer them a sense of belonging. To promote dialogue with the women might essentially be helpful to create open channels through the establishment of toll-free lines. Women require to be prepared for labour to ensure their preparedness for delivery, expect warm communication with care providers and if these are in place, they could experience high levels of satisfaction. Ratcliffe, HL., Sando, D., Lyatnu, GW. et al, (2017, doi.1186/s12978,) encourage this in their study for better quality of care.

Furthermore, participants from both FGDs and in Individual- In-depth Interviews, expressed that they received different messages on the initiation of FPDs from nurses/midwives, which has a bearing on the utilisation of information for better health base empowerment on family planning (FP) issues. They received confusing information on when to start FP, some were told they could start right away while others were told to start when they had stopped bleeding to give their bodies time to rest. They also said information on the use of the non–chemical FP method (condoms) was

not mentioned as an alternate FP method which is cheap and easy to use if properly managed. The giving of inadequate information concerning the initiation of FPDs could have a negative impact on the women's utilisation of these drugs. Spear, HJ., (2004); Kiesler, DJ., Auerback, SM., (2006) support the importance of giving sound information to facilitate drug adherence for example clients might not use them at all to plan and space their families, they may take them wrongly and fail to get protection against pregnancy and fail to get maximum protection from condoms against STIs, HIV and Aids as well. They also fail to arrest unwanted pregnancies with the ripple effects of committing unhygienic street abortions which can result in complications such as renal failure, and anaemia. These negative consequences may compromise the UN's sustainable strategic goal number 3.3 &3.8 on the promotion of maternal health. To mention one major complication of street abortions is puerperal sepsis that is the number one cause of MMM.

Some participants also reported that their babies were discharged without getting the BCG vaccine, the first vaccine against Tuberculosis because of it either being out of stock or the syringes not being available. They echoed that nurses at the referral hospital (name withheld) at times referred women to the family health clinics responsible for immunizations, FP and growth monitoring responsibilities for information on the immunization schedule which could be a sign of a knowledge gap on this aspect. Some participants said nurses told them to go to these same clinics for their services when they knew the vaccines, or the syringes were out of stock, women ended up moving up and down for the unavailable vaccine or syringes.

Women can default prenatal and postnatal visits and fail to have their babies immunized according to the immunization schedule. It is posited that women require clear and consistent information to help them understand what Ministry of Health Child Welfare, disseminate to them. These authors concur with the notion, (Raven, JH., Tolhust, RJ., Tang, S., van den Broek, 2011; Heatley,

2015; Vogel, et al 2016). It becomes imperative to give clients adequate and accurate information to avoid misunderstanding and frustrations that can be caused by chasing services that are not available because of scarcity of resources to ensure quality. Women in Gambia in north Africa for example, resorted to home deliveries assisted by TBAs or a relative as their first option, because they had experienced communication barriers between themselves and the care professionals, (Cham, et al., 2005). The woman was told by the nurse to report to hospital when in labour. When labour began the relatives decided not to go to the hospital because she was not told to report to hospital before labour began. If vaccines or the syringes are out of stock it might be helpful to send this information on platforms that are recommended by the floor managers to avoid the mentioned frustrations that were suffered by these clients/women and their babies. Such inadequate instructions have negative implications that can lead towards poor protection of babies and neonates leading to poor immunity boosting for the babies leading to NIMM.

Some participants did not get adequate information on (EBF) to ensure a better outcome since it is the best infant food that prevents jaundice and dehydration. Furthermore, benefits of breast care enhance best breastfeeding that can facilitate the reduction of problems like engorgement and nipple cracks were not given in detail. They further stated that information on how to position the baby for optimal breastfeeding is not mentioned or if said it is done at discharge which reduces optimal breastfeeding. Inadequate information on breastfeeding, can result in infant loss of weight, poor bonding, dehydration, jaundice as noted by Suksumek, N., Plrunnet, T., Cimmanvanaky, S., et al., (2010). Other researchers concur with this finding on the impact of giving women inadequate and inaccurate information on breastfeeding, as noted by Baker, Choi, Henshaw, et al., (2005); McKinnon, L., Prosser, SI., Miller, YD., (2014); Sibindi, et al., (2016) and Mugadza, et al (2017). Staff should take due care when giving information to women during childbirth to ensure

QOC and maximum utilisation of the health centres. This may go a long way to prevent them from using TBAs, forums that can make them susceptible to pregnancy related complications, (Atuyambe, et al., 2006; Gundani H.V., & Gandanga, S., 2011). It might also be helpful to establish breastfeeding forums where women can share breastfeeding information in the health care centres to equip the new mothers with breastfeeding concepts at every stage of pregnancy that is prenatally, in labour and postnatally to reduce any misconceptions, inconsistency and insufficient breastfeeding information and other important information on FP and immunisations.

Some of the participants reported that they could not book for their pregnancy because the clinic appointment system was fully booked which caused anxiety, despite the presence of a booking system. Clients are expected to make appointments with the health centre for the first booking which unfortunately is not recorded. It becomes important for the service managers to come up with flexible policies that are sensitive to the women's needs concerning the booking system that is failing to do what it is intended to achieve. It is thus, suggested that a notice board with clear information on the booking system's purpose and the actual amount of both maternity fees, ambulance fees and any other fee service charges ought to appear on this board for everybody to see. Greedy, D., Schouhet, J., Horsefell, J., (2000); Sil al SP., Penn –Kekana, L., Harris, B., et al (2012) reported that childbirth systems, incidents and other contributory factors have a bearing on the way women access and receive QOCS which was the thrust of this inquiry. Additionally, it is suggested that the health department of the city of Harare administration and its top management need to establish systems that will come up with staff incentives in order to provide social and financial needs. This incentive could also promote staff morale and motivation.

A rigid maternity fee- cash payment system is in place but is not known or written anywhere for women to read for themselves. This causes serious delays in the booking of their pregnancies for

early screening of pregnancy related complications such as pre -eclampsia, diabetes in pregnancy and cardio -vascular diseases and cases of cephalo-pelvic disproportion. This delay to book can hinder a positive outcome for both the mother and baby and could be worsened by the current economic financial constraints that exist in the country where most young people are not employed. Similar findings were reported in a Malawi study by Kumbani, et al., (2013) where user fees interfered with the clients' booking patterns. Furthermore, Ensor, T., Ronoh, J., (2005); Parkhurst, JO., Ssengooba, F., (2009) reiterated on the effectiveness of financing the MHCS for better outcomes in their study. It is therefore, suggested that a part -payment plan could be instituted to facilitate early booking although it has its own problems of tracing these clients. Excerpt of participant, Tamuka, 22 years, supports this. To mitigate this, challenge an inbuilt recovery plan through partnership with groups in the community such as the business people, churches and others could improve the QOCS. This finding addresses the study objective 2, to explore the socio-economic factors regarding the women's access to this care undergirded by the Southern Relational Path framework for the delivery of resources/services that are acceptable to both parties for better care to reduce mistreatment, abusive language and disrespect of child bearing age women.

The Southern Relational Path has a close link with the environment were people and animals live together for a common purpose and it is also the medium that allows people to create for procreation regardless the circumstances (Lessen, & Schieffer, 2014/2017). At the time of collecting data nurses were not at work because some of the nurses were on an Industrial action for better cost of living adjustment. Some participants in this study showed displeasure with the congestion in the admission area, prenatal, labour and postnatal wards, prohibitive waiting time for prenatal service and inflexible prenatal services. However, some participants were happy with

the cleanliness of the facilities. A conducive environment is known to facilitate individual's wellness, (Neaumen, 2003). Furthermore, in another study in Maharastitra, India, which compared public hospitals, birthing centres and private hospitals it was found that some of these institutions had similar situations that is clean environment, water and adequate rooms, (Griffts, P., & Stephenson, R., 2001; Matthews, Z., Stones, R, W., Ramsubban, R., Singh, B., and Hulton, 2000). In addition, some participants reported the lack of entertainment either through the radio or television at both local and referral levels. They complained that the facilities did not have any radio or television to watch soccer or a popular drama series and to listen to the news, they however, were happy the walls had informative charts to look at. Additionally, a study conducted in Gambia by Jallow, IK., Chou Y-U., Liu, L-L. Huang, N., (2012:6), reported that women perceived the facility where prenatal care was being conducted as being crowded, which prohibited the participation of their spouses, significant others or relatives. Also, few studies on user perspective of healthcare services undertaken in Nepal revealed similar findings where the quality factors that are pertinent to clients included attitudes, interpersonal and behavioural skills of service, (Rao, Peters 2006/2018). Some women regard QOC as treatment that includes a clean environment, prompt service, accurate information, opportunity to learn and to be given adequate time to interact with staff and receive feedback, (Senarath, U., Fernado, DN., Rodrigo, I.,; Godlee, F., 2009; Heatley, 2015; WHO, 2016). It is was emphasized that clients required attractive and welcoming facilities that offer them first class customer services for best outcome.

