UNIVERSITY OF CAPE TOWN

Development of Woman-Centred Midwife-led Model of Care through Participatory Methods for the Uasin Gishu County Hospital, Kenya

BY

Everlyne Chepkemoi Rotich
(RTCEVE001)

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Supervisors: Assoc. Prof. Minette Coetzee (University of Cape Town),
Assoc. Prof. Sheila Clow (University of Cape Town)

University of Cape Town

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DECLARATION

I declare that the thesis, entitled “Development of Woman Centred Midwife-led Model of Care through Participatory Methods for the Uasin Gishu County Referral Hospital, Kenya”, that I have presented for PhD degree at the University of Cape Town, South Africa, is my original work. It is my original work both in concept and execution has not been presented elsewhere for academic, research or any other purposes.

Everlyne Chepkemoi Rotich

Signature_ Signed by candidate   Date___18/10/2020

(RTCEVE001)

ABSTRACT

Background: The concept woman-centred care is gaining currency in maternity care and is increasingly being used to guide provision of quality care. The midwifery philosophy supports woman-centred care and is associated with positive pregnancy and birth outcomes. Development of a woman-centred midwife-led model of care requires involvement of the users (women), service providers (midwives), and health administrators to ensure representativeness of the model.

Purpose: The purpose of this study was to explore, through participatory methods, the views of women midwives and health service managers on current maternity care, and describe desired maternity care and develop a woman-centred maternity care model for Uasin Gishu County, Kenya.

Methodology: Appreciative Inquiry 4-D cycle was used in the study. The Human Scale Development framework guided the study. Thirty two midwives, 85 women attending maternity and well-baby services at the facility, and four facility and three county health service managers participated in the study. Focus group discussions and interviews were carried out from May 2015 to April 2016 using the four phases of the Appreciative Inquiry cycle. Phase one "discovered" what best maternity care looks like, phase two "dreamt" what best maternity care would look like, phase three "designed" the model, and phase four "destiny" was used for development of implementation strategies. Data was analysed using thematic analysis augmented by thematic networks analysis and NVIVO 11 software. Ethical approval was obtained from the University of Cape Town and the Moi University and Moi Teaching and Referral Hospital Research Ethics Committees. Individual's participation was voluntary, informed consent was obtained and confidentiality maintained. There was no compensation for participation.

Findings: After the first three cycles of Appreciative Inquiry, analysis culminated in the design of the UPENDO-S wheel – an acronym for: User-friendliness, Person-focused care, Excellence in evidence based care, Networking, Dedicated supported midwives, Organization of care and Supportive leadership. *UPENDO* is a Swahili word for love. Phase four of the study resulted in development of strategies for implementation of the model.

Recommendations and Conclusions: The UPENDO-S Wheel provides a novel approach to delivery of maternity care in Uasin Gishu County Hospital and contributes to existing body of knowledge in Midwifery for Kenya a low-middle income country.

DEDICATION

I dedicate this thesis to my parents, Mr. John Nyangwaria and Mrs. Leah Nyangwaria, for their passion for education and lifelong learning. They instilled in me the value for education, hard work, determination, resilience and vision. ‘Thank you for the encouragement and support towards this journey’. I also dedicate this thesis to my husband, Richard Rotich. Your support and love made it happen. I was always assured that the children were well taken care of even in my absence pursuing doctoral studies. To our children, Dan, Laura, Lynn and Stacy, who kept asking me why it took so long just to write a 300-page document, I thank and love you all for understanding that “mama” had to study. I was encouraged by the fact that you looked forward to my graduation. Finally, I dedicate this thesis to my siblings Julius, Joyce, Arnold, Kim, George and Martha: I pray that each of you achieve your desired dreams.

QUOTES FROM CASTANEDA CARLOS CASTANEDA

The trick is in what one emphasizes. We either make ourselves miserable, or we make ourselves happy. The amount of work is the same.

A man of knowledge lives by acting, not by thinking about acting.

All paths are the same, leading nowhere. Therefore, pick a path with heart!

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ABBREVIATIONS/ACRONYMS

AI: Appreciative Inquiry

BeMONC: Basic Emergency Obstetric and Neonatal Care

CINAHL: Cumulative Index to Nursing and Allied Health Literature

DHIS: District Health Information Systems

FGDs: Focus Group Discussions

GT: Grounded Theory

HIV: Human Immunodeficiency Virus

HMT: Health Management Team

HREC: Human Research Ethics Committee

ICM: International Confederation of Midwives

ICPD: International Conference on Population and Development

IREC: Institutional Research and Ethics Committee

KDHS: Kenya Demographic and Health Survey

KEPH: Kenya Essential Package for Health

LMIC: Low-to-middle income countries

MDGs: Millennium Development Goals

MOH: Ministry of Health

NHIF: National Hospital Insurance Fund

NICE: National Institute for Health and Clinical Excellence

PMTCT: Prevention of Mother-To-Child Transmission

RCM: Royal College of Midwives

RCOG: Royal College of Obstetricians and Gynaecologists

SDG: Sustainable Development Goals

TBA: Traditional Birth Attendants

UK: United Kingdom

UN: United Nations

UNICEF: United Nations Children's Fund

USA: United States of America

USB: Universal Serial Bus

WHO: World Health Organization

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1. INTRODUCTION

Woman-centred care is a philosophy that recognises a woman as unique with individual needs, expectations and aspirations, who forms a relationship with the midwife to support her through the childbirth period with the woman taking the lead in decisions regarding her care (Cole, LeCouteur, Feo, & Dahlen, 2019; Maillefer, de Labrusse, Cardia-Vonèche, Hohlfeld, & Stoll, 2015). Woman-centred care is premised on childbirth being a normal physiological process (Technical Working Group, 1997; Kennedy, Shannon, Chuahorm, & Kravetz, 2004). This then requires evaluation and incorporation of the woman's psychosocial, emotional and interpersonal elements to woman-centred care which are considered only a luxury for high resource countries (Van Lerberghe *et al.,* 2014). The woman-centred care discourse recognises the diversity of women's experiences and proposes systems of care that are flexible and appropriate to women's circumstances and needs during pregnancy and childbirth (Jenkins *et al.,* 2015).

1.1 Global initiatives to improve maternity care

Maternity care refers to care during pregnancy, childbirth and the postpartum period (Wiegers, 2009). The provision of maternity care is guided by women's needs and expectations, societal norms, cultural expectations, government policies, health care regulations, professional boundaries and institutional policies (Benoit *et al.,* 2005). The provision of maternity care is usually based on different models aimed at achieving favourable maternal and neonatal outcomes (Sandall, Soltani, Gates, Shennan, & Devane, 2016). The model of delivery of maternity care impacts on the experience the woman will have and influence memories that women create during their childbirth period (Lundgren,

Karlsdottir, & Bondas, 2009). Lavender & Chapple, (2004) in their study that utilised Appreciative Inquiry in 14 different maternity sites in England reported that the culture in a maternity setting influenced the model of care provided with the medical model dominating in some units. Settings in which began by maternity care had midwifery model dominating. Models utilised was also dependent on training of midwives with those training in the advent of technology not considering childbirth a normal process.

The White Ribbon Alliance advocates a broader dimension to childbirth as a rite of passage, with the cultural significance to the woman and her family (Alliance, 2017). This requires a critical evaluation of the social determinants of health such as conditions in which people are born, grow, live, work, water and sanitation, nutrition, education, gender equity and age (World Health Organization, 2017). Homer *et al.,* (2014) groups the forces that shape maternal health into the distribution of money (economic policies), power (political systems and social policies) and resources at global, national and local levels. Other factors that need to be considered include the rising cost of living, health system challenges (mainly inadequate human resources), infrastructure, supplies and equipment, non-functional referral system and poor health worker attitudes (Tunçalp *et al.,* 2015).

Over the years, there have been initiatives to improve the quality of maternity care. These initiatives have placed the emphasis on overall maternal health and little prominence on woman-centred care (Alliance, 2017). Some of the initiatives include the 1987 Safe Motherhood Initiative (Starrs, 2006; Thaddeus & Maine, 1994), the 1994 International Conference on Population and Development (ICPD) goals, and the 2000 Millennium Declaration at the UN summit that formulated eight Millennium Development Goals (MDGs). The MDGs then transitioned to the 2030 Sustainable Development goals (SDG). Specifically, SDG number three, which broadly calls for achieving good health and

wellbeing, and one of the targets is the reduction of the maternal mortality ratio from 147 deaths per 100 000 live births target for 2015 of Millennium development goals (MDGs) to 70 deaths per 100 000 live births by 2030 (Buse & Hawkes, 2015). The introduction of safe motherhood placed the emphasis on physical safety, through skilled birth attendance as a proxy indicator for maternal mortality rates (Berhan & Berhan, 2014). However, the impact of traditional birth attendants (TBAs) that had been embraced by the World Health Organization (WHO) in the early 1970s and later discontinued needs to be evaluated further (Kruske & Barclay, 2004).

However, the challenge to international initiatives and declarations lies in the actions countries can mount in response. Concerted efforts are required to ensure the provision of woman-centred quality care by ensuring appropriate physical infrastructure, adequate supplies, defined models of care, knowledgeable, skilled providers, focused leadership with management skills and involvement of the community (Tunçalp *et al.,* 2015). In the United States of America (USA) and Sweden for example, different models are used for provision of maternity care (Shaw *et al.,* 2016). Most of the births are attended to by skilled care providers and they occur in a variety of settings including homes, birth centres, and midwifery-led birthing units in hospitals and in high intervention birthing facilities. In these countries, there are usually good maternal and neonatal outcomes and interventions are readily available during high risk situations associated with pregnancy. In addition, women have access to antenatal and postnatal care in different settings including through a midwife or a health visitor at home. The provision of woman-centred care is threatened by the move from the provision of maternity care from primary healthcare facilities to centralisation in large hospitals, as witnessed in the Netherlands (Wiegers, 2009).

1.2 Woman-centred care in low- and middle-income countries

There are notable improvements in maternal and neonatal health care outcomes in low- to middle-income countries (LMIC) with varying levels of uptake of maternity care. Provision of woman-centred care is dependent on the accessibility of health care and the availability of resources. In some of the Sub- Saharan countries, health facilities are sparsely distributed and the few available lack the necessary resources and capacity to provide the services (Gerein, Green, & Pearson, 2006). An example of such lack is shortages of skilled birth attendants. Statistics from the national surveys (Service Provision Assessments by the Demographic and Health Survey Programme) in five African countries (Kenya, Namibia, Rwanda, Tanzania, and Uganda) between April 2006 to May 2010 indicate a poor quality of maternal care in primary healthcare facilities, which contribute 40% of the facility deliveries (Kruk *et al.,* 2016). The report is based on assessing the quality of basic maternal care functions using an index of 12 indicators comprising structure and processes of care, infrastructure and use of evidence-based routine and emergency care interventions. The quality of basic maternal care functions was substantially lower in primary (index score 0·38) than secondary care facilities (0·77). A low birth volume was consistently associated with poor quality, with differences in quality between the lowest versus highest volume facilities of –0·22 (95% CI –0·26 to –0·19) in primary care facilities and –0·17 (–0·21 to –0·11) in secondary care facilities.

The concept of woman-centred care has gained prominence in South Africa, where (Maputle & Donavon, 2013), through extensive database search concept analysis, evaluated woman-centred care within the Batho Pele principles to customer care approach. Key in their findings is the midwife consulting and involving the woman to be able to respond to their physical, psychosocial and emotional needs and being able to make decisions and choices relevant to their care. Lambert, Etsane, Bergh, Pattinson, & van den Broek, (2018), in their descriptive

phenomenological study among women, health care providers and policymakers in 11 urban health facilities in South Africa, report distrust and feelings of abandonment among women and health care providers. Health care providers' focus on the completion of tasks and procedures rather than individual women's needs.

1.3 Maternity care in Kenya

The foundation for health service delivery priorities in Kenya is the Kenya Essential Package for Health (KEPH), which has six levels of care delivery (Muga, Kizito, Mbayah, & Gakuruh, 2005). Level six tertiary (referral and teaching) hospitals; level five (secondary) hospitals; level four (primary) hospitals; level three health centres, maternities and nursing homes; level two dispensaries and clinics; and level one community-level services. The main activities of levels four to six are curative and rehabilitative, while levels one to three offer promotive, preventive and curative services (Muga, Kizito, Mbayah, & Gakuruh, 2005). Levels three to six facilities offer a wide range of healthcare services, including essential and comprehensive maternity services, while level two facilities offer mainly antenatal and postnatal services. This system is directed at meeting the needs of women during pregnancy, labour and birth, and the postnatal period provided at multiple contact points.

Kenya has put in place different measures to improve maternity care. The 2010 revised constitution of Kenya places emphasis on maternal health through its inclusion of quality reproductive health as a right (Constitution, 2010). The 2009-2015 Reproductive Health Strategy put in measures to improve maternal and child health in Kenya through nationwide door to door vaccination targeting children less than five years and increase in the number of health facilities providing antenatal, labour and birth and immunisation services (Bhutta *et al.,*

2010). In addition, the department of health developed community maternal newborn care guidelines.