Some participants reported crowding in the admission area, labour and post-natal ward which was prohibitive for relatives or partner support. Failure to offer adequate space for women during all the stages of pregnancy and childbirth hindered the involvement of spouses, significant others as preferred by clients, which can result in women especially first timer mothers getting poor signals

about the care providers and the MCS delivery system. Foster, J., Burgos, R., Caceres, R., et al., (2010) in a community –based participatory study to establish the perceptions of the Dominican Republic women regarding the care they received concurred with our study findings as they reported that women expressed that the waiting area, admission and labour wards were congested which discouraged partner involvement.

Nurses in–charge could create conducive space or time for spouses, significant others and relatives to allow the women the support and the exposure for their relatives to OCS concepts. It is being suggested that women be permitted to stay for two to three days longer for rest in the postnatal ward to allow for adequate rest post -delivery and allow them to learn more on hints about EBF for better breastfeeding enhancement. Participant, Tecla, 19 years alluded to these sentiments.

Participants also, reported long waiting times and limited sitting space in the prenatal facility on booking day. Participants, Grace, Rose, Ramwai and others in #6 FGDs expressed their displeasure with the crowdedness of the prenatal area which could have prohibited husband or partner involvement in pregnancy related activities. This can also, hinder emotional support that young women especially the first timer mothers require in order to cope with pregnancy related discomforts, problems and complications. These findings are consistent with a study conducted by Foster, et al (2010) in Nepal which reported over-crowdedness with high bed occupancy and the heavy load, which made it difficult for the staff to cope and offer respect, dignity and professional care to the pregnant women that unfortunately, resulted in poor interpersonal performance as well. Furthermore, Smith & Roberts (2009) in a study on young parents' perceptions to barriers to prenatal and postnatal care expressed similar sentiments from that study's FGDs.

First-line managers should at all times ensure that spouses/significant others and other preferred relatives by expectant mothers, are willing to participant in the women's pregnancy-related

activities; and are offered space and chance to do so as support plays a key role in reducing pregnancy related discomforts. The researcher suggests that allocation of a special day where partners, spouses and relatives could come for pregnancy related fun day to learn and interact with care providers. This could go a long way in imparting knowledge to them and could perhaps, reduce negative decisions that partners and in–laws at times take, which can prohibit the provision of quality care to pregnant women and their unborn babies.

Some of the participants noted that the care settings had little entertainment to offer some diversional therapy for women as they sought and received MC during all the stages of pregnancy. What was available was the print on wall charts, but some had overstayed their welcome and were discoloured, as some participants observed. Participants reported that there was no radio or television which was at least an affordable form of entertainment available in most homes, in the birthing facilities and the referral hospital. This could affect booking patterns should a competitor arise in the area and is able to provide what the women need because this could be an aspect that might reduce pregnancy related stressors. These findings are contrary to the Southern Relational path that promotes conduciveness of the environment where people are expected to live in harmony to promote happiness.

VandeNusse, A. (2008); Luce, et al., (2016) in the high-income countries such as the USA, Great Britain and Australia respectively, where the media is used extensively to give varied images about childbirth in some instances it gives the women the impression that medicalized care is the best which confuses the client. Furthermore, Price, S., Noseworthy, J., & Thornton, J., (2002) in their study also noted similar experiences of mothers on social aspects during birth. Rao & Peters (2018); Ratcliffe, et al, (2017) expressed the importance of patient–centred care to promote optimal health for the mother and her unborn baby. It is being suggested that some form of entertainment

like radio and television, and also the use of non-pharmacological therapies could be introduced to reduce pregnancy stressors and discomforts, (Marshall, J., Raynor M., 2014).

Some participants in this study described their sense of fear of ill treatment and discrimination because of stature and age, by midwives and failure to pay fees for MHCS and they expressed their wish to see a change of this pattern of behaviour to reduce the observed practice. For the reason that this treatment was observed and shunned, some of the women might prefer to seek pregnancy related services at certain birthing centres. They may also prefer to seek these services at the TBAs an aspect that should be discouraged. Unresponsive care, deprived standards of privacy, indiscretion and unethical judgements by health care providers are elements that could have caused fear and discrimination. In a study conducted in South Western Nigeria participants reported similar findings nearly 100% -(93.2%) incidence of disrespect and abuse. This calls for reorientation of healthcare workers and rigorous awareness of this sequalae in communities to reduce its occurrence, Ogunlaja, AO., Fehintola, OA., Ogunlaja, IP. Popoola, G., et al (2017). Gila, S., Bhavya, R., Adil, I., (2018: DOI. 10.1080/09688080) share similar views about this phenomenon which is causing women pain and stress that needs aggressive attention to reduce it to ensure quality. Furthermore, a Jordanian study by Oweis, A., Abushaikah, (2004) reported some of the worst experiences of the women during childbirth that encompass abuse and disrespect, which might induce fear and intimidation to the women forcing them to book late or not to book.

Nurses /midwives and other health care team players take up vows to offer optimal are to clients /patients regardless of colour, creed, religion, class, status and yet may fail to maintain maximum degree of confidentiality as stipulated in the patient's charter of Zimbabwe that requires to be adhered to. Sparks, (1990; Mselle, et al 2013; Bradeley, et al 2013) in a study on TBAs alluded to a similar notion in the study on roles and practices of traditional birth attendants in the country.

Aspects that surround negative birth experiences and discrimination issues have a negative effect on women during the seeking and accessing MC. In this study it was found that midwives induced fear or showed negative attitudes which could lead to discrimination. This feature has become, 'hot spots' in maternity care centres and need to be nipped in the bud to reduce occurrence. Dodzo & Mhloyi (2017) revealed similar sentiments. The study frameworks alluded to the importance of shop floor friendliness, promptness and alertness during all the stages of pregnancy, labor and birthing to ensure proper prenatal attention and an easy and reduced delivery complications for better outcomes.

A study conducted in Canada on the Somali women, revealed that the women felt discriminated in the care they received, Chalmers, (2002) which may affect the place to book for the next pregnancy or might mean late booking which can result in adverse maternal care outcomes. Schooley, et al., (2009); Fenwick, et al., (2009) in a Kenyan study reported that women were discriminated and stigmatized which affected the uptake and provision of labour and delivery services. Wholesomely, a sense of fear or ill treatment and discrimination because of age or non – payment of fees could interfere with future accessing and seeking maternity care services and ultimately uptake of QOC. Midwives, nurses and supportive staff need to be sensitive to women's needs to reduce fear and discrimination. MCS managers might run customer care workshops for all the staff to ensure friendly and warm care at all the time regardless of person's status, age and education but the honors remain with the individual to practice according to the protocols provided.

Some participants expressed their sense of neglect or abandonment by midwives or spouse /significant other, which had a bearing on their physical, emotional, economical, psychological wellbeing and this sequela could escalate in pregnancy. Additionally, few of the participants elucidated that some midwives and spouses were very aloof during the course of care. This type

of behaviour can cause psychological trauma which can initiate post -delivery puerperal psychosis if not well managed. This can result in delayed infant formula feeding, and delayed lactation for those mothers interested in breastfeeding and in turn, interferes with EBF initiatives f the Ministry of Health and Child Care is advocating in Zimbabwe. Hall, et al., (2009); Fenwick, et al., (2009) concur with the study findings. Mitchels, (2013) in his online publication, reported that women, if they experience psychological trauma before pregnancy, during the prenatal period, in labour and birthing can have some post-delivery stress related problems that can affect mother to child bonding, breastfeeding and wellbeing. Okafor, II., Ugwu, E.O. Obi, S.N., (2015) reported in their study that, disrespectful behaviour and abusive treatment during any phase of the pregnancy can result in negative outcome for the mother and baby. Mengistu, et al, (2017 /2018) in their Ethiopian study share similar sentiments which calls for close monitoring of deliveries in maternity care units constantly. It is being emphasized that pregnant women need all the support they can receive to avoid the mentioned stressors.

According to the Southern Relation Path, Lessem &Schieffer, (2010 /2014/2017), nature, heritage and environment can provide for the less privileged to ensure better OC and uptake. However, in this study it was contrary, women failed to access OC because of socio –economic situations more than cultural/religious constraints. One of the participants mentioned that she was sent home for at least three times. Further, it was reported that midwives and other health care workers were insensitive about culture and religious values of the clients (Dodzo, &Mhloyi, 2017). This can inhibit clients' MC uptake. Conservatively, in a study by Ha, W., Salama, P., Gwawuya, S., Kampala, C., (2014), a participant's endeavor in the Individual -In-depth- Interview, was desperate to a point of wanting to commit suicide, as she was abandoned by her boyfriend who disappeared on learning about her pregnancy. She had no track of the boyfriend up to almost point of delivery.

She got hold of the mother-in-law who was also a destitute. Initiation of hotlines for desperate and abandoned cases that can be used to provide assistance for such cases can go a long way since most people in Zimbabwe own phones. Additionally, health centres can have such lines for the same purpose as well as create active youth friendly corners for such cases to reach out to other young mothers that require instant help to avert negative impact on the QOC rendered. Furthermore, there is a need to educate both boys and girls at schools, churches and community, at meetings on important reproductive health concepts such as pre–conceptual concepts delayed sexual debut to reduce STI/HIV/AIDS, taking of folic acid tablets when one plans to get pregnant to combat Anaemia. The study findings confirm the mentioned sentiments and a participant said this to confirm, (Maria 18 years*)*.

Differences between the cultures of health care services and service users have been reported as a major issue in service delivery and this aspect is the focus of the Southern Relational Path, promotion of culture for better life outcomes (Lessem and Schieffer, 2010/2014/2017). Perceived or actual cultural insensitivity or incompetence of professionals can lead to perceptions of poor-quality care by users or discrimination of certain users by providers, resulting in a lack of trust in services and service providers as suggested by Liamputto, et al., (2005); Fouka, G., Plakas, S., Taket, A., et al., (2012: 1058 -68). Their study findings stated that the health–related religious rituals can improve the uptake of maternity care services. In the same vein, Leininger, M., (2006) encourages that nursing needs to respect cultural diversity and universality to enhance the women's seeking and accessing behaviors. Also, a study conducted by Aziato et al., (2016) reported that 13 of the participants used the power of prayer to ease the discomforts that come with pregnancy, labour and birthing and pain management in the postnatal periods. The research advocates that MC that is led by care providers who are culturally sensitive during all the stages of pregnancy

could ensure an excellent quality of care delivery. This is further highlighted in the developed model of care to concretize the aspect for better care of the women and their babies and to share with other countries in resource restricted settings globally, regionally and locally.

Religious values, childbirth, and the time around birth, is a social and cultural event that is often governed by norms as suggested by Mahaka, W., (2014). In addition, Camacho et al., (2006); Gabrysch et al., (2009); reported that culture had an influence on the health seeking behavior at all stages of pregnancy. Nursing through the use of the nursing process can let culture permeate through all the aspects of the care of women, as suggested by Amin et al (2010). However, in most societies, the dominant culture, is expressed through social institutions such as the health care system, which regulates how health issues are both perceived and addressed. It is thus, best to incorporate it into nursing in its curriculum for an easier implementation across the levels of learning.

Many authors have recommended that cultural factors should be taken into account in the planning and delivery of services in order to effectively encourage service uptake as an important step to reduce maternal and newborn mortality, (Faley, et al., 2013). Intercultural approaches to the design and delivery of national policies are well-established in some countries, particularly in Latin America as noted by Camacho, et al., (2006). The need for 'culturally-appropriate' health facilities is core to the care WHO's mandate on 'health for all' as was also reported by Gabrysch, et al., (2009). It can be argued that a strategy that can facilitate the improvement of maternal and newborn health as well as the reduction of MM if QOCS can be assured at all levels of care. These findings address what the researcher set out to establish in objective 2 of the study.

5.3 Overview of the research journey

The study findings created an imperative need to address the health concerns of the women and their experiences were useful in the crafting of an adapted model of care as well as appreciating the Southern Relational Path, proffered by Johnson, (1987); Lessem & Schieffer, (2010) and the Hulton et al., (2000/2007) framework on maternity satisfaction of care. The Southern Relational Path is intrinsically humanistic in nature and community and resonates well with Women's Beijing Platform for Action for health. Uncovering nature and cultural orientations can give birth to the GENE concept from the word genius. GENE is an acronym for Grounding, Emerging, Navigation and Effecting, (Lessen & Schieffer, 2010). In the introductory chapter an explanation of the burning issue/burning desire was done to express what was at the heart of the researcher, the concerns of the women's health and the seeking and accessing of MC.

The researcher from her young days was interested in caring for others. She did not go further with her secondary education to attain a degree after her Cambridge certification, so she could help her siblings with their school fees to better their future qualifications. Her second name Vupenyu (Life) points out to an indication that later on in life she would put in her energies in making a difference in people's health. She worked hard to gain knowledge and skills in nursing, midwifery foundation and community health nursing. She obtained a Kellogg Foundation scholarship to do a Master of Science degree with dual major in Community Health Nursing and Administration in nursing to fulfil this dream. The burning issue is not relevant to the researcher only, but to society in total, this is seen by the efforts big international and local institutions have made to improve women's health, to mention some; WHO/World Bank/ USAID /UNDP/ UNFP, INC/MDGS /SDGs no 3.1 &3.8 on the promotion of gender equity and reduction of MINMM, United Nations on the Convention on the Elimination of All Forms of Discrimination against

women UNCEFDW /Beijing Platform for Action (BPFA) Zimbabwe Nurses Association (ZINA), Zimbabwe Women's Coalition Network (ZWoN), Zimbabwe Organization of Women Lawyers (ZOWLA) and currently addressed through nursing, midwifery, obstetric and other health care team players by Goal number 3.1 & 3.8 (UN Sustainable Development Goals, Agenda 2030).

Hence, a phenomenological inquiry was followed which focuses on a deep immersion of the researcher in the "*lebenswelt*" German life world, as it is given in the research context, lived experiences which were shared by the women on QOCS, (Lessem, & Schieffer, 2014; Tufanani, C., Attard, M., 2012). The women shared comfortably their experiences and knowledge on OC. These shared experiences on OC, and the gaps identified exhibited the possibility of developing an adapted model on the Calabash of Excellence in Quality Maternity Care Model (CEQMCM). In addition, it is the stories being told and written on women in urban resource- restricted settings, which are scarcely written in books.

The lived experiences of the participants were described to bring out the broader picture of their experiences with care providers, the nature of the facilities, challenges with the provision of the care itself, issues of communication, the practice itself, cultural and religious norms. The women, despite all the challenges they encountered, they still managed to express a certain level of satisfaction with the care rendered as evidenced by, booking for their pregnancies, giving birth despite the systems' rigid policies in the booking system itself, the user fees, shortages of essential drugs, vaccines, medical sundries such as gloves, syringes among others.

Figure 5.1 below depicts the overall research picture from the burning issue to the development of the adapted model. The core features of the journey are the Mabvuku maternity centre and its Satellites and the experiences of the women on the QOCS. The anchor of the study activity was to

interpret the essential data and information collected and analysed. Thorough and careful analysis happened with the help of the research supervisors and research team members. The use of Giorgi's analysis protocol ensured the generation of relevant, and practical ideas shared among the research team members, whilst rooted in Husserl's interpretivistic philosophy. (Figure 5.1 depicts the research journey).

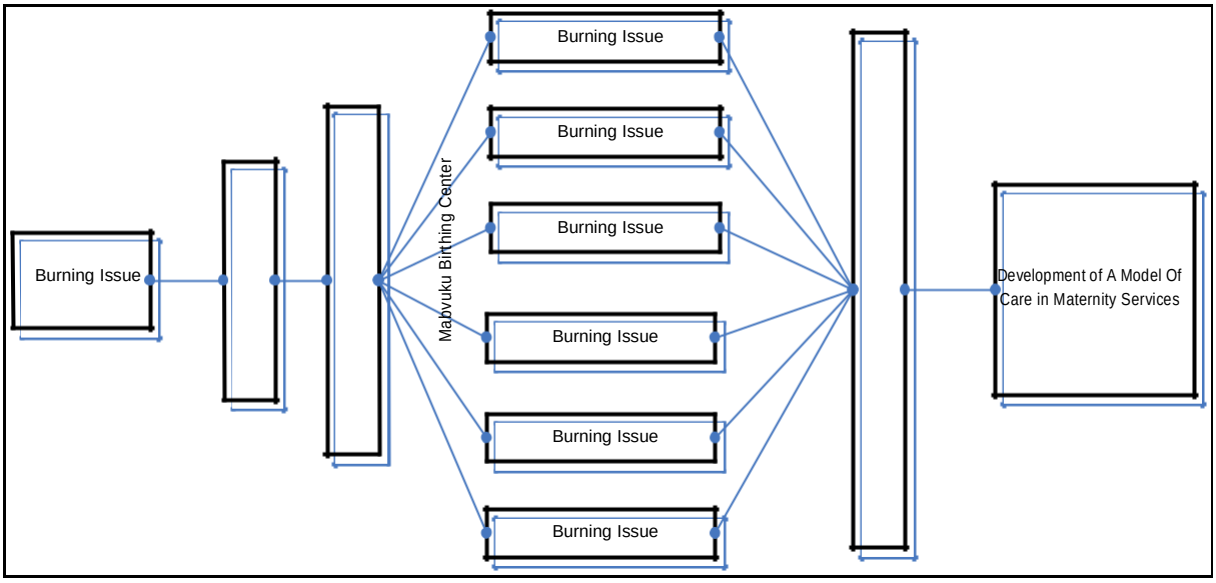


Figure 5. 1: (Adopted from Tagarira Mutengo, 2016; developed by Helen V. Gundani, 2017).