Another initiative aimed at improving maternal health in Kenya is the elimination of user fees and the provision of free maternity care at the point of care paid by the Government of Kenya through the National Hospital Insurance Fund (NHIF). Tama *et al.,* (2018) through their study in Kenya through in-depth, focus group discussions, and facility records and documents reviews, identified that the implementation of the free maternity care was implemented without adequate stakeholder engagement and a lack of understanding of the policy. In addition, the introduction of the policy led to unanticipated facility deliveries without adequate capacity leading to poor quality care. The emphasis on quality maternal health care has also been advocated by the First Lady of Kenya, Her Excellency Margaret Kenyatta. In a programme dubbed the "Beyond Zero Campaign", the First Lady fundraised for mobile clinics to ensure that each of the 47 counties in Kenya has a mobile clinic that specifically provides services in areas for maternal and newborn health and care for HIV-related complications.

There has been improvement in the maternal indicators with an increase in the number of facility births from 44% in 2008/2009 to 63% in 2014 (Kenya Demographic Health Survey (KDHS), 2014). The maternal mortality ratio has declined from 590 to 360 deaths per 100 000 live births World Health Organization, (2012). This is above the target of 70 deaths per 100 000 live births envisaged to be achieved by the 2030's sustainable development goals.

Maternity care in Kenya is provided mainly by nurses/midwives, doctors and traditional birth attendants (Kenya Demographic Health Survey (KDHS), 2014). The Kenya Nursing

workforce report (2012), estimates the number of registered nurses in Kenya to be 39,919 (Rodgers, 2012). These are nurse/midwives due to the comprehensive training of nurse/midwives with no specific midwifery cadre. The nurse population density in Kenya is 0.42/1,000 (Wakaba *et al.*, 2014). Approximately 96% of women seek antenatal care at least once during pregnancy, of which 66.3% are seen by nurses/midwives and 28.6 % by medical doctors. Skilled attendance at birth stands at 62%, of which 37.8% is provided by midwives and 24.3% by medical doctors. Those who are assisted by traditional birth attendants are 21.6% and 13.3% are assisted by relatives or friends. This finding is supported by studies that have been done in western Kenya which reported that most women would seek the services of traditional birth attendants during labour, with a few seeking services from a health facility and others birthing on their own (Dietsch, 2010; Ouma *et al.,* 2010).

There are socio economic, political and cultural factors that impact on maternity care as evidenced in a study done in Kenya that identified male partner factors mainly level of education and income to have an influence in seeking for maternity services (Nanjala & Wamalwa, 2012). The main factors include lack of knowledge by male partners on pregnancy related complications, cultural beliefs and money paid at health facilities. Similarly, a qualitative study done in Mwingi identified female genital mutilation, traditional, health seeking behaviours, religious influence, deficiencies in health care service provision, unreliable transport and infrastructure, illiteracy, poverty and food insecurity to influence seeking of maternity services (Nzioki, Onyango, & Ombaka, 2015).

1.4 Factors influencing uptake of maternity care

Maternal and neonatal health outcomes, is not only influenced by cost, other factors including poor quality of care, distance to facility, poorly equipped health facilities and traditional and

cultural factors have been shown to have an impact (Gitobu, Gichangi, & Mwanda, 2018). Uptake of maternity care is dependent on women and community factors and infrastructure and health institutions factors.

1.4.1 Women and community factors

Women and community factors, that influence uptake of maternity care include socio-demographic and cultural factors, perceived benefit/need of skilled attendance, awareness of services offered at health facilities, economic and physical accessibility and the availability of services at health facilities (Amooti-Kaguna & Nuwaha, 2000; Gabrysch & Campbell, 2009; Simkhada, Teijlingen, Porter, & Simkhada, 2008). Thaddeus & Maine, (1994) use the three-delay model to describe factors that hinder the utilisation of existing maternity services: delay in making a decision to seek health care, delay in reaching the health facility, and delay in receiving appropriate treatment while at the facility, related to the availability of supplies, waiting times and the use of interventions.

The socio-demographic factors that influence the uptake of maternity care include maternal age, parity, level of education, marital status and income (Gabrysch & Campbell, 2009). Older women and those of higher parity are more able to influence decisions on their care than younger women. Women of higher parity draw on their past childbirth experiences to make decisions on whether or not to seek professional care, as they understand biological risks that they are prone to (Fotso, Ezeh, & Essendi, 2009). Those women who experienced complications during previous births or loss of the newborn are aware of the dangers of childbirth and the benefits of skilled interventions and thus seek skilled care during subsequent births (Navaneetham & Dharmalingam, 2002). On the other hand, those women having their first birth may have little or no information on the expectations of childbirth and have to seek services (Gabrysch & Campbell, 2009; Navaneetham & Dharmalingam, 2002).

Educated women are more receptive to information on health, which helps them understand the benefits, risks involved, type and quality of care provided in health facilities, and influences their decisions to seek care (Ahmed, Creanga, Gillespie, & Tsui, 2010; Gabrysch & Campbell, 2009). A woman's partner/husband's level of education also influences the decision to seek maternity care services. Men who are educated are aware of the services and benefits of seeking skilled care at birth and can promote positive healthcare-seeking behaviours while their uneducated counterparts may prevent women from seeking services as part of the general constraints they put on women's mobility (Stephenson, Baschieri, Clements, Hennink, & Madise, 2006).

Marriage also influences decision-making with women who have the freedom to make decisions in marriage also able to make decisions on whether or not to seek maternity care. In some cultures, women have to wait for their husbands, or mothers-in-law or relatives to make decisions for them (Thaddeus & Maine, 1994). In Uganda, for example, the choice of the utilisation of skilled birth attendance and location of birth was mainly made by women in consultation with their spouses (Kabakyenga, Östergren, Turyakira, & Pettersson, 2012). In Kenya and the Ivory Coast, women in monogamous unions seek care more often (Stephenson, Baschieri, Clements, Hennink, & Madise, 2006). Single or divorced women may not seek services, as they may fear being stigmatised at the healthcare facilities and instead opt to deliver at home with the assistance of a traditional birth attendant or a friend (Duong, Binns, & Lee, 2004).

The status of women and autonomy influence their decisions to seek maternity care (Gabrysch & Campbell, 2009). Those women who are economically empowered can pay for themselves or make independent decisions to enrol in health insurance and seek services (Blanchet, Fink, & Osei-Akoto, 2012). Those women who suffer poverty are less likely to

seek healthcare services. The cost of care-seeking may include the cost of transportation, medication and supplies, and official and unofficial provider fees, as well as the opportunity costs of travel and waiting time lost from productive activities (Thaddeus & Maine, 1994).

Cultural and religious beliefs also influence the decision to seek care (Kyomuhendo, 2003). Cultural beliefs may hinder some women from using maternity services, for instance in some African cultures women who experience obstructed labour are believed to have engaged in infidelity during pregnancy and those women who are aware of these myths are afraid to seek care when they experience obstructed labour (Maimbolwa, Yamba, Diwan, & Ransjö-Arvidson, 2003).

1.4.2 Infrastructure and health institution factors

Thaddeus & Maine, (1994) expound on how the distance to a health facility exerts a dual influence on use, as a disincentive to seeking care and as an actual obstacle to reaching care after a decision has been made to seek care.

Distance to a health facility depends on the availability of transport and state of the roads. Poor road infrastructure, poor communication, poverty and the unavailability of transport may force women to walk long distances to a health facility (Gabrysch & Campbell, 2009). This may prevent some women from even making attempts to reach a facility for birth, since walking many kilometres is difficult in labour and impossible, especially if labour starts at night, with no reliable means of transport (Amooti-Kaguna & Nuwaha, 2000; Duong, Binns, & Lee, 2004, 2004; Gabrysch & Campbell, 2009).

In addition, travelling away from home causes stress to parturient women resulting from financial constraints, separation from spouse, children and community, and a lack of continuity of care (Kornelsen, Stoll, & Grzybowski, 2011). Those women who travel long

distances are prone to physiological and psychological stress associated with parturition in unfamiliar settings, thus interfering with the normal process of labour (Kornelsen, Moola, & Grzybowski, 2009). This may lead to an increased rate of complicated births, higher rates of prematurity, higher costs of neonatal care, and higher chances of induction of labour compared to women who do not require travelling (Klein, Johnston, Christilaw, & Carty, 2002). The cost of seeking maternity services in private facilities, in spite of the often good quality, also deters women from seeking the services (Amooti-Kaguna & Nuwaha, 2000).

Where people have the choice between several facilities, sometimes they will travel a greater distance if the target facility is perceived to offer superior quality care (Thaddeus & Maine, 1994). Some policies are not favourable and may have a negative impact on employees, contributing to low morale and high employee turnover, as seen in studies conducted in the United Kingdom (UK) and Denmark (Curtis, Ball, & Kirkham, 2006). The uptake of maternity services is also influenced by how women are treated at the healthcare institution. The White Ribbon Alliance identifies a correlation between disrespectful and abusive care to the utilisation of maternity care services (Alliance, 2017). Women who experience mistreatment report dissatisfaction with maternity care and resort to not utilising skilled attendance at birth nor seek maternity services for their subsequent pregnancies.

Kyomuhendo, (2003) reports dissatisfaction with rude, arrogant and neglectful behaviour at health facilities to women not seeking maternity services and instead preferring the care of a TBA or relative. Dietsch & Mulimbalimba-Masururu, (2011), in their study in some districts in western part of Kenya where they interviewed 84 participants, found that women preferred traditional birth attendants, as they focused on building relationships with women and creating an enabling birth environment through caring and practising intuitively. They stated that caring was demonstrated by being humble, patient, and kind.

1.5 Summary

The chapter has presented an overview of woman-centred care, the global initiatives put in place to improve maternity care, maternity care in low- to middle-income countries and maternity care in Kenya. The chapter also highlights the factors that influence uptake of maternity care.

1.6 Thesis organisation and structure

Chapter 2 presents a review of existing literature, problem statement and research question. It summarises related studies that informed the study. Chapter 3 describes the methodology used during the doctoral research. Chapter 4 presents the findings of the four Appreciative Inquiry phases of the study. Chapter 5 is the discussion of the findings and Chapter 6 presents the implications of the study, recommendations for further research and conclusions.

2. LITERATURE REVIEW

2.1 Introduction

Chapter 2 begins with the approach used to conduct a literature review. It then presents literature reviewed, gaps and weaknesses, problem statement, purpose of the study, research question and summary of the chapter.

2.2 Approach to literature review

An integrative literature review was done *post-hoc* to increase the rigour and focus the study after an initial narrative literature review. In hindsight, the original literature review had a number of limitations that were not addressed earlier in the research process. This included a literature search that needed to be more focused and a review that needed to be more in-depth. This is because a narrative literature review has the possibility of being biased, risks the exclusion of good research as its scope is broad, covers a wide range of issues within a topic, is general, and descriptive (Dixon-Woods *et al.,* 2007; Pae, 2015).

An integrative literature review entails gathering representative information on a topic in a systematic way to generate new frameworks and perspectives and to identify inconsistencies, discrepancies and observations through critique and synthesis (Torraco, 2016). An integrative literature review adds rigour and provides scaffolding to order the review process (Hopia, Latvala, & Liimatainen, 2016). It enables integration of findings and perspectives from several empirical findings and inclusion of different research methodologies, both quantitative and qualitative, to build on evidence-based practices and a comprehensive understanding of particular research problems for the development of theory in practice, research and policy (Whittemore & Knafl, 2005).

An integrative literature review evaluates how the research was conducted, methodological choices and sampling and results, providing insights on how previous studies were done. An integrative literature review provided for a clear data-collection and abstraction strategy, which helped situate and focus the study (Evans & Pearson, 2001a). It identified concepts relevant to woman-centred care and guided higher-order thinking and the framing of the concepts and themes during the writing of the literature review, analysis, results and discussion enhancing the researcher's confidence.

Unlike other reviews, such as clinical trials, Cochrane reviews and meta-analysis, an integrative review does not focus on hierarchies and the use of statistical methods to review and quantify data, which exclude other research methods used in midwifery and nursing and classify them as low level (Evans & Pearson, 2001b). However, critiques of integrative literature reviews recognise the complexity of combinations of diverse methodologies that pose a potential to lack of rigour, inaccuracy and bias in reporting (O'Mathúna, 2000). Whittemore & Knafl (2005) and Note (2013) recognise the complexity and daunting task in the identification of relevant literature, analysis and synthesis of data from different research methods.

The steps for conducting an integrative literature review include problem identification, data collection, evaluation of data (quality appraisal), analysis and interpretation of data (data abstraction) and presentation of results (Whittemore & Knafl, 2005; Kangasniemi, Pakkanen, & Korhonen, 2015), outlined below.

2.2.1 Problem identification

Problem identification is the beginning of an integrative literature review. This stage is used to determine the variables of interest, appropriate sampling frame which facilitates literature search and, during data extraction, separates pertinent from extraneous information

(Whittemore & Knafl, 2005). The problem identification phase in the current study entailed defining woman-centred maternity and midwife-led care, the means to achieve woman-centred care and the benefits of woman-centred care. It also entailed describing the implications and application of woman-centred and midwife-led care.

2.2.2 Data collection and search strategy

Several databases were searched as recommended by Booth (2008). Databases searched were the Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Google Scholar, Medline, Sage Research Methods, Science Direct, Biomed Central and the Cochrane Database of Systematic Reviews. Keywords were identified using truncation to broaden the search and the Boolean operators 'OR' and 'AND' were used to link keywords and concepts to produce more relevant results (Booth, 2008). The following keywords were used: 'woman-centred care' 'women-centred', 'patient-centred', 'woman-centred AND midwife-led care', 'human scale development model', 'Appreciative Inquiry', 'maternity care AND Kenya', and 'maternity care AND low to middle resource countries'. The standard search strategy was enhanced by the use of 'cited by', 'related citations' and searching the reference lists to ensure significant literature was accessed (Papaioannou *et al.,* 2009).

The search was limited to peer-reviewed articles published in English and between 1990 and 2019. The limitation to 1990 is to capture progress made in woman-centred maternity care and increased focus on maternal health after the start of the safe motherhood initiative in 1987 in Nairobi, Kenya. Livoreil *et al.* (2017) recommends screening from a wide selection to minimise bias. The initial literature search yielded 1732 papers. The filtering of papers based on titles was undertaken and papers that focused on medical conditions during pregnancy, abortion, specific interventions such as weight gain during pregnancy, labour induction or specific conditions such as hyperemesis gravidarum were excluded. This reduced possible

papers to 284. Of these, 35 were duplicate articles, and another 120 were excluded based on the abstract as they did not discuss woman-centred care during pregnancy or in regards to maternity care. Abstracts and titles of the remaining 129 studies were further assessed and 10 papers excluded as they were conference programmes discussing woman-centred care and not research articles, leaving 119 articles for review. Out of those that met the inclusion criteria, 15 of the abstracts did not have sufficient information to assess relevance, requiring downloading of the full text, which met inclusion.

Further screening of all articles was done based on the full text of the documents, using the same inclusion/exclusion criteria. An additional 37 studies were identified from ‘cited by’ or ‘related articles’ proposed by supervisors or known to the researcher and met the set criteria and may have been left out by the search. However, Note (2013) cautions against the use of snowballing to minimise subjectivity. This method is used to determine which parts of the literature have been influential in the area. Seven PhD dissertations and two Master’s theses were reviewed to provide primary qualitative research on the topic and add finer detail to the narrative. Figure 2.1 below illustrates the selection process.

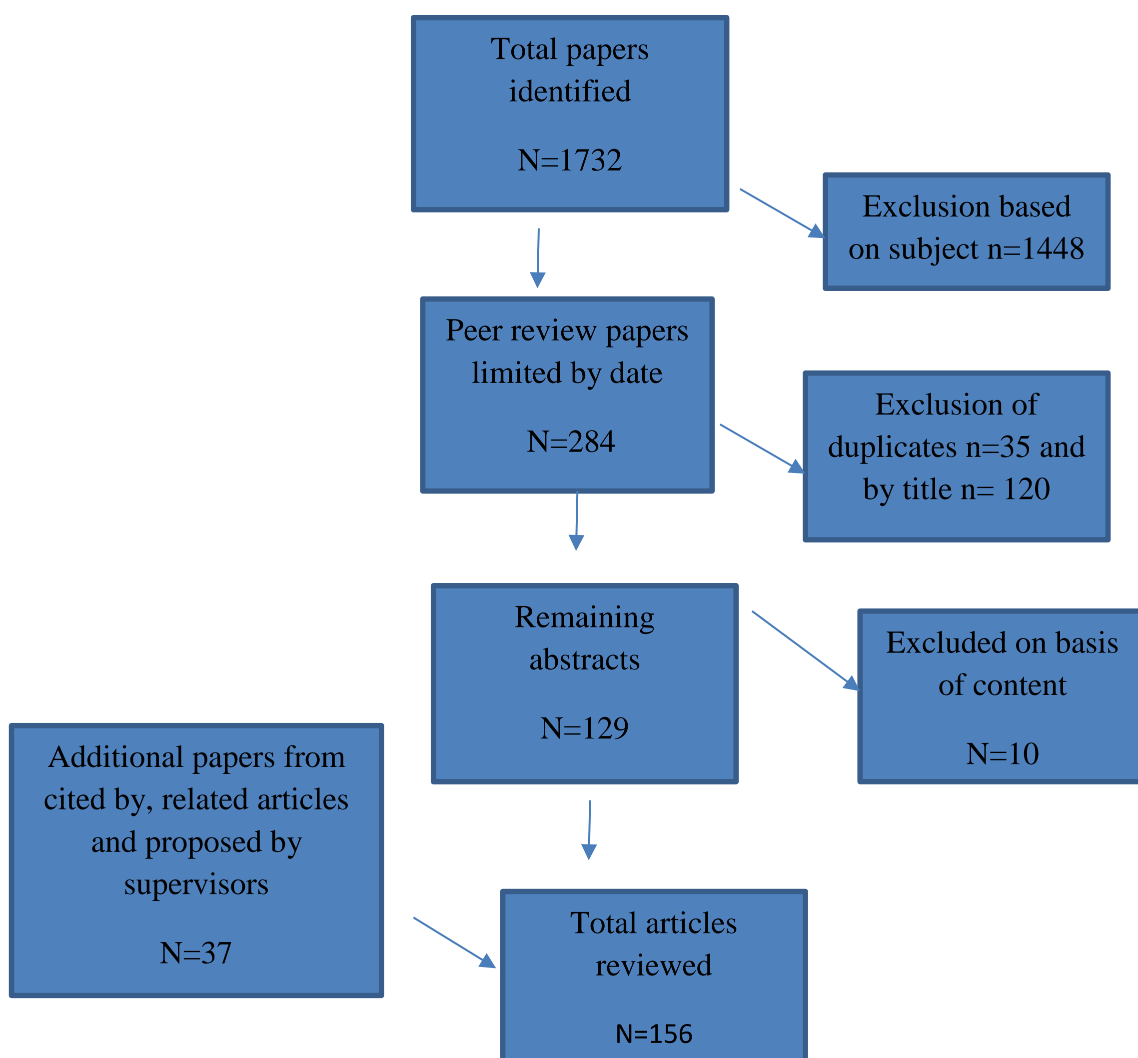

Figure 2.1: Flow chart showing the selection of research articles

2.2.3 Evaluation of data (quality appraisal)

The strength of the evidence was assessed through evaluation of the quality of writing and determining the authenticity of the primary sources. The screening process began during the search for relevant literature using credible databases and peer-reviewed journals. The quality of writing was determined through a critical analysis of the literature, examining the main ideas and relationships and how well the literature represented the question (Whittemore & Knafl, 2005). Whittemore & Knafl, (2005) and Kirkevold (1997) also proposes sampling from a wide variety of methods and evaluating the quality of writing based on the methodological information provided, mainly whether the methodology provided information

in passing or did not provide enough detail on how a study was done. It entailed evaluating the research design, effect size and the rigour of the study.

Further, quality appraisal included critical analysis to identify any theoretical inconsistencies, methodological flaws, sample size determination, site of research selection, the position of the researcher and generalisations (Livoreil *et al.*, 2017). Quality appraisal was also evaluated based on strengths and key contributions of the literature and the citation index. This entailed the identification of aspects of the topic that were missing, incomplete, or poorly represented in the literature, as well as inconsistencies among published perspectives on the topic across different studies and context that is global-regional or context-specific.

2.2.4 Extraction, synthesis, analysis and interpretation of data

Data extraction is dependent on a well-specified research purpose that facilitates accurate operationalisation of variables from primary sources (Kirkevold, 1997). Data were extracted from primary sources on sample characteristics and method as well as any reference to the main concepts of woman-centred and maternity care and/or midwife-led care, as recommended by (Whittemore & Knafl, 2005). It was then followed by data analysis, which involved ordering, coding, categorising and summarising the data into a unified and integrated conclusion about the research problem (Whittemore & Knafl, 2005). The analysis focused on the definition of woman-centred and/or midwife-led care, why woman-centred care, and the implications and implementation of woman-centred care. During synthesis, there were no predetermined themes and themes emerged from the coding of the studies.

2.2.5 Presentation of data

During the extraction of data, common elements, similar themes and concepts across otherwise heterogeneous studies were identified and grouped. This was followed by a

systematic categorisation of data to depict different patterns, directions, similarities, variations and relationships (Bradley, Curry, & Devers, 2007).

2.3 Woman-centred care

Woman-centred care is care that focuses on the woman's individual experience, meaning and manageability of childbearing and childbirth, as well as on her health and wellbeing and that of her newborn child (Leap, 2009). Maputle and Donavon (2013), in their concept analysis, describe woman-centred care as "a philosophy of care … mutual participation and the involvement of both the mother and the attending midwife". These concepts are in harmony with the International Confederation of Midwives' (ICM) (2017) woman-centred philosophy of care that entails partnership, normalcy around childbirth, cultural sensitivity, promotion of self-care and the right to self-determination. Berg (2005) in an analysis of three qualitative studies identified three major concepts in caring for women at risk: a dignity-protective relationship, embodied knowledge and a balancing of the natural and medical perspectives.

The philosophy of woman-centred care recognises the woman as pivotal, who takes the lead in her care and works in partnership and collaboration with a midwife through mutual trust and respect to achieve safe, skilled and individualised care. The individuality of the woman and the normalcy of childbirth is an important component of midwife-led care (Diane, 2004). The term *woman-centred care* is sometimes interchanged with *women-centred care* with the latter broadly denoting care provided to women in maternity settings (Brady, Gibbons & Bogossian, 2019; Leap, 2009).

Berg, Asta Ólafsdóttir and Lundgren, (2012), in their hermeneutic study in Sweden and Iceland that synthesised findings from 12 studies, identified five concepts that constitute woman-centred care: a reciprocal relationship; a birthing atmosphere; grounded knowledge; cultural context and the balancing act. Brady, Gibbons and Bogossian (2019), in their

integrative review of the literature of 17 papers on woman-centred care using predetermined themes on clinical practice, maternity services and education, identified the following components of woman-centred care: clinical practice; choice and control, empowerment, protecting normal birth, relationships and individual midwife; maternity service; model of care, continuity of care and maternity care systems; and education; registered practitioners and student midwives.

A qualitative study conducted in Ireland involving women and clinicians identified the following components of woman-centred care: protecting normalcy, education and decision making, continuity, empowerment and building capacity to make decisions (Hunter *et al.,* 2017). Sandall, Soltani, Gates, Shennan & Devane (2016), in their Cochrane review, identify the main elements of woman-centred care as choice, control and continuity of the caregiver. The subparagraphs that follow discuss: normal birth; choice, control, partner involvement and cultural consideration; continuity of care, and relationships in woman-centred care.

2.3.1 Normal Birth

The WHO (2016) recommends women to be supported to have a normal birth, which is an integral component of woman-centred care. This is because a woman's body is physiologically designed to birth babies (McKenzie & Oliphant, 2010). Promotion of normal birth entails the nurturing of the mother through labour, birth and the early postpartum period to in turn nurture and care for her infant and achieve successful breast-feeding and in turn achieve good outcomes for the mother and baby (Duncan & Bardacke, 2010). Spontaneous vaginal birth confers significant physiological and psychological benefits to mothers compared to other modes of delivery, such as a caesarean section (Lothian, 2009). It is associated with fewer postnatal complications and the building of confidence in women about their bodies (Birthrights, 2013; Kenyon *et al.,* 2012). Natural childbirth promotes feelings of

empowerment and control, unlike with highly technologically and medically controlled births, which have been reported to have ongoing detrimental effects (McKenzie & Oliphant, 2010).

Diane (2004), in a qualitative study that used semi-structured interviews among nine midwives in the East Midlands England, describes birth as a unique female experience that requires midwifery knowledge to support variations in how women react to birth to facilitate normal birth. Maillefer, de Labrusse, Cardia-Vonèche, Hohlfeld, & Stoll, (2015), in their qualitative study conducted in a maternity unit in Switzerland among pregnant women, midwives and medical officers, reported that the women identified physiological birth as being important, and thus important to minimise unnecessary interventions. The push for natural childbirth has culminated in movements to support natural childbirth, driven by women and health advocates who argue that physiological birth is superior to other forms of birth (Malacrida & Boulton, 2014). The birthing atmosphere is integral in the promotion of normal birth, as it promotes the woman's confidence in giving birth. A *"birthing atmosphere provides a place of birth that radiates feelings of calm, trust and safety"* (Berg, Asta Ólafsdóttir, & Lundgren, 2012 p. 83).

2.3.1.1 Evidence-based practices to support normal birth

Normal birth can be achieved through the use of evidence-based practices, proper monitoring, minimisation of unnecessary interventions, paying attention to abnormalities, the appropriate use of technology and a working referral strategy in case of complications (Hunter, 2008). The use of evidence-based practices during pregnancy and childbirth improves satisfaction among women and midwives and leads to reduced incidence of intrapartum caesarean sections, quicker recovery and better outcomes for mother and baby (Homer *et al.,* 2014; Renfrew *et al.,* 2014; ten Hoope-Bender *et al.,* 2014; Van Lerberghe *et al.,* 2014). This

therefore brings into question the use of standardised procedures during pregnancy, labour and birth, thought to facilitate the efficiency of service provision at the expense of women's satisfaction (Blaise & Kegels, 2004).

Iravani, Janghorbani, Zarean, & Bahrami, (2015) in their systematic review on normal labor practices evidence support continuity of midwifery care and support, encouragement of non-supine position and freedom in movement throughout labor. Other evidence-based practices found useful along the continuum of pregnancy and childbirth include the use of folic acid preconception, administration of dexamethasone for premature labour, spontaneous labour, mobility and change of positions, support and birth companion, minimisation and avoidance of unnecessary interventions, avoidance of supine birth position, following the body's urge to push, active management of the third stage of labour and immediate skin-to-skin contact between mother and baby after birth (Lothian, 2009).

Women appreciate immediate skin-to-skin contact despite the presence of bodily fluids after birth (Finigan & Long, 2014). Skin-to-skin contact between the mother and newborn confers many benefits to include averting the negative effects of separation, supports optimal brain development, and through attachment promotes newborn self-regulation over time (Phillips, 2013). This also promotes the normal newborn instincts and motivates immediate breastfeeding within the first hour of birth.