5.4 Model of care development

In this research project the African *Ubuthu/Hunhu* initiative was seen appropriate for the resource restricted settings that are focused on nature and culture and supported by the Southern Relational Path, Lessem &Schieffer, (2010 /2014 /2017). The community and the health care providers could adopt the crafted model of care Calabash of Excellence in Quality Maternity Care Model (CEQMCM) where women could be sensitized to a structured prenatal, intrapartum and postnatal package that is inclusive to accommodate the promotion of cultural and religious values (*Ubuntu/Hunhu*). This was built from the study findings of the participants' responses on their

lived experiences where gaps and weaknesses that were reported and supported by literature reviewed were brought to the fore. The fore–going paragraphs explain the model that is also supported by literature as suggested by Husserl, 2009; Creswell, (2009) which further addresses the study objective 3 on how QOCS can be improved through a care model.

The researcher, after identifying gaps in the QOCS rendered, found it noble to use the findings of this study in conjunction with literature as suggested by Creswell, (2009) to develop a model of care for countries in similar settings globally, regionally and locally to improve on QOC. Little evidence exists to show case a model of care for QOC provision, nationally. Husserl, 2009; Shafique, F., &Mahmood, K., (2010) stated that the development of a model of care which can be born from the literature, detected from the study findings can be developed. This is a determination to implement the global efforts to encourage the new SDGs as a way of improving the quality in the provision of OC. A qualitative study conducted by Kyaddondo, et al (2017) to establish the needs of the Ugandan women emphasized similar sentiments. This model is discussed under the GENE concepts that is the Grounding, Emerging, Navigating, and Effecting; in search of a model of care and defines the model concepts for reader understanding. Grounding describes the research path and research methods derived from the understanding of self and context. This led to the application of the Southern Relational Path which is centred on nature and community. The interaction between the researcher, and the participants' rich QOCS narrations facilitated the generation of new knowledge in terms of the unveiled experiences of women in resource-restricted urban settings as enunciated in the 8 themes. The interaction assisted the researcher to navigate through the complexities raised in the case study on the QOCS, such as the practice shortfalls, socio-economic, cultural, religious and spiritual factors that seemed to have a bearing on the QOC

rendered. The lessons learnt from the gaps identified in the study findings and discussions produced thematic areas that require to be addressed to improve care.

Furthermore, 'The formation of a model consists in conceptual making of a perceptual complex', (Meadows, L.M., & Morse, M., 1957 /2001; Shasha, M., Cox, C.L., Cohen, M.Z., et al., 2011). This process involves, the replacing of a part or parts of a conceptual complex by representation or symbol. Every model, however, is a pillar of symbols, rules and processes regarded as matching, in part or in totality, an existing perceptual complex. Each model thus, stipulates some correspondence with reality and some verifiability between model and reality, (Meadows, 1957, p.4; Shasha, 2011). According to Mckay, (1965) a model is a symbolic representation of perceptual phenomenon. In this instance the researcher formulated the model from the Southern Relational Path theoretical framework that is embedded in culture and heritage and the Hulton's framework on maternal satisfaction, (Hulton, et al., 2000 /2007; Lessen & Schieffer, 2014;2017). This helped in the formulation and the use of the Calabash which in African context symbolizes sentimental values and in the past only precious oils and drinks were stored in it. It represents the Utopia of African *Ubuntu/Hunhu*, (Smith, D., Roofe, M., Ehiri, J., et al 2003). In health every provider is expected to uphold their values and apply them diligently to achieve best practice through professionalism, (Nursing and midwifery pledge, 2002).

Additionally, the use and analysis of the study findings created an adapted model of care with use of the most pertinent 6 components already mentioned above that incorporated the elements of MCS into a model that is related to other models and techniques, transparent in terms of ease to interpret, its robustness or its sensitivity to the assumption being made which in this case, is to ensure excellence in maternity care services. Furthermore, it is rich and logical, simple, easy to modify and expand Leimkuhler, (1972). The model of care that is suggested in this study attempts

to order, clarify and systematize selected components of QOCS for women in a resource restricted, setting in the country and can be transferred to other states in similar settings. The adapted model can also influence practice for the day to day clinical activities of the nurse/midwife such as prenatal care on booking day, day of admission in labour, day of discharge home with the baby, day one at maternity clinics globally, regionally and locally and can hence become a useful reference tool at the shop floor and this applies to management as well. It is strongly believed that it can be applied, with modifications if necessary, in any other situation. The model being suggested here serves to simplify MC provision and by so doing it assists in simplifying, ordering, clarifying and analysing concepts of knowledge, skills and attitudes for personnel working in the provision of OCS. Caution is however, needed to avoid over simplification of QOCS.

The adapted model crafted consists of 6 major components namely, hexagons: 1) the nursing /midwifery practice where care providers should have prudent skills to conduct assessments accurately in order to make proper diagnosing and treatments, and to conduct structured health education; 2) organization of the care: deliver resources, that is: human/physical/drugs/vaccines/medical sundries and equipment; effective communication and emotional support; 3) the patients /clients' circumstances and needs: taking cognizance of the social–economic and environmental conditions; 4) care providers: uphold professionalism, possess valid clinical knowledge, skills and attitudes; 5) expectant management: ensuring quality service delivery 6) care users: accepting the care and appreciating the culture and religious norms. These 6 aspects resonant well with the WHO framework's categories of a woman's experiences of care key domains that are 1) effective communication that is responsive to her needs and preferences, 2) care provided with respect and dignity, privacy, confidentiality and informed choice; 3) emotional support to strengthen her own capabilities; 4) competent and motivated

human resources and 5) availability of physical resources for essential care and management of complications. The afore-mentioned WHO framework, together with the two study frameworks support the importance of the development of an adapted model of care to help guide OC utilization in resource-restricted settings, nationally, regionally and globally to help reduce MINMM.

Figure 5.2: Calabash six components of the model of care modified from Chigwada, (2015).

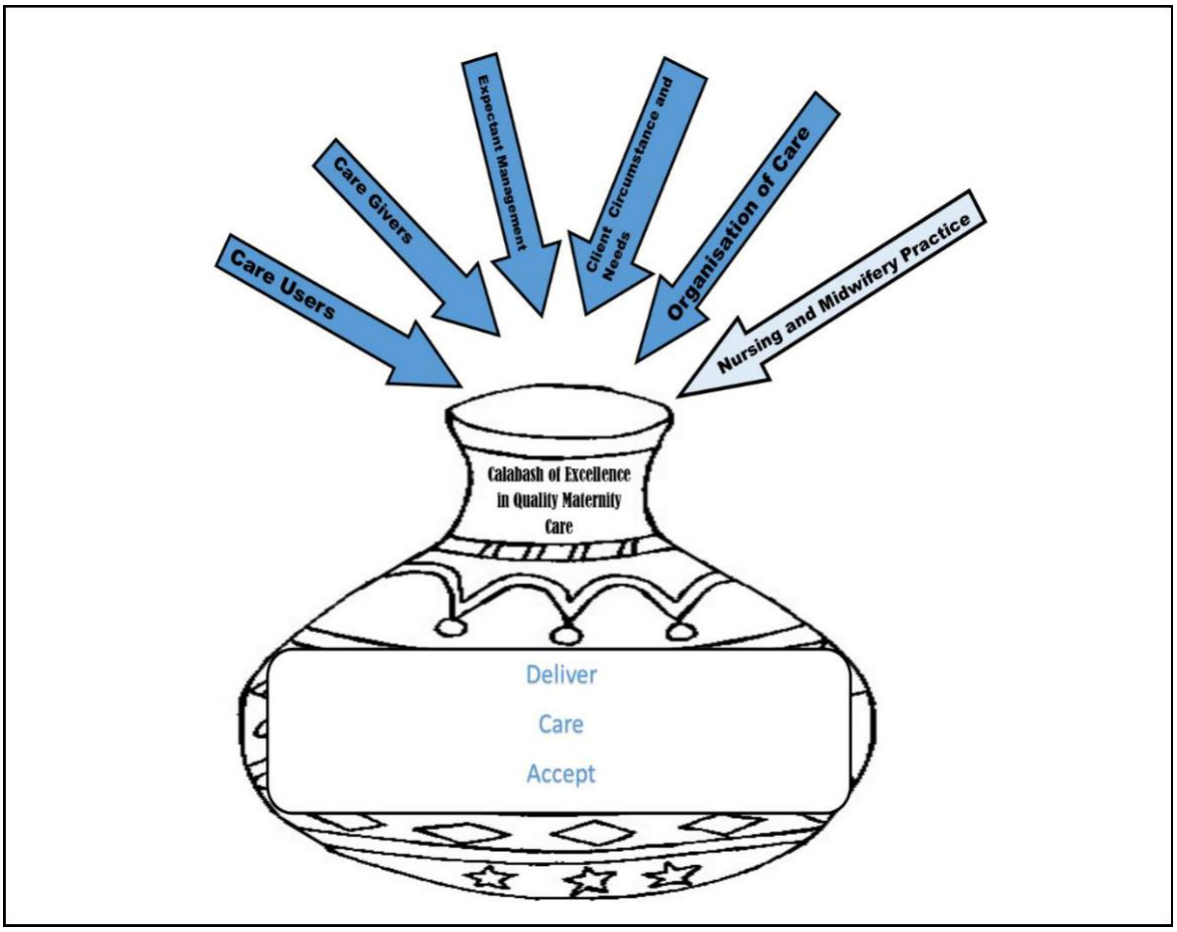


Figure 5. 2: Phase 1- the micro- picture of the Calabash of Excellence in Quality Maternity Care Model: Adapted and developed by Helen V. Gundani, 2017)