2.3.1.2 Interventions during childbirth

The provision of woman-centred care is challenged by the existing health culture that is "fast-paced," "high-risk," "medically focused," and with "diverse populations". This has led to a rise in the use of interventions during childbirth and a preference for obstetric medical practice, as evidenced in a Heideggerian, hermeneutic phenomenological study done in the United States (Giarratano, 2003). Miller *et al. (*2016) uses the phrase "too little, too late

(TLTL) and too much, too soon (TMTS)”, which represents diversity and divergence in maternity care. TLTL associated with inadequate resources, withholding care or care unavailable until too late to help. TMTS describes the routine over-medicalisation of normal pregnancy and birth. TMTS includes unnecessary use of non-evidence-based interventions, as well as the use of interventions that can be lifesaving when used appropriately, but harmful when applied routinely or overused.

Some interventions, such as caesarean sections, increased from nine per cent in 1980 to 20 per cent in 2000 in countries such as Canada, the United States and Italy (Johanson, Newburn, & Macfarlane, 2002). This exceeds the recommended 10% to 15% Caesarean section rate beyond which there is a minimal contribution to any change in maternal and neonatal outcomes (Johanson, Newburn, & Macfarlane, 2002, Betran *et al.,* 2015). However, there are other factors that have led to increased caesarean section rates, such as increased age at pregnancy and obesity in high-income countries (Ye *et al.,* 2016).

Apart from caesarean sections, there has also been an increase in routine medical interventions in births considered normal births that have not been proven to be beneficial, such as routine rupture of membranes, routine perineal shaving and routine administration of Oxytocic’s for augmentation of labour, especially in women with low-risk pregnancies (Basevi, & Lavender, 2001, Hodnett, Downe, & Walsh, 2012). These routine interventions offer no benefits. Iravani, Janghorbani, Zarean, & Bahrami, (2015) in their systematic review related to most common practices in management of normal labor and delivery, evidence did not support routine enemas, routine perineal shaving, intravenous infusion, artificial rupture of membranes, labour augmentation and uncontrolled administration of Oxytocin, restriction of oral foods and fluids, repeated vaginal examinations, routine episiotomy, continuous electronic foetal monitoring and application of fundal pressure, offer no benefit.

Routine use of interventions during labour and birth, especially surgical interventions, pose the risk of increased morbidity, compared to normal birth and are associated with problems of breastfeeding, postpartum haemorrhage, hysterectomy, wound infection and maternal hospitalisation beyond seven days (Jansen, Gibson, Bowles, & Leach, 2013). Routine procedures end up exacerbating the dehumanisation of women by focusing on physical and technical aspects over compassion and reducing them to cases instead of individuals.

2.3.2 Choice and control, partner involvement and cultural consideration

Another concept in woman-centred care is choice and control during pregnancy, labour and the childbirth process (Namey & Lyerly, 2010). It entails a woman having autonomy to participate and make decisions about her care (Maputle & Donavon, 2013). Some of the factors that influence women's choice, control and ability to make decisions during childbirth include the woman's knowledge and information on childbirth, traditional, societal and religious doctrines and practices, and hospital policies and guidelines. A study done in the Gambia associated maternal health decision-making to knowledge of pregnancy and childbirth, related taboos, traditional birth attendant patronage and religious beliefs and practices (Lowe, Chen, & Huang, 2016). Bohren *et al.,* (2014) in their qualitative evidence synthesis of 34 studies from 17 low to middle income contries using thematic analysis associate seeking of maternity services to sociocultural context and care experience. These include influence during antenatal care, previous birth expereinces, influence of others on delivery location, ease of home birth and effects of policies.

Social and cultural practices influence how women give birth and the model of care that supports birthing services (McAra-Couper, 2007). Sociocultural factors in a study done in some parts of Kenya are related to a patriarchal society where spouses and mothers-in-law

make decisions regarding childbirth (Rotich, 2011). Some women, due to economic constraints, are not able to pay for hospital costs, either direct or indirect, or are forced to depend on others to make decisions on their behalf. A descriptive study among postnatal women in Nairobi, Kenya reported the inability of women to make decisions on when and where to seek antenatal care and place of birth and instead depended on their husbands or other family members to make the decision on economic/affordability grounds rather than health needs. Women expect midwives to provide their partners with information about pregnancy to enable them to participate and are involved in pregnancy (Maillefer, de Labrusse, Cardia-Vonèche, Hohlfeld, & Stoll, 2015).

Decision to seek care among women is influence by power relations where mother in-law or the husband through the interpersonal and societal expectations gives directions on the place and time for the woman to seek care. In Nepal, men are involved in giving advice, supporting with household work, arranging money and transportation to place of birth (Thapa & Niehof, 2013). This is also dependent on the woman's self-esteem and self-regard. In a study done in Bangladesh by Rahman *et al.,* (2018) reported male involvement in maternal health is associated with increased maternal access to antenatal and postnatal services, allayment of stress, pain and anxiety during delivery. However, increased dominance or over-involvement of men has its downside associated with escalation of labour difficulty when husbands become anxious in delivery rooms. Woman-centred care aims at the building of relationships between the woman, family and midwife through good communication, trust, and person-centred, safe and culturally sensitive care in an appropriate birthing atmosphere (Berg, Asta Ólafsdóttir, & Lundgren, 2012; Martin, Bulmer, & Pettker, 2013; Perriman, Davis, & Ferguson, 2018).

Healthcare facilities that operate through adherence to routines and laid down policies and procedures are a hindrance to women making choices and having control over their birthing process (Cole, LeCouteur, Feo, & Dahlen, 2019; Maputle & Donavon, 2013). Such policies are restrictive and do not offer women alternatives and instead expect them to adhere to protocols and guidelines without questioning. For example, women are expected to conform to restriction of movement at birth and the use of medical and surgical interventions during labour (Cole, LeCouteur, Feo, & Dahlen, 2019).

Rules are also concerned with asserting the authoritative professional knowledge of biomedicine and women are scolded or sometimes abused for seeking care from traditional birth attendants or rebuked for using herbs (McMahon *et al.,* 2014). Bradley, McCourt, Rayment, & Parmar, (2016) and Sadler *et al., (*2016) report that professionals who believe in the supremacy of professional identity do not uphold woman-centred care and use technical elements beyond the scope of the woman to make birth a medical event so they can control women's bodies and knowledge. Control of women's bodies is by manipulation on how women behave during labour, especially in their expressions of pain and the timing and direction of the pushing stage of labour (Bradley, McCourt, Rayment, & Parmar, 2016). Kwaleyela & Kearns, (2009) identify authoritative paradigms in health facilities that do not consider the woman's decision, for example, when a 'woman has the urge to push, a woman's bodily; tacit knowledge of what her body needs to do'. The effect of all these forms of control and assertions of power relegate women to the role of a bystander, not participant, in their birth experience. This status of women as bystander reflects the underlying ideology and practice of labour and birth services as an institution, rather than woman-centred.

Choice and control are hindered when women are not provided with information about their condition or progress of labour. Thompson and Miller, (2014), in a survey done among 3542

women in Queensland Australia on the extent to which women are informed and involved in decisions of pregnancy and childbirth, revealed varying provisions and involvement of women in different procedures, such as 4% not being provided with pre-labour caesarean-section information, and 60% of women not being informed of the benefits and risks of vaginal examination. Similarly, findings from a qualitative study done in England among 32 pregnant women revealed a degree of uncertainty among women on the level of pain expected during labour and the options available for pain relief (Lally, Thomson, MacPhail, & Exley, 2014). The study reported that women were not provided with choices of pain relief and were not able to make decisions on pain-relief methods and, in some instances, healthcare providers made decisions on their behalf without providing adequate information to them.

A qualitative study carried out in Zimbabwe among ten primiparous adolescent women on their knowledge and choices on the birth process revealed a dependence on midwives to guide and inform them throughout labour and birth and, where this was not met, it became a source of distress and anxiety (Murira, Ashford, & Sparrow, 2010). Similarly, a qualitative study done among 15 postnatal women in a western region of Kenya reported that women depend on midwives to provide them with information that influenced their choices and decisions during the childbirth period (Rotich & Wolvaardt, 2017).

In a study done in Morogoro, Tanzania, women reported not having control during childbirth and punishment in the form of scolding meted out to them for acts such as presenting to the health facility too early or too late, or pushing too soon or not hard enough (McMahon *et al.,* 2014). In other instances, as reported in studies done in South Africa and Kenya, nurses and midwives demonstrated power by reprimanding women for delivering without a midwife or on the floor or in the wrong place or getting off the bed to move around during labour (Bazant & Koenig, 2009; Jewkes, Abrahams, & Mvo, 1998). In some parts of Kenya, midwives, in an

attempt to remain in control of maternity care, take charge of organisational processes in health facilities and do not listen to or are inconsiderate and unresponsive to the needs of the women (Bazant & Koenig, 2009; Okwako & Symon, 2014). Choice and control are also hindered by the deliberate withholding of information about the progress of labour or the baby's health, with reports of women being scolded and threatened when they ask questions (Okwako & Symon, 2014).

Communication, provision of information and involvement of women in their care by their caregiver promotes the feeling of being in control of their health (Waldenström, Brown, McLachlan, Forster, & Brennecke, 2000). Multiple contacts and interactions between the woman and midwives over time promote the development of trust, which enables the woman to make choices, get involved and have control over her care and relationship with the midwife (Brady, Gibbons & Bogossian, 2019). Feeley, Thomson and Downe (2019) describe three themes associated with women's decision-making: perceptions of women decision making, conflicting tensions as caregivers, and ways of working with women. These three themes relate to midwives' perceptions of the ability of women to make decisions which are dependent on the woman's characteristics, previous experience of childbirth, fears and vulnerabilities, midwives concerns over medico-legal implications and the relationship between women and midwives. The study reported different tensions attributed to women declining certain care and facing the consequences in the event of poor outcomes.

2.3.3 Continuity of care in woman-centred care

The Royal College of Obstetricians and Gynaecologists (RCOG) and the National Institute for Health and Clinical Excellence (NICE) guidelines define continuity of care as care provided by a small group of professionals with whom the woman feels comfortable (RCOG 2011and NICE 2008). The principle of continuity of care is sometimes interchanged with

continuity of carer; the latter entails the provision of care all or most of the time by the same professional while the former means that care is provided by different professionals, but mechanisms are put in place to ensure each professional is adequately briefed about the woman to avoid fragmentation of care and conflicting advice (Green, Renfrew, & Curtis, 2000). Continuity of care in woman-centred care entails monitoring the physical, spiritual, psychological and social wellbeing of the woman and family throughout the child-bearing cycle (Homer *et al.,* 2014; Renfrew *et al.,* 2014; Sandall, Soltani, Gates, Shennan, & Devane, 2016; ten Hoope-Bender *et al.,* 2014; Van Lerberghe *et al.,* 2014).

The geographical concept of 'continuity across location' has been described in the family medicine literature as care that is provided with continuity regardless of the location (Kerr, Schultz, & Delva, 2012). There is usually a likelihood for a pregnant woman to experience care in different locations across the pregnancy continuum (antepartum, birth and post-partum) of the index pregnancy (World Health Organisation, 2016).

Sometimes women may have to travel to other locations for their daily activities and appointment times find them in another location. In other contexts, women must travel long distances to other locations to receive maternity care, due to limited access to local resources. Another reason for travel to other locations is to receive more specialised or advanced care not provided at the nearest facility (Baker *et al.,* 2007; Haggerty *et al.,* 2003; Hatem, Sandall, Devane, Soltani, & Gates, 2008).

Hildingsson, Haines, Cross, Pallant, & Rubertsson, (2013), in their survey of 123 Australia and 386 Swedish women, identified continuity of caregiver as being important for women in Sweden, but in Australia, the personal encounter with the caregiver was more important than meeting the same midwife each time. Women in Switzerland who experienced continuity of

carer in a private health facility thought it promotes communication and the building of trusting relationships (Maillefer, de Labrusse, Cardia-Vonèche, Hohlfeld, & Stoll, 2015). Continuity of carer, establishes and facilitates free communication between the woman and the carer and builds trust and establishes a relationship where the woman and midwife develop an understanding of patterns and processes of childbirth and enables the midwife to develop clinical skills and make them safe birth practitioners (Deery & Kirkham, 2006; Kirkham & Morgan, 2006; Maillefer, de Labrusse, Cardia-Vonèche, Hohlfeld, & Stoll, 2015; Sandall, Soltani, Gates, Shennan, & Devane, 2013; Sandall, Soltani, Gates, Shennan, & Devane, 2016).

Although continuity of carer has been promoted as an important feature of midwife-led care, some studies have disputed its actual value to women over continuity of care and the feasibility of attaining continuity of carer (Green, Renfrew, & Curtis, 2000). Continuity of staff is where the same healthcare provider follows up the woman through pregnancy and birth. This is essential for effective monitoring and management of the pregnancy. Women appreciate the continuity of staff, as this person has all information regarding the woman and is able to follow through the pregnancy (Jenkins *et al.,* 2015). The healthcare provider can recognise the woman's circumstances and needs throughout the pregnancy period to provide woman-centred care.