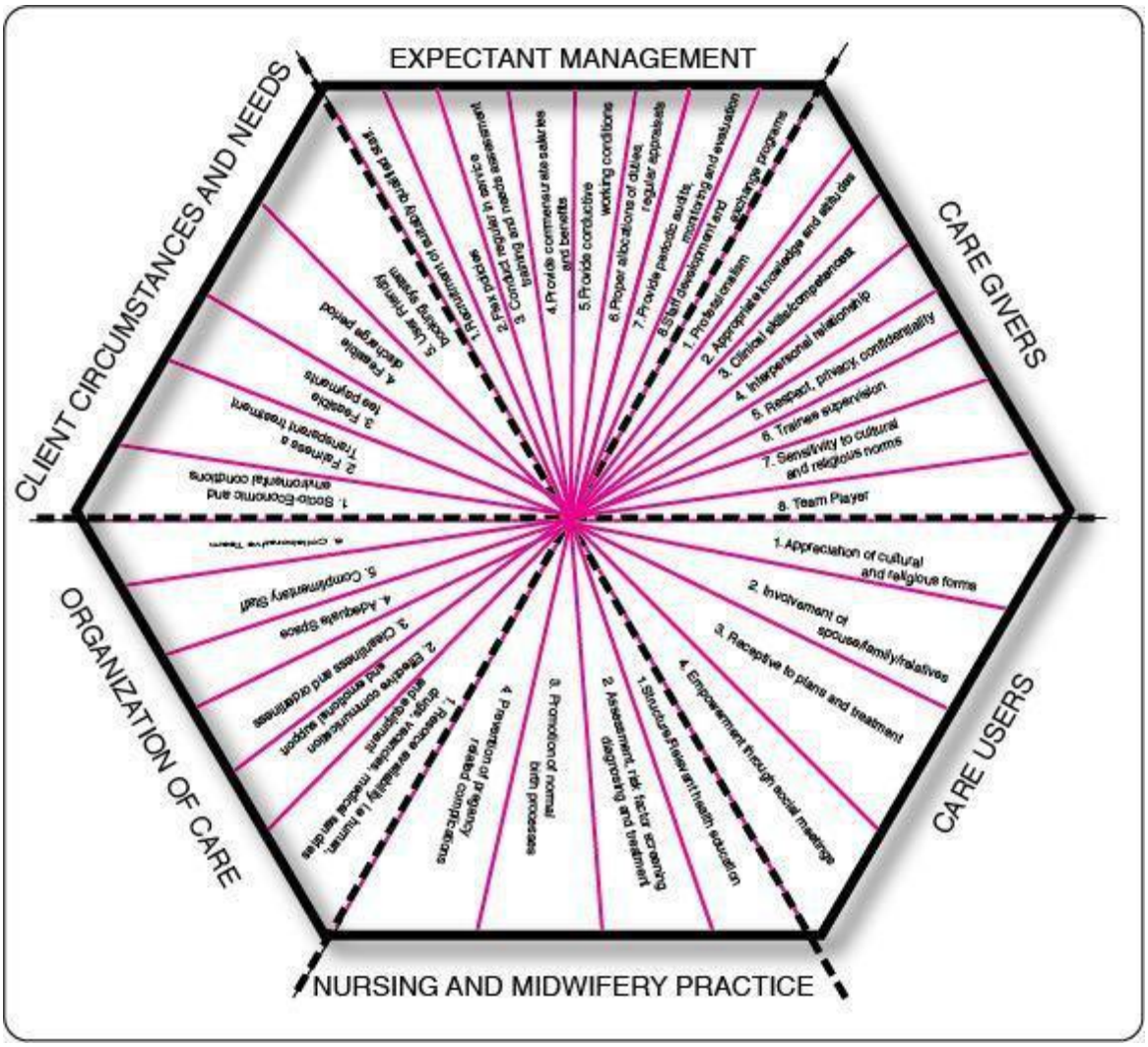


Figure 5. 3: The macro –picture of the CEQMCM developed by Helen V. Gundani

Thus, the researcher was able to develop a usable practice model, based on concepts chosen drawn from the 8 themes that emanated from the study. Suppu, F., (1977) posited that it is necessary to validate this model (CEQMCM), which is the suggested adapted model of care for resource restricted settings, albeit an activity beyond the scope of this study.

In consequent, it is envisaged that the adapted model might build and develop innovative skills for the first-line managers and could in turn enhance their problem-solving capacity which is vital to reduce some of the challenges that exist in the MCS. Its use might reduce some of the obstetric

care barriers in access and uptake as reported in a systematic review of sub -Saharan Africa by Minerve Kyei -Nimakol, et al, (2017).

Summary

In this chapter, findings that were derived from a qualitative design which followed a phenomenological theory approach, discussed the reported 8 broad themes, and 18 sub–themes culminating in the development of a model of care. The findings were discussed using the 31 participants' verbatim on quotes and literature. A detail of how study objectives were addressed and fulfilled through the discussion of texts, analyzed using the Giorgi's analysis protocol for a phenomenological theory approach, backed by literature was done. To this end, in the next chapter, the summary, conclusion, recommendations and limitations are presented.

CHAPTER 6

CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

6.1 Introduction

This study explored the QOCS as experienced by women in the prenatal care, labour and postnatal care periods. Several studies reviewed in literature on MCS used the qualitative approach, globally and regionally. Little was done from the consumer of care's perspective in urban restricted settings such as Mabvuku /Tafara in Zimbabwe using the phenomenological approach. Giorgi's technical analysis (1975 /1987 /2005 /2009), became the most relevant to uncover QOCS provided. Further the qualitative method using FGDs and individual in –depth interviews allowed the narrations of the life stories of the women on QOCS. It also, enabled the capture of rich data for the research and allowed for the exploration of narrations of stories of the socio –economic and cultural and religious values were heard from the perspective of the users. Utilizing Husserl's interpretivistic philosophy was used to develop a model of care to assist in addressing the obstetric care needs of women of urban resource restricted settings in Harare, Zimbabwe.

6.1.1 Summary of findings

Study findings indicated that QOCS in urban restricted settings in Harare is compromised by human and physical resources challenges. Maternity health centres do not have full staff compliments. The few nurses /midwives who may be available were overworked or demotivated. The physical spaces such as the prenatal, admission, labour, postnatal wards and the waiting areas were not adequate and were congested. This prohibits the support of the women by spouses, significant other or any other relative. Drugs, vaccines, medical sundries such as syringes, needles and gloves were reported to be in short supply. Also, the findings suggested that the women's

socio-economic and cultural values, and their environmental issues interfered with their seeking and accessing of quality care.

Additionally, findings also indicated that the health education given was inadequate. Overdone HIV education and activities delayed the service delivery. Little was said about labour signs and symptoms, family planning, immunizations and its schedule, breastfeeding and breast care information was inadequate. The findings also generally supported that the women recognized and valued the QOC received. Some of the women found the nurses to be caring and professional. Male nurses were singled out as good performers. To be offered a warm cup of tea or a bucket of warm water for a bath after delivery was very pleasing to the women. As well as a nurse who used her discretion by putting up an intravenous Oxytocin line to facilitate labour.

However, some were critical of certain aspects of the care rendered. The health care system factors such as the negative attitudes and technical skills interfered with the quality of the care. Namely, being denied treatment for one reason or the other, abusive and maltreatment by care providers, poor monitoring of the labour processes, vaginal tears at delivery and user fees requirements. From these findings, it is evident that a model of quality care for use in Harare's MC clinics may help to enhance the care. Furthermore, using a model in maternity clinics may improve the care in these facilities. Additionally, it may demonstrate the special advantages and opportunities provided by this particular intervention which is necessary to monitor standards of care in maternity units. Within the theoretical framework of the midwifery practice, it is therefore, suggested that the city of Harare Health department gives priority to staff development in using the model in these setting. This could help the organisation to produce qualities and skills needed to spearhead a quality oriented maternity care system. The study has also supported a notion of a model of quality

obstetric care in the maternity care centres in Harare, nationally, regionally and globally as the challenges raised appeared to be similar to those reported globally in the literature reviewed.

6.2 Conclusion

The study findings indicate that rudeness, mistreatment and abuse of women during childbirth occur in Harare, Zimbabwe just as much as they do in other parts of the world as reported in the literature reviewed. This, phenomena constitute a present day problem, in maternity care. Nurses /midwives, responsible authorities, such as government, local authorities and churches, should add appropriate measures to attend to its elimination. Inservice training on the topic and close monitoring of deliveries could assist in its reduction. These findings could be added to existing knowledge on this phenomenon which describes the different forms of the sequelae regionally and globally. For Zimbabwe the information that emerged in the study is novel and may be a significant contribution.

The findings also suggest that use of the model of quality of care proffered in this paper, might help to enhance the QOC and uptake resulting in fewer maternal deaths and babies. In addition, the inadequacy of the health education and overdone education on HIVAIDS cited were disturbing especially when we consider the literacy level of most of the participants in resource restricted settings. Moreover, the women need correct information on health issues for promotion of wellbeing all the time. They may not be in a position to read and understand the information on their own. Abusive language, exploitation, discrimination and misinformation can cause clients /patients to have a low perception of maternity care service. Abuse, disrespect and mistreatment have become ‘hot spots’ in maternity care.

A collaborative support is expected of users, staff, and stakeholders /partners, which for this community exists but needs strengthening at every level. However, it is of paramount importance to encourage honesty, integrity, transparency and effective communication to avoid ambiguity which can derail the positive outcome and reduce MNIMM.

Application of the model concepts (DO it - as shown in the diagram below) in a non–threatening manner could keep staff morale burning for efficiency and for reduction of staff burnout. Negative maternal and infant outcomes have an impact on MCS delivery systems. It is hoped these processes might help in the reduction of morbidity and mortality of the women and their babies, (Figure 6.2 has the outline of the DO it process below).

Figure 6. 1: (This is adopted from the International Labour Organization Standards, 2015; adapted by HV. Gundani, 2016).

6.3 Study strengths and limitations

The researcher with the help from the research assistant, managed to conduct FGDs and in –depth interviews which allowed them to observe non-verbal cues and to probe for additional information

relevant for data interpretation, (Balls, P., 2009; Chang et al 2016). The study used a small-scale phenomenological approach which makes its findings transferable and the study can be replicated with a bigger sample. It can be problematic to do bracketing of one's pre–conceptions, which LeNasseur, J.J., (2013) acknowledged in his study. This was taken care of by the researchers' use of Giorgi's (1985) analysis technique to reduce the limitation. The use of Giorgi's bracketing method at the initial analysis stage allowed for and took account of pre-conceptions that emerged during the data collection and the analysis**.** Additionally, rigorously auditing of the data and procedures helped the study audibility, (Long, T Johnson, M., 2000:30; Loh, J., 2013:1-15;). The various decisions made during the different stage of the analysis were clearly documented by the researcher to ensure the study's credibility, dependability, transferability, trustworthiness and confirmability processes.

However, no research project can be termed a perfect designed study (Patton, et al., (1992). Study limitations demonstrate that the researcher was aware that no overweening claims were made about study transferability or conclusiveness relative to what one has learned.

Furthermore, the research was conducted in one study community setting and involved a modest study sample of 31 participants the study findings are transferable to similar settings nationally, regionally and globally. Also, the fact that data was collected mainly from the perceptions of the users, which on its on is recommended (Hulton's model 2000) but leaves room for understanding QOCS from the providers also. Therefore, further research is needed that will examine the view points and actual practices of the key players such as nurses, midwives and doctors as well as husbands, significant others and in–laws to hear their own perspectives on the QOC practice.

However, it is being suggested that midwifery /nursing platforms can begin to offer some practical recommendations based on the participants' point of view. Finally, this study can become a sound

baseline study for a bigger study that will cover more health centres in Zimbabwe and the dissemination of its findings will allow policy makers to make a second look at what is currently obtaining and the application of the model with success might be a game-changer in the reduction of maternal and neonatal morbidity and mortality. What is noteworthy is the corroboration of the results of this study with reviewed literature world-wide, which makes it difficult to ignore the contribution of the study findings to knowledge of midwifery practice in Zimbabwe.

6.4 Competing Interests

The researcher has no conflict of interest.

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APPENDICES

Appendix A: INTERVIEW GUIDE

ATTACHMENT 1

Interview Topics

- Expectations of pregnancy, labour and birthing.
- Conception of fear, anxiety, dismay about pregnancy labour and birthing, child care.
- Hopes, wishes of ideal pregnancy, labour and birthing experiences and how personal was the labour experience?
- Health education formal and informal during pregnancy, labour and birthing and postnatally.
- Human and physical resources; availability and status of buildings, equipment and staff attitudes and suitability.
- Respect, dignity and equity; patient -nurse /midwife relationship, respect of privacy and dignity; communication mechanisms throughout pregnancy related services.
- Cognition: Communication between the care provider and client to easy diagnosis and treatment. Privacy, confidentiality, empathy, care and relations between the two parties etc.
- Emotional Support: care of client giving advice and information to make informed decisions, physical and psychological support measures etc.

ATTACHMENT 11

The grand question: "What is your lived experiences of quality obstetric care services provided by midwives in Mabvuku maternity centres and its Satellites in Harare, Zimbabwe?

Interview Prompts

How would you describe the first day of the booking visit?

-Did you have any expectations on this visit? (If so) can you describe or talk about them?

-What was done or said to you by the attending nurse /midwife?

-Do you have any thoughts or feelings about what was done to you? (If so) talk about them.

- Did you feel prepared to go for the first booking visit? (If so or not what made yoi feel prepared or unprepared?

- What kind of effect do your first visit booking experiences had on your seeking of pregnancy related services has for your future reproductive wellness and that of the baby?
- What kind of health education were you given at the maternity centre? Please describe it fully. (from signs and symptoms of pregnancy, danger signs of pregnancy, signs of labour, diseases associated with pregnancy such as Anaemia, Diabetes, Heart problems, High blood pressure etc, HIV/AIDS, family planning, breast care and breastfeeding, early infant feeding, prevention of hypothermia, birth plans etc.
- Describe your experiences about the preparation for labour and birthing? Include what was done on subsequent prenatal visits. (If yes or no say why? (if yes or no tell me why?).
- Did you feel prepared for labour and birthing? (if so or not say why?).
- What made you go to the maternity centre to give birth? Tell me at what stage did you decide to go to the clinic /hospital? Tell me at what stage did you decide to go to the clinic (Was it pain, fear, anxiety etc).
- Did you visit the maternity centre during pregnancy? (if so or no tell me why).
- Where did you get information on labour and birthing? Eg. The internet, friends, books family etc.
- Describe your relationship with the nursing staff include the mix, obstetrician, paediatrician, rehabilitation technician, ambulance medic, laboratory technician, pharmacy nurse etc during pregnancy, labour and postnatally.
- What are your experiences of the maternity ward in terms of it being homely, clean, friendly etc? (If yes or no tell me why).
- Tell me about your experiences of the labour and birthing include what was said /done by the midwives at every stage of the processes.

  -What were some of the ways you took to prepare for labour and birthing?

- Did you feel you could express your needs, problems to the staff at the clinic? (IF yes or no say why).
- Would you book with maternity centres in Harare on your next pregnancy?
- What information can you give other young women who might like to get quality care?
- What do nurses talk about regarding the socio -economic issues and your receiving any of the services they provide?
- What information do nurses talk about regarding culture, religion and beliefs and pregnancy and labour and birthing?

Appendix B: PARTICIPANT'S INFORMATION SHEET

MRCZ

No._/A/1973

DEPARTMENT OF NURSING SCIENCE

P. O. Box A 178
Avondale
Harare, Zimbabwe

Telephone: 791631
Telex: 26580 UNIVZ ZW
Telegrams: UNIVERSITY
Fax: (263) (4) 724912

UNIVERSITY OF ZIMBABWE COLLEGE OF HEALTH SCIENCES

PURPOSE OF THE STUDY:

You are being asked to participate in a research study of lived experiences of young women of the quality of obstetric care services provided**.** The purpose of the study is to determine, explore and document the views of the young women of the obstetric care provided by midwives. You were selected as a possible participant in this study because you received maternity care in the city of Harare health centres and delivered in the clinics. The study will be conducted with about 35 young women who will be recruited from Mabvuku /Tafara health centres in the Eastern District, Harare.

THE STUDY TITLE:

THE LIVED EXPERIENCES OF YOUNG WOMEN OF THE QUALITY OF OBSTETRIC CARE SERVICES PROVIDED BY MIDWIVES IN CITY OF HARARE HEALTH CENTRES, ZIMBABWE.