Successful implementation of continuity of care requires commitment and support from service leaders and managers with appropriate personal skills and attributes. It also requires commitment from all stakeholders, including women, community and other health professionals (Sandall, Soltani, Gates, Shennan, & Devane, 2013). The imperative for midwives to be supported through the implementation of midwifery continuity of care is reinforced in the work of Ruth Deery and Mavis Kirkham in the UK (Deery & Kirkham,

2006). Continuity of care enhances confidence and restores faith in normal birth, since the midwifery culture in some institutions remains highly contested, with midwives struggling to provide woman-centred care often challenged by the risk-averse nature of obstetric care (Fenwick, Sidebotham, Gamble, & Creedy, 2018). Continuity of care enhances confidence in women in their ability to have a normal birth. Different health regulatory bodies clearly outline professional boundaries, which include 'over-involvement', namely, "boundary crossings, boundary violations and inappropriate relationships with the woman, her partner or family by the midwife" (Kelly *et al*., 2014). Pregnant women in a qualitative study conducted by Maillefer, de Labrusse, Cardia-Vonèche, Hohlfeld, & Stoll (2015) in a maternity unit in Switzerland among pregnant women, midwives and obstetricians reported fragmentation and omission of some aspects of care. Women cited instances when laboratory results were not reviewed when they received care from three different obstetricians in a private facility laboratory, as one obstetrician made the request and the next time the woman was reviewed by a different obstetrician not aware that laboratory results were to be reviewed.

Continuity of care models accrues benefits for midwifery students. They provide a holistic framework for students to gain diverse midwifery experiences and facilitate a nexus for theoretical knowledge and practice. Through partnerships between students and women, students develop appropriate clinical skills required for registration, thereby promoting their confidence and competence (Hatem, Sandall, Devane, Soltani, & Gates, 2008; Sandall, Soltani, Gates, Shennan, & Devane, 2013). Continuity of care allows students to engage in women-centred care, which is not always achievable to them while on standard clinical placements (Sweet & Glover, 2011). The experiences significantly increase students' confidence and skills throughout their education. Continuity of care can be achieved through

information, clinical management, relationships, continuity of staff and across locations and pregnancies (Freeman & Car, 2007; Jenkins *et al.,* 2015).

2.3.3.1 Informational continuity

Informational continuity uses disease- or person-focused information as the common thread linking care from one provider to another and from one healthcare event to another (Haggerty *et al.,* 2003). Informational continuity concerns the timely provision of relevant patient-related information, including laid-down policies and procedures and the emphasis placed on record keeping. The importance of accurate, updated health records that are accessible to all healthcare providers is important (Fraser, 1999). Having accurate data about a woman that are accessible in health records ensures understanding of the woman by different providers who can, in turn, provide consistent information based on records.

As women have multiple interactions with multiple healthcare providers during pregnancy, birth and the postnatal period, information continuity is essential as inconsistency of advice and conflicting information can occur as seen in a study among postnatal women in some western regions of Kenya (Rotich & Wolvaardt, 2017). The women cited inconsistencies in information by different providers during pregnancy and the childbirth period. McInnes & Chambers, (2008) associate a lack of continuity of care with conflicting advice.

2.3.3.2 Clinical management continuity

Clinical management continuity entails management from several providers who could otherwise work at cross-purposes, especially in complex or chronic diseases, for purposes of providing care in a timely and coherent manner (Haggerty *et al.,* 2003). It provides for coordinated care in the management of complex pregnancies that may involve different levels and the need for transfer and multidisciplinary care (Jenkins *et al.,* 2015). This kind of continuity is evident when, for example, a woman develops a condition such as hypertension

during pregnancy and it requires a physician to be included in the management of the woman. Clinical management continuity includes consistent approaches and care models to provide coordinated care and the communication of facts and judgments between the team, institution, patients and professionals (Salisbury, Sampson, Ridd, & Montgomery, 2009).

Clinical management continuity includes management of previous pregnancies, which influences the care based on previous experience, expectations or pregnancy complications, which may arise from a previous history. Management continuity of the index pregnancy depends on an accurate account of what happened through the rest of pregnancy (or previous pregnancies), including the treatment given and the settings for treatment (Saultz, 2003). Continuity across pregnancies is expected to extend relational aspects and management and informational continuity, including good communication within the system, health providers and consistent policies for women (Green, Renfrew, & Curtis, 2000; Haggerty *et al.,* 2003).

2.3.3.3 Relational continuity

In relational continuity, care is provided with the same healthcare providers, such as the same group of midwives who rotate in a maternity unit, birth centre or at the woman's home (Jenkins *et al.,* 2015). Women have a chance of meeting all of them during pregnancy so that, when they go into labour, they meet familiar faces. Contact with a limited number of healthcare providers in relational continuity serves as a mechanism to overcome fragmentation, inconsistency and long waiting times and promotes satisfaction with the care provided (Green, Renfrew, & Curtis, 2000; Tuominen, Kaljonen, Ahonen, & Rautava, 2014).

Relational continuity builds on the accumulated knowledge of patient preferences and circumstances that are rarely recorded in health records, interpersonal trust based on the experience of previous care, and positive expectations of future competence and care (Guthrie, Saultz, Freeman, & Haggerty, 2008). Huber & Sandall, (2009), in their qualitative

study carried out in England among women, their partners and midwives identified calm as a very important outcome in relational continuity. This arises from familiarity among the different parties and minimises conflicting advice from midwives building their confidence and wisdom.

2.3.4 Relationships in woman-centred care

Hunter, Berg, Lundgren, Ólafsdóttir, & Kirkham, (2008) used the metaphor "maternity care as a tapestry in which the weft threads" are the visible factors such as clinical outcomes, technology, policies and protocols while "human relationships are the hidden warp threads" that hold it all together, but are hidden in the finished work and can be enhanced by effective communication and emotional skills.

Berg, Asta Ólafsdóttir and Lundgren (2012), in their hermeneutic approach in the development of a woman-centred model, identified a reciprocal relationship between the woman and the midwife as important. A reciprocal relationship is dependent on presence, affirmation, availability and participation in supporting birth and affirming and encouraging the woman's abilities in participation in her care. The ability of women to establish effective relationships with midwives is emotionally rewarding to both (Hunter, 2006).

The formation of relationships promotes teamwork between women and midwives in the development of a plan of care, since relationships are important not only for the 'soft side of care' but are also integral to clinical safety (Kennedy & Lyndon, 2008). First time mothers interviewed in new-Zealand consider relationships important before, during pregnancy and birth and the postnatal period as is the basis to mothers feeling good about their birth experience (Howarth, Swain, & Treharne, 2011). The quality of relationships is fundamental to the quality of maternity care, which is dependent on the care environment, arrangements and available support systems (Walsh, 2007). The relationship between the woman and the

midwife ensures personalised care, trust and empowerment through continuity-of-care models (Perriman, Davis, & Ferguson, 2018).

The formation of relationships between women and midwives during the encounter, especially one-to-one models of care, lead to job satisfaction among midwives (Enkin, Glouberman, Groff, Jadad, & Stern, 2006). Feather, (2009) emphasises the importance of nurses and midwives having emotional intelligence so that they can recognise their own feelings and those of others and foster positive relationships. The nurturing of respectful relationships among healthcare providers is dependent on the mutual understanding of each professional role and responsibility (Munro, 2013).

2.4 Models for delivery of maternity care

Hunter distinguishes two paradigms for the delivery of maternity care: the biomedical model of curing and the holistic caring model (Hunter, 2006). Davis-Floyd, (2001) indicates three paradigms representing a technocratic (medical) and holistic (midwifery) but also adding a dualism in-between model of humanism. The humanistic paradigm believes in the aggregation of body and mind and believes in the shared responsibility between the practitioner and the patient (Najafi, Roudsari, & Ebrahimipour, 2017). Davis-Floyd, (2001) humanistic model considers the body as an organism and a patient as a relational subject. The holistic model focus on “mind, body, environment and society all at once” (Najafi, Roudsari, & Ebrahimipour, 2017 p. 5449). The biomedical model, with varying levels of midwifery input, is the most dominant in large obstetric units with bureaucratic systems (Wernham, Gurney, Stanley, Ellison-Loschmann, & Sarfati, 2016).

The biomedical model, also referred to as the *medical-technological model*, views childbirth as a risk requiring medical interventions (Downe, 2008). It places reliance on using

technology for surveillance to identify abnormalities and, therefore, the need for intervention and control. This control is typical of the patriarchal nature of the biomedical model, where decisions are made by the healthcare provider and the woman is expected to comply, removing the power over her body from the woman and giving it to the healthcare provider, who may turn the childbirth process into a risky undertaking (Hunter, 2006).

The biomedical model propagates the use of mechanistic language using terms such as "floppy cervix, boggy fundus, lazy uterus" and "Braxton-Hicks contractions" (named after the person who discovered the contractions), rather than experiential language according to the woman who feels the contractions (Hunter, 2006). The debut of obstetric care has led to the erosion of midwife-led care, shifting from social childbirth to the medicalisation of childbirth and hospitalisation in high resource countries such as Ireland in the 19th century (Butler *et al.,* 2015). The ripple effect of the shift from midwife-led to the biomedical model has seen a rise in the use of epidural analgesia, augmentation and induction of labour and caesarean sections.

Hunter, (2006) further illustrates the mechanical view of the woman's body by use of terms such as referring to the uterus as a machine and terms such as "the mechanism of labour" or calling a woman's labour that does not progress on a specific timetable "arrested." Other terms include "active management", "failure to progress", "inadequate" or "false" contractions, and "unfavourable" or "incompetent" cervix. This results from socialisation that resulted to medicalisation change (Christiaens & van Teijlingen, 2009). A woman's gestational term is called a "confinement" and babies are "delivered" by the provider not "borne" by the mother. A vaginal birth after a previous caesarean birth is called a "trial of labour" and, if unsuccessful, is yet one more failure for the woman, as her body betrays her and is referred to as a "failed attempt" at vaginal birth. First-time mothers have "untried

pelves." Ultimately, mother and baby become the mechanistic "maternal-foetal unit" (Hunter, 2006).

The psychosocial model (otherwise referred to as a *midwife-led model of care*) provides a means for the delivery of pregnancy and childbirth care on the premise of childbirth being a normal physiological process (Foureur, 2008). This philosophy encourages women to trust their bodies and imbues in them the confidence to have a normal birth (Wakelin & Skinner, 2007). Midwife-led care promotes a partnership between the woman and a midwife for a continuous relationship that supports advocacy and autonomy (Bradley, McCourt, Rayment, & Parmar, 2016; Bryers & Van Teijlingen, 2010; Gould, 2000; McKenzie & Oliphant, 2010; Pollard, 2011; Soltani & Sandall, 2012).

Given the coexistence of different approaches to childbirth and competing claims for authoritative knowledge, there have been few studies that focus specifically on inter-professional relationships in maternity care. The differing ideological and professional differences have existed for decades (Reiger & Lane, 2009). The midwifery discourse, however, frequently positions doctors as employing a reductive, interventionist approach that anticipates danger and emphasises risk, although this rather simplistic dichotomy fails to acknowledge a continuum of practice along which individual midwives and doctors are situated (Bryers & Van Teijlingen, 2010). Downe, Finlayson, & Fleming, (2010) warns against a self-perpetuating pattern arising from tensions among professionals, known as "fractal in the complexity theory". Fractals are perpetual systemic problems that arise from a conflict between two professions that may lead to continuous tension over unresolved issues.

Hunter, (2007) describes how the introduction of a clinical pathway in Wales, UK, to support normality in labour did not achieve any difference in the impact of normal births; rather it

increased tensions between midwives and obstetricians. Downe, Finlayson, & Fleming, (2010) give an example of the tension between midwives and junior physicians, where midwives expect physicians to learn certain aspects that the physicians think may not be necessary, building tension and, since physicians move up the hierarchy quickly in healthcare, they soon become senior and carry the tensions forward. This can cause inter-professional tensions and become 'viral' across all organisational levels, presenting major problems, not only for safe practice but also for healthcare reforms. To mitigate the establishment of a self-perpetuating pattern, a collaborative approach is recommended to decipher disharmony reinforced by existing prejudices.

2.5 Midwife-led care

Midwife-led care is defined as care in which the midwife is the lead professional in the planning, organisation and delivery of care given to a woman, from initial booking during pre-conception, pregnancy, and the intrapartum and the postpartum periods (Hatem, Sandall, Devane, Soltani, & Gates, 2008; Sandall, Soltani, Gates, Shennan, & Devane, 2016). The World Health Organisation (WHO) recognises midwives as primary care providers for child-bearing women (Koblinsky *et al.,* 2006; Technical Working Group, 1997). They are expected to uphold professional autonomy and responsibility in providing care and advice to women during pregnancy and childbirth. Midwifery practice dates back to early biblical times. Midwives in the bible cared and gave encouraging words to women during childbirth and protected the mothers and babies from being harmed, gaining favour from God (Genesis 35:17; 38:28; Exodus 1:15-21). The term 'midwife' traditionally meant "with woman". Hunter, (2002), (p. 650) defines being "with woman" as

the provision of emotional, physical, spiritual and psychological presence and support by the caregiver as desired by the labouring woman.

The International Confederation of Midwives (ICM), in addition to defining a midwife, sets out the status of a midwifery education programme within a system that is recognised and regulates midwifery (International Confederation of Midwives (ICM), 2017). A midwife is

a person who has successfully completed a midwifery education program…has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery and use the title midwife and who demonstrates competency in the practice of midwifery (ICM, 2017).

Berg, Asta Ólafsdóttir, & Lundgren, (2012) state that midwives during provision of care combine *"theoretical, experience-based and sensitive knowledge"* (p. 84) in that the senses of sight, hearing, smell, touch and intuition are used to reflect and integrate care provided to the woman. Midwives are trained to observe, identify, and encourage the physiological process of pregnancy and childbirth, and to be attentive to any abnormalities (Lavender & Chapple, 2004).