INVITATION TO PARTICIPATE INTO THE STUDY

I would like to invite you to take part in this research study. Before you decide you need to understand why the research is being conducted and what it involves you. Please take time

to read the following information carefully. Feel free to ask questions on what you read if it is not clear feel wee to ask for clarification of the information. Take time to decide whether to take part or not. the information

Routine care is based upon the best known treatment and is provided with the main goal of helping you as an individual patient. The main goal of research study is to gain knowledge that may help future patients of childbearing age to reduce pregnancy related complications.

We cannot promise that this research will benefit you. Just like regular care, this research can have side effects that can be serious or minor.

You have the right to refuse to take part, or agree to take part now and change your mind later.

Whatever you decide, it will not affect your regular care.

Your participation is voluntary. Take time to read information and make a decision accordingly.

We give you this information so that you may read about the purpose, risks, and benefits of this research study.

PROCEDURES AND DURATION

If you decide to participate, you will undergo the processes of a research study and you can be selected to participate in focus group discussions (FGDs). The groups will comprise of six to ten women of childbearing aged 16 to 40 years. The research personnel will inform you in good time if you get selected to participate in the FGDs. The FGDs will take place at the health centre during the regular maternity care services. In these FGDs you will discuss freely the issues of the obstetric care you received during pregnancy, that is on the first visit what do midwives do in terms of routine investigations, health education; birth plans and preparations, and in labour nature of the midwife reception and relationship, health assessments done to yourself, the baby and all the postnatal assessments and treatments rendered. Suggestions to challenges met will also be expected from you without cohesion. The FGDs will be tape recorded and this might take 40 to 50 minutes of your time.

RISKS AND RISKS AND DISCOMFORTS

All due care will be ensured throughout to avoid discomforts, however, some questions might make you feel uncomfortable. You should feel free to decline to respond to such questions. A minimum psychological harm might occur during the interviewing process. In the event of suffering some psychological discomforts the investigator who is a trained counsellor will provide counselling and if she is not present the participant will be referred to the clinic nurses for help.

RISKS TO PREGNANT WOMEN

No major risks are anticipated as this is an observational study.

BENEFITS AND/OR COMPENSATION

The major benefit of this study is the chance to hear from young women themselves talk about some burning issues about the obstetric care they receive as they interact with health care providers. It is hoped some of the challenges and solutions shared might help in addressing some of the problems young women face while pregnant, during labour and birthing and during the postnatal period. Additionally, the health educational talk sessions might be more enriching to young women and hopefully midwifery guidelines might be improved to reduce some of the pregnancy related complications. If funding is availed you will receive at least USD $5 as compensation for the time, transport expenses and any inconvenience caused. It is therefore, difficult to promise you any benefits from this study.

ALTERNATIVE PROCEDURES OR TREATMENTS

You are assured of continued access to routine maternity care from the birthing centers apart from being in this study if you opt to participate in the study.

CONFIDENTIALITY

If you indicate your willingness to participate in this study by signing this document, we plan to disclose to the City of Harare Health Director and the Nursing Directorate to update them on the pertinent study findings that could help in the improvement of policy and care to young women as they seek and receive obstetric care during pregnancy, labour and birthing and up to the postnatal period. You are compelled to keep information shared during FGDs in confidence and trustworthiness is expected during discussions and thereafter. The discussions will be tape recorded. Thereafter the discussions, the recordings will be transcribed into scripts and the recordings will be kept in well protected files to be used in case of queries that can arise concerning the data. No coding will be done on the forms if need be pseudo –names will be used to protect the participants and the investigator only will have access to the signed consent forms, scripts, diary and the detailed journal and these will be kept in a steel lockable cabinet for safe keeping. The investigator only will have access to these data. The data will be stored in tight safety for a period of three to five years after the study for in the case of queries or audits by the research ethics committees. It should be made very clear that you are free to withdraw from participating from the study at any time without any penalty.

ADDITIONAL COSTS

Not applicable.

IN THE EVENT OF INJURY

In the event of injury resulting from your participation in this study, treatment shall be offered by the study.

In the event of injury, contact:

Helen V. Gundani

University of Zimbabwe, College of Health Sciences

Department of Nursing Science

PO. Box A. 178

Avondale, Harare.

Phone: 04 -791631 /9 Ext 2221

Cell: 0782 -405 -330 /0776 -743 -759

Email address: helengundani@gmail.com

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the City of Harare Health Services, Mabvuku /Tafara health centres its personnel, and associated hospitals. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty.

ADDITIONAL ELEMENTS

NIL

OFFER TO ANSWER QUESTIONS

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

Audio, Recording

Statement of Consent to be Audio -taped

I understand that audio recordings will be taken during the study.

- I agree to **being audio recorded** **Yes** ☐

No ☐

_____ _____

Name of Research Participant (please print) Date

Principal Investigator: Helen V. Gundani, [Mrs]

Cell #..... 0782 -405 -330 / 0776 -743 -759

Appendix C: FOCUS GROUP CONFIDENTIALITY BINDING FORM

MRCZ No._/A/1973

P. O. Box A 178
Avondale
DEPARTMENT OF NURSING SCIENCE
Harare, Zimbabwe

Telephone: 791631
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Telegrams: UNIVERSITY
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UNIVERSITY OF ZIMBABWE COLLEGE OF HEALTH SCIENCES

FOCUS GROUP CONFIDENTIALITY BINDING FORM

RESEARCH STUDY TITLE: THE LIVED EXPERIENCES OF YOUNG WOMEN OF THE QUALITY OF OBSTETRIC CARE SERVICES PROVIDED BY MIDWIVES IN CITY OF HARARE BIRTHING CENTERS, ZIMBABWE.

Principal Investigator Helen V. Gundani, [Mrs] Cell

Number: 0782 -405 -330 / 0776 -743 -759 **What**

you should know about this research study:

We give you this information so that you may read about the purpose, risks, and benefits of this research study.

Routine care is based upon the best known treatment and is provided with the main goal of helping the individual patient of childbearing age.

The main goal of research studies is to gain knowledge that may help future patients.

We cannot promise that this research will benefit you. Just like regular care, this research can have side effects that can be serious or minor.

You have the right to refuse to take part, or agree to take part now and change your mind later.

Whatever you decide, it will not affect your regular care.

Please review this information carefully. Ask any questions before you make a decision.

Your participation is voluntary.

Trustworthiness and confidentiality of information shared in FGDs is critical and should not be shared outside this FGDs session to protect each other and to ensure study credibility in fulfilment of research requirements.

Focus group Confidentiality Binding

SIGNATURE PAGE

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

Audio, Recording

Statement of Consent to be Audiotaped

I understand that audio recordings will be taken during the study.

- I agree to **being audio recorded** **Yes** ☐

No ☐

_____ _____

Name of Research Participant (please print) Date

_____ _____

Signature of Participant or legally authorized representative Time

_____ _____ _____

Name of Staff Obtaining Consent Signature Date

_____ _____ _____

Name of Witness (*if required)* Signature Date

YOU WILL BE OFFERED A COPY OF THIS INFORMATION TO KEEP.

Appendix D:GWARO REKUBVUMIRANO KUPINDA MUTSVAKURUDZO

MRCZ No._/A/1973

P. O. Box A 178
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Harare, Zimbabwe

DEPARTMENT OF NURSING SCIENCE

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UNIVERSITY OF ZIMBABWE COLLEGE OF HEALTH SCIENCES

GWARO REKUBVUMIRANO KUPINDA MUTSVAKURUDZO –FOCUS GROUP DISCUSSIONS (Shona)

TSVAKURUDZO: "MAONERO ANOITA MADZIMAI ECHIDIKI KUNAKA KWERUBATSIRO RWAVANOWANA KUBVA KUNAVANA MUKOTINYAMUKUTA PAMAKIRIKI MUGUTA REHARARE"

Varikuita tsvakurudzo iyi ndiva: Helen V. Gundani (MRS) anova mudzidzi pa College ye Health Sciences pa Enivesiti yeZimbabwe.

Runhare mbosha nhamba inoti: 0782 -405-330/ 0776743759

Zvamakafanira kuziva nezvatsvakurodzo iyi:

- Muchapiwa gwaro iri kuti muverenge chinangwa, matambudziko nezvakanakira tsvakurudzo iyi.

- Kurapiwa kwenyu kuchatevedzerwa sezvasviri takatarisana nekukubatsirirai semunhu arimuzera rekubatsirwa pakubara vana (child bearing age). Chisurwiro chechinangwa chetsvakurudzo ndechekuti tiwane ruzivo runobatsira vanamai vechidiki.

- Hatikuvimbisei kuti pangava nechokubata. Asikana ndawana mari yetsvakurudzo munongoda kuzowana mari yekufambisa nezvimwewo zvakadaro. Sezvinongoita kurapiwa tsvakurudzo iyi ingangoita kuti musangane nematambudziko angavamakuru kana aripazeranezera.

- Munobvumirwa kuramba kupinda mutsvakurudzo iyi uye mune mvumo zvekare yekuti mambobvuma munongoda yenyu kuramba pamberipo.