Midwives enormously impact public health through the health promotion and preventive care that they provide (Biro, 2011). Renfrew *et al.,* (2014) illustrate the impact of poor maternal health and how midwifery interventions can improve quality care and address intergenerational inequalities in health. The development of a quality framework that supports normal reproductive processes recognises that midwives can provide safe and cost-effective

care even without additional investments in maternity care when there is increased demand for services (Renfrew *et al.,* 2014).

Midwife-led models of care promote the application of effective maternal and newborn interventions in a timely and cost-effective manner (Homer *et al.,* 2014). The philosophy of midwife-led care promotes the avoidance of unnecessary interventions, such as the routine rupture of membranes, an instrumental delivery or an episiotomy (Renfrew *et al.,* 2014). Walsh & Devane, (2012) associated reduced intervention rates to agency among women and midwives in midwife-led units. Countries like Switzerland and Ireland reviewed their policies to introduce midwife-led care in the provision of maternity care, with the aim of minimising interventions during pregnancy and labour (Devane, Murphy-Lawless, & Begley, 2007). The use of midwife-led care has been reported to lead to satisfaction with information, advice, explanation, birthplace, preparation for birth and labour and pain relief choices (Sandall, Soltani, Gates, Shennan, & Devane, 2016). In Canada, a study that compared birth outcomes between midwife-led care versus physician-led care could not provide conclusive evidence on the safety of midwife-led care, due to the small sample size (Simonet *et al.,* 2009).

However, midwives are faced with uncertainties when they provide care as, despite normalcy in childbirth, there are risks associated with childbirth (Alaszewski & Brown, 2007; Scamell, 2011). Scamell, (2011) compares midwives to swans:

> *Us midwives: we are like swans swimming across a lake. On the top we look all serene and tranquil but under the water our little feet are flapping about like mad (p 987).*

The analogy illustrates the risk associated with childbirth and the tension experienced by midwives while caring for women (Coxon, Scamell, & Alaszewski, 2012). The view of

childbirth as a risky event has contributed to the rigorous surveillance of pregnancy and labour with the view that things may change. The risk view is seen by the prescriptive antenatal visits, the routine monitoring of contractions and foetal heart rate (Scamell, 2011).

Maillefer, de Labrusse, Cardia-Vonèche, Hohlfeld, & Stoll, (2015) describe challenges with midwife-led models of care in instances that midwives are reluctant to provide care to women who do not ascribe to their philosophy. They further question: 'is this midwifery approach being woman-centred or midwife centric?' The success of midwife-led models is achieved when emphasis begins early during training to ensure midwifery graduates are well-equipped to handle normal pregnancy, identify deviations early and refer appropriately (World Health Organisation, 2010). Van Wagner, Epoo, Nastapoka, & Harney, (2007) propose a competency-based curriculum that applies different pedagogies, including observations, role-modelling, storytelling, case review and oral methods of teaching.

Various woman-centred midwife-led models of care direct delivery of midwifery care and offer continuity of care. These include team midwifery, caseload midwifery, one-to-one midwifery practice and independent midwifery practice (Biró, Waldenström, & Pannifex, 2000; Page, 2003).

2.5.1 Team midwifery

In team midwifery, a team of midwives provides continuity of care to a defined group of women (Biro, Waldenström, & Pannifex, 2000; McCourt, 2006). A team of up to eight midwives are rostered and provide antenatal, intrapartum and postnatal care with access to doctors to refer risky and complicated cases (Donnolley, Butler-Henderson, Chapman, & Sullivan, 2016). Team midwifery offers women 24-hour accessibility to a midwife and a woman can communicate, access information and receive consistent advice from a midwife anytime they want, thereby having increased security and formation of a meaningful

relationship between woman and midwife (Donnolley, Butler-Henderson, Chapman, & Sullivan, 2016). Tinkler & Quinney, (1998) in their study established that participation and formation of relationships between women and midwives promote satisfaction and confidence with maternity care. Midwives who work in teams report experiencing job satisfaction as they utilise existing skills to achieve professional development (Crowther *et al.,* 2016).

Women who receive care in a team midwifery practice are likely to experience spontaneous commencement of labour, have a normal vaginal birth, lower rates of induction, fewer caesarean sections and not to require pharmacological pain relief (Wilkes, Gamble, Adam, & Creedy, 2015).

2.5.2 Caseload midwifery (midwifery group practice)

In caseload midwifery, a midwife works in a group practice, taking responsibility for the main provision of care for an agreed number of women (Tracy *et al.,* 2013). A known midwife provides antenatal, intrapartum, and postnatal care within a publicly funded model with backup from midwives and assistance from doctors during high-risk situations (Donnolley, Butler-Henderson, Chapman, & Sullivan, 2016). The aim of caseload midwifery is to offer greater relationship continuity by ensuring that child-bearing women receive their antenatal, intrapartum and postnatal care from one midwife or his or her practice partner (McCourt, 2006). The difference between team midwifery and caseload midwifery is that, in caseload midwifery, a midwife is responsible for a certain caseload and assisted by others while off duty. Team midwifery a team of midwives is responsible for a certain number of women (Donnolley, Butler-Henderson, Chapman, & Sullivan, 2016).

Caseload midwifery, unlike standard maternity care, provides an opportunity for highly individualised care versus fragmented, routine care (Burau & Overgaard, 2015). Women who

receive care in a caseload midwifery model experience good maternal and newborn outcomes (Sandall, Soltani, Gates, Shennan, & Devane, 2013). A study that audited clients records in Australia, reported good neonatal outcomes with an average gestation of 39.3 weeks, average birth weight of 3525 grams and fewer neonates requiring special-care nursery management among women who received care from caseload practice (Wilkes, Gamble, Adam, & Creedy, 2015). McLachlan *et al.*, (2012) in a randomized controlled study in Melbourne Australia that compared outcomes between women at low risk obstetric in early pregnancy who received care in caseload versus standard care. Findings revealed that women who received care in caseload midwifery were less likely to undergo caesarean section compared to those from standard maternity care.

Beake, Acosta, Cooke, & McCourt, (2013), in their study in the UK which utilised semi-structured individual interviews with women three to six months postnatally who received care from standard and caseload models, found that those who received care in a caseload midwifery model experienced personalised care due to ‘knowing and being known’, ‘person-centred care’, ‘social support’, ‘gaining trust and confidence’, ‘quality and sensitivity of care’ and ‘communication’. They appreciate the relationship they form with midwives and find it to be more genuine and authentic (Williams, Lago, Lainchbury, & Eagar, 2010). In the UK, for example, women who received care from caseload models of midwifery appreciate the formation of a personalised connection and development of professional friendship with the midwife whom the woman can confide in, trust and share their emotions with, in addition to receiving physical care (Walsh, 2007; Wilkins, 2000).

However, caseload models require midwives to be on call seven days a week, 24 hours a day, which has implications for their social and family lives. The lack of clarity on work-life balance and expectations of caseload midwifery was considered a major challenge by Danish

midwives, despite considering caseload midwifery an opportunity for professional development for continuity and quality improvement (Burau & Overgaard, 2015).

2.5.3 One-to-one midwifery practice

The one-to-one midwifery practice began in the United Kingdom in 1993 after the changing Childbirth Report, which aimed at improving the continuity of carer of midwifery services amidst other innovations (Page, 2003). One-to-one midwifery care promotes a personal relationship between each woman and her midwife. The practice allocates 40 women to a midwife who works with another midwife with the same caseload. The midwives work in a group of six to eight caseloads. It is similar to caseload midwifery only that a midwife works with a partner midwife unlike in caseload whereby a group of seven to eight midwives work in the same caseload. Both midwives take a caseload of 40 women and each midwife gets to know the caseload of the other (Page, 2003).

Midwives who begin one-to-one midwifery care require time to polish their knowledge and skills to enable them to handle women confidently from institutional settings to the development of skills in all areas of midwifery, as reported by midwives in the UK (Stevens & McCourt, 2002). Midwives in the UK report that one-to-one midwifery care is fulfilling, as midwives have control over their time, are able to build relationships with women they attend to and achieve personal and professional development (Stevens & McCourt, 2002).

2.5.4 Independent midwifery practice

Independent midwives are those who have dedicated their practice to providing holistic care to women outside the formal institutional setting (Evans, 2010). Outcomes of independent midwifery practice in a study done in Japan among 5477 women who received services from independent midwives at a birth centre or at home indicated a high degree of safety and application of evidence-based practices (Kataoka, Eto, & Iida, 2013). All women

experienced spontaneous vaginal birth. There was 60% intact perineum, and there were a few women who had over 500 ml in blood loss.

Miller & McLoughlin, (2014), in their study comparing care provided by independent nurse-midwife to maternity care provided in a district hospital in Tanzania, recognised that women felt more satisfied in an independent practice as the midwife provided culturally sensitive care in a familiar comfortable environment, unlike in the hospital setting where women felt that the care provided was inhumane and there was the building of relationships.

2.5.5 Implementing midwife-led models of care

Successful implementation requires a multifaceted approach, requiring conversations between women, midwives, obstetricians, midwifery training institutions and communities to formulate good, favourable policies and legislation (Hatem, Sandall, Devane, Soltani, & Gates, 2008; Renfrew *et al.,* 2014). Delivery of care in midwife-led models varies across regions. They range from midwives providing continuity of midwifery care to all women from a defined geographical location, acting as the lead professional guiding women whose pregnancy and birth is uncomplicated, and continuing to provide midwifery care to women who experience medical and obstetric complications in partnership with other professionals to providing care in a maternity unit as part of standard care (Sandall, Devane, Soltani, Hatem, & Gates, 2010).

Support from healthcare leadership and working health systems is crucial in the implementation of midwife-led care. In a qualitative study done in Tanzania among five midwives and 15 women who had experienced obstetric fistula, the midwives reported unfavourable organisational factors, including a lack of supportive supervision and a lack of motivation or even appreciation from the clinical manager for the good work done (Mselle, Moland, Mvungi, Evjen-Olsen, & Kohi, 2013).

Midwife-led services can be provided in hospital settings, standalone birth centres or community settings. Freestanding birth centres provide opportunities to foster creativity, facilitate reciprocity and community social networks, as the environment provides support and the building of relationships (Walsh, 2007). Birth centres create a homely birth environment and facilitate one-to-one care, which is beneficial to both mothers and midwives, facilitates the formation of relationships and is likely to reduce childbirth interventions (Hodnett, Downe, & Walsh, 2012). One important characteristic of birth centres is the embracing of family relationships and cultural factors observed during pregnancy and birth (Van Wagner, Epoo, Nastapoka, & Harney, 2007). Women who receive care from a birth centre experience normal birth and 'emerge from the experience confident and empowered' (Walsh, 2007). A study in Canada reported that women prefer birth centres because relocation for birth outside the community is associated with loss of autonomy, poor health, family stress and medicalised birth (Van Wagner, Epoo, Nastapoka, & Harney, 2007).

The reality with the "with woman" expectation that defines a midwife is challenged by Shimpuku, Patil, Norr, & Hill, (2013) and Okwako & Symon, (2014), who reported incidences in which women go into labour and give birth on their own with minimal presence or absence of midwives in some regions in Tanzania and Kenya, despite the emphasis and promotion of health-facility deliveries. Jallow (2007) & Kwaleyela & Kearns, (2009) are of the view that the expectation of the midwife-led care of having a midwife with a woman through the process exists theoretically and is far-fetched in some countries, like Gambia and Zambia, where women report receiving attention from the midwives only during the second stage of labour and there are instances when midwives appear when the mother has already delivered on her own. Concerns about the absence of midwives or them only arriving during the second stage of labour has led women in some facilities in Tanzania to take precautions

by placing their mattresses on the floor in fear of the baby falling and, in some instances, bringing along traditional midwives to be present just in case they are left on their own (McMahon *et al.,* 2014).

Bradley, McCourt, Rayment, & Parmar, (2016) report workload and staffing challenges as major impediments to the provision of care in midwife-led models of care. McMahon *et al.,* (2014), in their study, reported occasions when a midwife was left alone at a health facility and expected to attend to five or six women in different stages of labour on her own. As a result, a midwife may not be available all the time to attend to all the women, resulting in some women going through labour without any assessment being done on them and others giving birth on their own (Mselle, Moland, Mvungi, Evjen-Olsen, & Kohi, 2013). Other concerns revolve around the way midwives work and their perception of a work-life balance. Some midwives working in continuity-of-care models find working 24 hours and seven days a week while 'on call' as being not 'midwife-friendly' and prefer shared models of care (Homer *et al.,* 2009). While there are factors beyond the midwife's control that hinder them from being available to attend to women, there are occasions when midwives are unavailable to attend to women, and yet they sit and watch television, chat, make phone calls or even sleep while on duty (Murira, Ashford, & Sparrow, 2010).

2.6 Gaps and weaknesses in the literature review

This is the first study done in Kenya on woman-centred maternity and midwife-led care. Woman-centred care models have been implemented in high-resource countries, such as Europe, North America and Australia. Most of the literature on woman-centred and midwife-led care is largely from western and higher resource countries with different contexts and culture. This therefore depicts a need for studies to determine how woman-centred care can be implemented in countries with different socio-cultural and economic dynamics, as the

review located a dearth of literature in the low-to-middle resource countries setting up the need to address this gap.