- Zvamunenge mafunga kuita hazvifaniri kukukanganisai mukurapwa kwenyu pamakiriniki.

- Torai mukana wekuverenga muchinzwisisa gwaro irori uye sungunukai kumvudza mibvunzo yamunayo yese yamungada kuziwa musati mabvuma kupinda mutsvakurudzo.
- Kupinda kwenyu mutsvakurudzo iyi kuda kwenyu uye hamumanikidzwe.

CHINANGWA

Murikukumbirwawo kupinda mutsvakurudzo iyi yemaonero emadzimai echidiki kunaka kweusawira naanmukoti nyamukuta.

Tsvakurudzo iyi zvekare irikuda kudzwa nesverubatsiro rwomunowana kudaanamukuti ivaya kubvira makazvitakura, mavakurwadziwa nepakubatsirwa mwana kusvikirama maviki matanhatu kubva pakubatsirwa kwenyu. Zvichabuda mutsvakurudzo zvinogona kuudza rumwe rubatsiro rutsva runogona kubatsira nekuwedzara pamusoro pezvirikuitiwa naanamukoti mukubatsira madzimai echidiki pavanengevachida rubatsiro mumakiriniki ekuMabvuku ne Tafara. Izvi zvose zvinogona kubatanidziri nekunatsidziri ruzivo runopiwa madzimai nezvekutakura nhumbu. Maonekwa kuti munongona kupinda mutsvakurudzo ino nekuti makabereka mwana nekuti murimuzera remakore 16 ku zvika makore 36 mumapoka maviri acho. Tsvakurudzo iyi ichange inamadzimai makumi matatu namasere muzera randabva kutaura. varivagari veMabvuku ne Tafara

ZVINOTARISIRWA MUTSVAKURUDZO

Pamadzimai makumimatatu nemasere vachasarudzwa vamwe vachasarudzwa kupinda mumapoka mana ema FGDs. Boka rinenge rinamadzimai masere kana gumi. Vanotungamira tsvakurudzo iyi vanoshanda nemi vachakuzivisai kana muchinge masarudzwa kuvamumwe wevarikupinda mutsvakurudzo dzemapoka iwaya. Hurukuro idzi dzichaitirwa kumakiriniki eMabvuku ne Tafara panguva dzamangara muchiuya kuzotariswa. Muchange muchikurukura nezvemunoitirwa zuva rekutanga kunyoresa, zvinoitwa navanamukoti nehutano rwenyu, pamuviri penyu, kugadzira kwemazamu, kugadzirira kubatsirwa nekurongo nezvekubatsirwa kwacho, zvekuita pakugomera nekubara mwana, kuchengeta nekuyamusa mwana, kuchengetedze kudziirwa kwemwana, njodzi dzinoitika pakubara mwana nezvese zvekuchengetedza utano rwamai ne mwana. Hurukuro ichangona kutora maminitsi makumi mana kana mashunu enyu.

MATAMBUDZIKO ANONGONA KUITIKA

Muongororo achaidza chaizvo nepaanogona kuti musasangana nenjodzi kana kukuvara kushungurudziwa/ka mutsvakurudzo iyi, munokwanisa kubvudzwa mibvunzo ingakushungurudzai kana kunyadzisira kana yamusina kusungunuka kudaira. Makasungunuka kusaipindura mibvudzo iyoyi. Mukasagana nezvinoshungurudza munowana rubatsiro kubva kumungorori sezvoarimukanzera wevanoshungurudzika kana asipo munoendeswa kunaanamukoti vepa

makirinika

MATAMBUDZIKO ANGANGOSANGANA NAMADZIMAI ANEPAMUVIRI

Tsvakurudzo iyi iripo kuita nezvekutarisa zviru zvirikuitwa kwamuri uye haina chekuitane zvekukuvadzai imi nemwana wamakabara aiwa kwete.

ZVINGAKUBATSIRAI

Tsvakurudzo iyi yakanakira kuti zvirozvinopotsekana mukuonekwa kwamadzimai echidiki nevana vavo mukubatsirwa, mukubara nemurapwa zvinogoda kungadzisiviswa svichazoderedza ukazha wemarwadzo nezvinokodzeresa kufa. Zvichabatsira kuita urongwa rwekugadzirisa matambudziko iwawa. Zvinotarisirwa kuti madzimai echidiki anyatsotevedzera marapirwo, maitiro kuderedza njodzi dzinosanganikwa nadzo kumadzimai vachirikubereka vana.

MAMWE MARAPIRWO AMUNGANGOSANGANA NAVO

Kurapwa kwenyu hakufaniri kuvanesanduko pamakiriki enyu hazvinei nekuva kwenyu mutsvakurudzo iyi.

KUCHENGETEDZA KUSASHAMBADZA KUZIVIKANWA NEZVEKUITA NEZVENYU (CONFIDENTIALITY)

Hurukuru dzese dzichaitirwa mumba musina vamwe vangadzwa zvirikukurukurwa. Zita renyu harina parichanyorwa pagwaro iri. Tinenge tichishandisa manamba chete ichange ichizivikanwa namungorori chete. Hurukuro ingangotora mamitsi anokwana makumi namashanu. Hurukuro dzemumapoka dzingatora hadzo makumi mana zvekare manzwi achatapwa nerekodha. Mushure mehurongwa urwo hwemumapoka zvinezenge zvataura zvinozonyorwa pasi zviri murekodha zvichachengetedzwa mukabodhi resimbi kuitira kudziiridza nekuchengetedza kodzero dzenyu.nepasinga nzwisisiki. Kabondi iyoyi inongovurwa ne muongorori ndiye onga. Zvekare mangwaro iwawa achachengetedzwa zvakasimbarara kwemakore mashanhu mushure mehurukuro ozoparadzo hawo kuitira zvingangoda umwe umbowo nezvenhaurirano idzi.

MUCHINGE MAKUVARA

Mukange makuvara muri mutsvakurudzo iyi makasungunuka kutsvaka munhu uyu anonzi:

Appendix E: KUSAMANIKIDZWA KUPINDA MUTSVAKURUDZO

Helen V. Gundani

University of Zimbabwe

College of Health Sciences

Department of Nursing Science

PO. Box A. Avondale

Harare.

Phone: 04 -791631 /9 Ext 2221

Cell: 0782405330 /0776743759

Email address: helengundani@gmail.com

KUSAMANIKIDZWA KUPINDA MUTSVAKURUDZO

Munokwanisa kusarudza kusapinda kana kupinda muchizomuda mutsvakurudzo iyi pasina zvingaitika kwamuri zvakanangana nemabatirwo enyu pamakiriniki eMabvuku ae Tafara. Munebvumo nekodzero yekubuda mutsvakurudzo kana manga matombotangisa zvenyu.

MIMWE MIRIPO INGANGOVAPO

Pari zvino hapana.

PEJI YESIGINICHA

MATAMBUDZIKO ANONGONA KUSANGANIKWA NAYO MUKUTEVEDZERA MARAPIRWO ANOKURUDZIRWA ANOSANGANIKWA NAWO NEMADZIMAI VACHIRIKUBEREKA VANA.

KUPINDURA MIBVUDZO

Musati masinira gwaro iri, bvudzai mibvudzo yese yamuinayo yamusiri kunyatsokunzwisisa nezve tsvakurudzo iyi.

Chitorai henyu nguva muchinyatsoku nzwisisa zvese zvirikutaurwa mugwaro.

MVUMIRANO

Muri kuita sarudzo yekupinda mutsvakurudzo iyi. Siginicha yenyu inovamufananidzo wekuti mavarenga zvose mukanzwisisa zvinyurwa pamusoro, mapindurire emibvudzo yese unye masarudza kupinda mutsvakurudzo iyi.

_____ _____

Zita reapinda mutsvakurudzo Zuva

_____ _____ _____

Zita rearikuita tsvakurudzo Siginicha Zuva

__Zita remubereki…… Siginicha……..
Zuva……

_____ _____ _____

Zita remufakazi Siginicha Zuva

MUNOPIWA RIMWE REGWARO IRI KUTI MUCHENGETA

Focus Group Information Sheet

Kana muinemibvunzo maererano netsvakurudzo iyi pamwe nekubvuma kupinda mutsvakurudzo isina kunyatsokudavirwa nemuongorori yakafanana nemibvudzo yetsvakurudzo, kodzero dzenyu semunhu apinda mutsvakurudzo, kukuvara muripakati petsvakurudzo kana kuti muine kunyunyuta nemabatirwo emaitwa mutsvakuridzo sunungukai kutaura nemunhu asiri mutsvakurudzo iyi, sunungukai kubata ve Medical Research Council Zimbabwe (MRCZ) parunhare iyi (04 791792 kana 04 -791193 uyezve nerunhare mbozha uru 0772433 166 kana 077 439 -564. Mahofisi Emrcz ari pazvivakwa zve kuNational Institute of Health area pakona pa Josiah Tongongara naMazoe Road muHarare.