The concepts of woman-centred care have not been clearly articulated within the different spheres of policy, practice, research and education in the low-to-middle resource countries. There is a hybrid of delivery of maternity care in different settings without a standardised definition of woman-centred care. The articles focused on women with no mention of the newborn. There were few articles that discussed the birthing atmosphere and needed to implement woman-centred care.

Another limitation is the *post-hoc* nature of literature review. If done earlier, it would have helped focus and narrow the study which was broad in scope. The *post-hoc* literature review identified the gaps and weaknesses in previous research which would have guided the research question appropriately. However, Giles, King, & de Lacey, (2013) recommend deferment of the literature review to the end of data analysis to provide for emergent theory to arise from data rata than preconceived theory as is the practice in Grounded Theory. Corbin & Strauss, (1990) propose deferment of literature review as "there is always something new to discover (p.36). However, the iterative process of reviewing the literature expanded the scope of contextual literature which was not identified in the first review done before data collection (Whittemore & Knafl, 2005).

2.7 Problem statement

Woman-centred care has not been given prominence in Kenya, evidenced by the lack of literature on the topic. Neither was literature on midwife-led care found. The Kenyan literature found lacked woman-centred care concepts, mainly normal birth, agency, choice and control, the building of relationships and continuity of care. The literature review reveals

prevailing models of maternity care that are institution-centred, medicalised and hierarchical, where the exigencies and rules of the institution are played out.

Nevertheless, the emphasis has been placed on improving maternal healthcare in Kenya, evidenced in the enshrining of sexual and reproductive healthcare in the constitution of Kenya (2010) and the declaration by the president of Kenya in 2013 for the provision of free maternity care at the point of service, catered for by the government through the "Linda Mama" programme to improve access and the provision of quality maternity care. These initiatives are critical as they are aimed at contributing to achieving the good health and wellbeing Sustainable Development Goal Three by 2030.

The introduction of free maternity care in Kenya was implemented without an evaluation of capacity, especially the available number of midwives and other healthcare providers (Tama *et al.,* 2018). Recent statistics estimate the number of live births per year in Kenya to be about 1.7 million, approximately 4800 births each day. The new policy created a large load without a commensurate increase in health capacity, straining the available resources. This, therefore, requires innovative ways to meet the demand for maternity care services and provide quality care. These gaps therefore necessitated the need to engage women, midwives and health-service managers on how best maternity care can be provided.

2.8 Purpose of the study

The purpose of this study was to explore, through participatory methods, the views of women and midwives on current midwifery care, describe desired midwifery care and develop a woman-centred midwife-led model of care for Uasin Gishu County, Kenya.

2.9 Objectives

The objectives formulated for the study were:

1. To enrol women who have utilised the service and midwives to describe the current practice and care at the selected facilities and explore what promotes or impedes midwifery care (Appreciative Enquiry phase one: discovery)
2. To explore the desired midwifery care and what best care would be in this setting to plan the desired model for delivery of midwifery services (Appreciative Enquiry phase two: dream)
3. To design a model of care with the participants to guide in the provision of desired midwifery care (Appreciative Enquiry phase three: design)
4. To support participants to adjust and improvise practice in ways that can sustain woman-centred midwife-led models of care (Appreciative Enquiry phase four: destiny)

2.10 Research question

What kind of woman-centred midwife-led model of care would facilitate the delivery of quality, acceptable, preferred maternity care?

2.11 Conclusion

Woman-centred care has gained prominence in the western countries with the call to have women taking the lead in decisions regarding their care during pregnancy and childbirth period. Key in woman-centred care is agency and women being able to make decisions and choices, receive compassionate, respectful care, be empowered with information, facilitated to build relationships and achieve continuity of care. Woman-centred care models have proven effective and beneficial and contribute to favourable maternal and neonatal outcomes. The review identified the different models for the delivery of maternity care and the different midwife-led models of care. Midwives are recognised as lead care providers for normal childbirth.

2.12 Chapter summary

The chapter discussed the approach to the literature review, woman-centred care, midwife-led care and models for delivery of maternity care. The chapter finally presented gaps and weaknesses in the literature, problem statement, and purpose of the study, objectives and the research question.

3. METHODS AND DATA MANAGEMENT

3.1 Introduction

The previous two chapters presented the introduction and a review of existing literature that guided this study. Chapter three is organised in sections as follows: introduction (3.1), study setting (3.2), study design (3.3), study participants (3.4), procedure for recruitment of participants and ethical considerations (3.5), data collection (3.6), data management and analysis (3.7), data presentation (3.8) dissemination of findings (3.9), trustworthiness of the study (3.10), expected outcomes (3.11), and summary (3.12).

3.2 Study setting

The study was carried out in Uasin Gishu County Hospital. Uasin Gishu County is one of the 47 counties in Kenya and is situated in the mid-western part of the Rift Valley region, about 320 km north-west of Nairobi, Kenya. The county covers an area of 3327.8 km^2 with an estimated population of 1 200 179 people. The facility has a catchment area of 12 653 women of childbearing age (15-49 years) (Kenya National Bureau of Statistics, 2016). Eldoret Town is its administrative centre (see Appendix I: Map of Uasin Gishu County). Uasin Gishu County Hospital serves a multi-ethnic population and provides maternity services, mainly antenatal, labour and birth, postnatal, immunisation and family planning.

Uasin Gishu County Hospital provides the seven basic emergency obstetric and newborn care (BeMONC) signal functions described by the World Health Organisation namely; administration of parenteral antibiotics, administration of parenteral uterotonics, administration of parenteral anticonvulsants for pre-eclampsia and eclampsia (magnesium sulphate), manual removal of the placenta, assisted vaginal birth, removal of retained

products (manual vacuum aspiration), and basic neonatal resuscitation (Chou *et al.,* 2010). Uasin Gishu County Hospital is staffed mainly by nurses/midwives who work in different maternity units. A clinical officer and a medical officer who hold administrative positions are consulted occasionally when there are complications. There is no obstetrician or any other medical specialist working at the facility.

Records obtained from the hospital showed that each month, the facility provides antenatal services to an average of one thousand (1000) women with approximately seventy (70) births per month and thirty (30) women seeking follow-up postnatal care (up to 42 days post-birth) two to six weeks after birth in a month (Uasin Gishu County Hospital, 2015). These statistics indicate missed opportunities for skilled attendance at birth and a low uptake of postnatal services, considering the number of women who seek antenatal services to those who seek birth and postnatal services as illustrated above. The statistics agree with the Kenya population survey done in 2010 that identified that the majority (70%) of births in Uasin Gishu County occur at home, with approximately 30% occurring in health facilities or at least with skilled birth attendants, compared to 44% skilled attendance at birth countrywide (Kenya National Bureau of Statistics, 2010).

Homer *et al.* (2014), in their study, highlight the vicious cycle of unskilled attendance at birth and emphasises on the need for scaling up midwifery services during preconception, pregnancy, labour, birth and the postnatal period. Births that occur at home in the Kenyan context are either assisted by traditional birth attendants or friends and family members (Kenya Demographic Health Survey (KDHS), 2014). This scenario advised the choice of Appreciative Inquiry that considers what is done best at the facility and building from it to realise improvement and the choice of Uasin Gishu County Hospital (Mantel & Ludema, 2000).

Given the nature of the study and the implications for the physical and governance re-organisation, a detailed review of the prevailing conditions at the hospital was necessary. The facility offers maternity services in two sections. One section serves as a day maternity unit and is situated at one end of the facility. This section is divided into five rooms, namely, the records room, one family planning room, one room for the weighing and immunisation of babies, one room for antenatal check-ups and another room for counselling and testing services for Human Immunodeficiency Virus (HIV) for prevention of mother-to-child transmission (PMTCT). The PMTCT room is used for counselling and testing for HIV of all mothers attending the antenatal clinic for the first time during pregnancy, with an option to opt out, and also those tested HIV positive and follow up care. There is a corridor connecting the different rooms that is used as a waiting bay. The corridor is lined with benches where women sit as they wait to receive care.

The second location is the inpatient maternity unit building that is divided into three sections. It is divided into the labour and birth unit that has four beds separated by a curtain, a combined antenatal and postnatal unit with four beds and a room that serves women with abortion-related complications, which is also used as a counselling room and for continuous professional development presentations for staff. This setting poses a challenge to privacy and maintaining confidentiality.

3.3 Study design

The study was qualitative in nature, adopting an Appreciative Inquiry approach. The Human Scale Development framework guided the study to elicit the organisational context and provided a vehicle to achieving organisational change through collective participation. Appreciative Inquiry is a theoretical research approach that evolved from action research

towards the achievement of organisational learning and change (Trajkovski, Schmied, Vickers, & Jackson, 2013). . The choice of Appreciative Inquiry is its unique characteristic of ownership to change from inception of research to the end. The preference of Appreciative Inquiry to other frameworks, grounded theory and ethnography, is the unique characteristic of Appreciative Inquiry to embrace the positive from the institution and its involvement of different stakeholders in designing a desired future with a higher probability of collective responsibility and ownership. Participants are involved in designing and implementing changes. Sections 3.3.1 and 3.3.2 discusses other designs that can be used in the development of theory in research.

3.3.1 Grounded theory

Grounded Theory (GT) was developed in the early 1960's by Glaser and Strauss for use in social science (Strauss, & Corbin, 1994). It's used mainly in the study of shared group experiences to generate new theory (Watkins, 2012). Grounded theory provides for collection of rich data through flexible, practical approaches that allows for interpretation of complex social phenomena (Charmaz, 2006). GT utilizes different data sources and has explicit guidelines grounded in particular context that is concrete and structured to direct researchers on how to carry out the study (Charmaz, 2006; MacDonald, 2001). GT has an intuitive appeal for immersion in data through its characteristics of concurrent data collection, constant comparative analysis, theoretical sampling, coding and memoing (Lazenbatt & Elliott, 2005; Myers, 2009). The systematic approach to data analysis provides for rigor and ensures trustworthiness in the emerging theory. Researchers in GT are able to derive meaning from the data and analysis using creative, inductive processes that leads to the emergence of theory from original data findings (Jones, Kriflik, & Zanko, 2005). Charmaz, (2006) asserts that GT

provides novice researchers with the needed principles and "heuristic devices" to "get started, stay involved, and finish your [the] project" (p. 2).

Analysis in GT is complex and may cause a novice researcher to become inundated at the coding level, as open coding is a time consuming, tiring and laborious process (Myers, 2009). Researchers are cautioned of the notion of over simplicity that leads to undermining of the complex research method. Reviewing the literature is a contentious and debatable issue in GT that sometimes discourages scholars from using the method (Hussein, Hirst, Salyers, & Osuji, 2014). Throughout the evolution of GT, researchers have repeatedly debated how best to approach and utilize existing literature within the research study (Bryant & Charmaz, 2007).

3.3.2 Ethnography

Ethnography is a social science research that studies people in their natural setting to capture meaning in their ordinary life with the researcher participating directly in the environment in activities to capture data and social meaning without the researcher imposing meaning (Elliott & Jankel-Elliott, 2003). Reeves, Kuper, & Hodges, (2008) further elaborates that ethnography examines social interactions, behaviours and perceptions within groups, teams and organizations. It entails researcher immersion in people's culture to learn about a certain phenomenon (Watkins, 2012).

Ethnography has been a solution to providing the actual lived experiences as during the study of human behaviour, what is the extent that people can report fully and accurately their behaviour with the limitations of asking (Mariampolski, 1999). Ethnography is "Getting the seat of your pants dirty… in the real world not the library" (Fielding, 1993), p.157). This then means the researcher is required to be in the field for longer periods of time which may be time consuming and expensive. Data collection in ethnography is through: non-participant

observation, interviews, informal interviews and casual conversations and informant diaries (Elliott & Jankel-Elliott, 2003). Ethnography has been used traditionally in anthropology, but has gained currency in consumer research (Valentin & Gomez-Corona, 2018).

Participants or situations in ethnography are sampled on an opportunistic or purposive basis. It is also usual for ethnographers to focus upon specific features (for example, culture in medicine and decision making in healthcare) that occur within a research setting (Goodson & Vassar, 2011). Analysis of ethnographic data tends to be under taken in an inductive thematic manner: data are examined to identify and to categorise themes and key issues that "emerge" from the data. Through a careful analysis of their data, using this inductive process, ethnographers generate tentative theoretical explanations from their empirical work (Reeves *et al.,* 2008).

3.3.3 Appreciative Inquiry

Appreciative Inquiry (AI) was found appropriate for this study because of its participative positive approach and focus on strengths and achievements to realise organisational change (Avital, 2008;Trajkovski, Schmied, Vickers, & Jackson, 2013). Appreciative Inquiry achieves transformational change through sharing of the best positive stories and recognition of achievements (Cram, 2010; Richer, Ritchie, & Marchionni, 2010; Stefaniak, 2007). Whitney & Trosten-Bloom, (2010) affirm that Appreciative Inquiry’s participatory approach redefines the people involved and those who have access to information in an organisation from some to all of the people. The unique characteristic of this approach involves workforce engagement and brings together different internal and external stakeholders in a healthcare context to achieve organisational learning and positive change over one meeting or series of meetings, unlike traditional problem solving approaches (Koster & Lemelin, 2009; Ludema & BARRETT, 2009; Reed, 2006; (Trajkovski, Schmied, Vickers, & Jackson, 2013).

Appreciative Inquiry is dynamic and flexible (Whitney & Trosten-Bloom, 2010). Its fluid nature provides alternative ways of doing things in organisations and shifts assumptions of what drives organisations in the process of change through new ideas and theories as a team (Bushe, 2007; Richer *et al.,* 2010). Appreciative Inquiry, despite focusing on the positives, provides an avenue into the discourse on dynamics that contribute to failure through "naming the elephants", that is, talking about things that no one wants to talk about in organisations (Hammond, 2013). Keefe maintains that change is envisaged through reflection on professional practice and identification of what works well and what is needed to perpetuate best practices through appreciation, creativity and self-awareness (Keefe & Pesut, 2004).

Appreciative Inquiry has been used in both private and government institutions successfully. It has been used in various settings to engage groups and achieve a unified approach to achieving change to include religious, education, business and healthcare settings (Carter, 2006; Havens, Wood, & Leeman, 2006; Liebling, Elliott, & Arnold, 2001). A food manufacturing firm in Brazil utilised Appreciative Inquiry and organised a four-day appreciative strategic planning summit for its workers. After the summit, the organisation achieved a 35% increase in sales, after closing the firm for four days (Cooperrider & Whitney, 2001).

Appreciative Inquiry evolved from the doctoral work of (Cooperrider, Srivastva, Woodman, & Pasmore, 1987). It is based on four characteristics :

- appreciative: listens for the positive core of the institution's sharing of positive stories;
- applicable: looks for solutions known to have worked in the past in the same context;
- provocative: involves taking risks on future endeavours;

- Collaborative: involves the whole organisation or a representative section.

Appreciative Inquiry is based on five principles (Cooperrider, Whitney, Stavros, & Stavros, 2008; Whitney & Trosten-Bloom, 2010):

a. the constructionist principle requires the managers to build relationships and “unleash the potential and imagination of individuals and groups to construct the future” and through social knowledge influence the organisational destiny (Cooperrider *et al.,* 2008)
b. the positive principle, where effective organisational change is achieved through positive focus
c. the simultaneity principle where enquiry and change happen simultaneously
d. the poetic principle encourages understanding human organisations and regarded as an “open book”, where there is sharing of past, present and future positive stories
e. the anticipatory principle, where positive images of the future influence the actions chosen.

Appreciative Inquiry has four distinct phases, referred to as the 4-D cycle, which formed the structure for this study (Cooperrider *et al.,* 1987). The 4-D cycle is Discovery, Dream, Design, and Destiny (Whitney & Cooperrider, 2011). The 4-D cycle begins with the definition of an affirmative topic that is of strategic importance to the organisation to be studied (Cooperrider & Whitney, 2001; Whitney & Trosten-Bloom, 2010). The topic, according to Whitney & Trosten-Bloom, (2010), may be an aspect of the organisation’s positive core that has the potential of expanding the organisation’s success if improved on or could be a host of problems that, if stated in the affirmative and studied, would improve organisational performance (Whitney & Trosten-Bloom, 2010).

3.3.3.1 Discovery phase

The discovery phase is a stage in which participants share their values, practices, peak experiences and what works best in their organisation to implore discussions on future possibilities (Cooperrider *et al.,* 1987; Cooperrider *et al.,* 2008). It aims at illuminating the factors that contribute to the 'best' in situations (Ludema, Cooperrider, & Barrett, 2006). It also provides an avenue into the discourse on the dynamics that contribute to failure through "naming the elephants", that is, talking about things that no one wants to talk about (Hammond, 2013). Participants in this phase of the study shared what works best in the maternity unit and other maternity best experiences and what does not work.

3.3.2.2 Dream

The dream phase is described as a practical and generative process in which participants share their vision and aspirations (Cooperrider *et al.,* 2008; Cooperrider & Whitney, 1999; Whitney & Trosten-Bloom, 2010). Participants think and create "great" possibilities for their organisation (Cooperrider *et al.,* 1987). The dream phase amplifies the positive core, challenges the status quo and works on the "blue sky" (Cram, 2010). Participants during the dream phase envisioned more valuable and vital futures, better bottom-line results, and contributions to a better world (Whitney & Trosten-Bloom, 2010).

3.3.3.3 Design

The design phase involves discussion of possibilities and finding a common ground (Ludema *et al.,* 2006) moving from a vision to a more specific plan (Cooperrider & Whitney, 1999). During the design phase, participants incorporated phase one and two data in the design of the model. Participants identified the different elements in systems, processes, leadership, policies and relationships that need to be included in the model (Cooperrider *et al.,* 2008).

3.3.3.4 Destiny

The destiny phase involves identifying means of achieving aspirations (Cram, 2010) and nourishing the intended future (Cooperrider *et al.,* 2008; Cooperrider & Whitney, 1999). Participants worked together in the development of action plans for implementation of the model and developed a timeline of activities, communication strategies, and a list of measures to monitor the impact of the implementation of the model. Shendell-Falik, Feinson, & Mohr, (2007) and Cooperrider *et al.,* (2008), during the destiny phase, organised projects and prioritised initiatives to move their vision into daily practice, discuss future projects, staff allocations, and the potential impact of project implementation.

Figure 3.1 outlines the 4-D steps of Appreciative Inquiry used in the study and Figure 3.2 illustrates the application to the study.

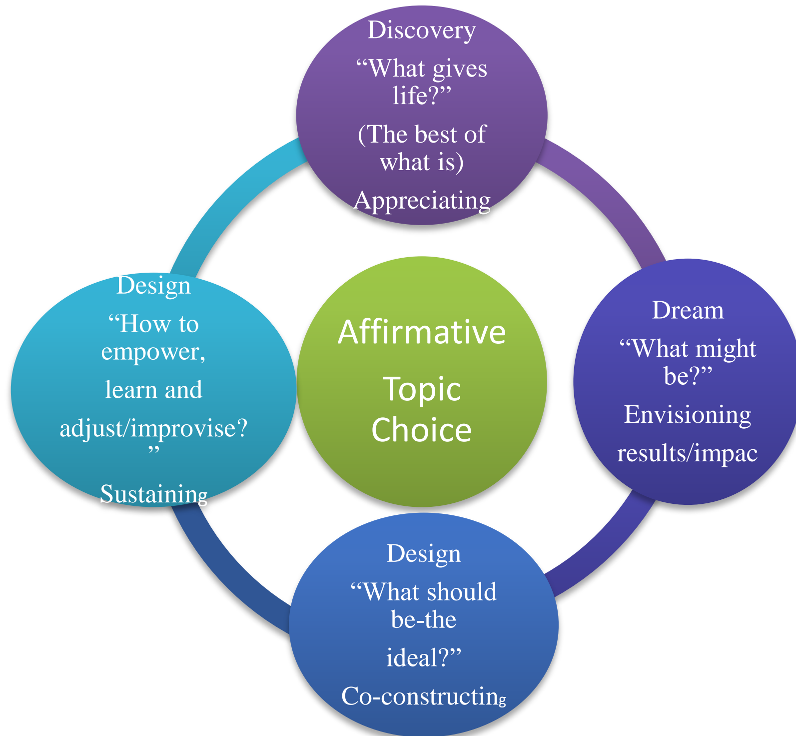

Figure 3.1: The 4-D Circular Model of Appreciative Inquiry (Cooperider et. al., 2008 p 5)

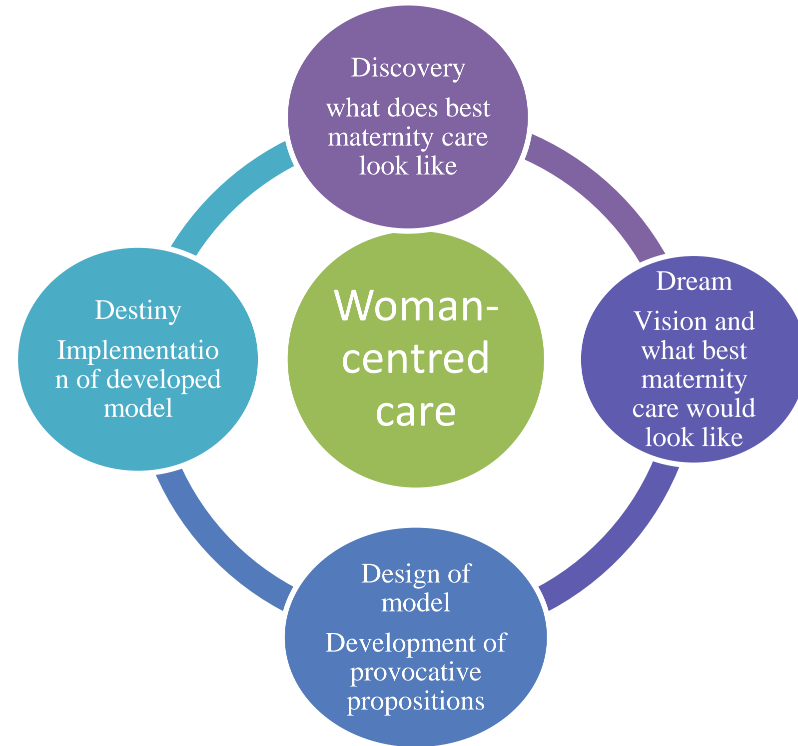

Figure 3.2: The 4-D Circular Model of Appreciative Inquiry as Applied to the Study

3.3.4 Human Scale Development Framework

The Max-Neef Model of Human Scale Development ascribes the best development for improvement in people's quality of life (Max-Neef, Elizalde, Hopenhayn, & Sears, 1989). Max-Neef describes the Human Scale Development framework as "focused and based on the satisfaction of fundamental human needs, on the generation of growing levels of self-reliance, and on the construction of organic articulations of people with nature and technology, global processes with local activity, of the personal with the social, of planning with autonomy, and of civil society with the state" (Max-Neef *et al.,* 1989). Smith & Max-Neef, (2011) proposes the use of the framework to identify political, economic, social and cultural factors in an organisation to satisfy fundamental human needs. The framework grew from the crisis in Latin America in the 1970s that converged from a multitude of social, economic, cultural and political crises (Max-Neef *et al.,* 1989).

The Human Scale Development framework classifies fundamental human needs into two: axiological (those things that we value) and existential needs (concerned with the meaning and purpose that interactions have for a person) (Max-Neef *et al.,* 1989) (Appendix II) . There are nine axiological needs: subsistence, protection, affection, understanding, participation, idleness, creation, identity and freedom; and four existential needs: being, having, doing and interacting, demonstrated in Figure 3.3. The theory proposes the engagement of communities in the process of change and is based on the following assumptions:

- "Fundamental human needs are finite, few and classifiable, and are the same in all cultures and in all historical periods" (Max-Neef *et al.,* 1989) (p. 20). In other words, needs do not change but the way or the means by which needs are satisfied do.

- "Simultaneities, complementarities and trade-offs are characteristic of the process of needs satisfaction" (Max-Neef *et al.,* 1989), p. 49).
- People make two main errors while creating a future: errors of perception and errors of action (Max-Neef *et al.,* 1989). Errors of perception arise when a crisis is linked to external factors and passing historical circumstances (Max-Neef, 2007).
- Satisfaction of fundamental human needs can be achieved through five satisfiers that influence consumption and wellbeing (synergic satisfiers, singular satisfiers, inhibiting satisfiers, pseudo-satisfiers, and violators or destroyers). The satisfiers are further divided into endogenous and exogenous satisfiers (Guillen-Royo, 2010; Max-Neef, 2007).
- People satisfy their needs in three ways: 1. *Eigenwelt* (needs satisfied by self), 2, *Mitwelt* (within a social group) and 3 *Unwelt* (within the environment). Improved quality of life is achieved when fundamental human needs are satisfied.

Bina & Vaz, (2011) recognise that the Human Scale Development framework makes explicit each employee's creativity when they initiate changes and take up responsibilities. In applying the framework to pregnancy and childbirth, when women seek services during this period, they are in search of ways of satisfying some of their fundamental human needs. Any fundamental human need that is not adequately satisfied leads to human poverty, which generates pathologies (Cruz, Stahel, & Max-Neef, 2009). The Max-Neef participatory approach was used in this study to engage women, midwives and health service managers in their interaction to understand how their needs are satisfied, what contributes to the needs not being satisfied and what could be done during the encounter for the needs to be satisfied with

interaction of both objective and subjective elements to enhance quality of life (Costanza *et al.,* 2007).

MAX-NEEF'S FUNDAMENTAL HUMAN NEEDS	
Subsistence	Health, food, clothing, shelter, water, warmth
Protection	Attack, infection, exploitation
Affection	Warmth, intimacy, respect
Understanding	Educated, aware, need to be understood
Participation	Involvement in deciding, planning, implementing, learning
Idleness	Relaxed state of mind and spirit that allows for reflection
Creation	Expression of creativity within us
Identity	Clear sense of self and belonging
Freedom	Freedom to choose the kind of care needed

Figure 3.3: Diagram of Max-Neef Human Scale Development Model (M Max-Neef, 1987)

3.3.5 Synchronising Appreciative Inquiry and the Human Scale Development Framework

The Appreciative Inquiry approach and the Human Scale Development framework were blended during data collection. The two provided a systematic approach and a structured way of engaging participants to develop a model. The concurrent data collection and analysis in the different phases of the study espoused the different aspects considered important and were thus included in the development of the model.

Appreciative Inquiry facilitated intellectual foci to the positive traits and subjective experiences of people rather than giving pathological attention to correcting the worst things that occur and propelled participants to carry out their plans (Froman, 2010). The Human Scale Development

framework guided the identification of the needs and ways of meeting the needs, consequently, contributing to the development of the model (Max-Neef, 1991a).

3.4 Study participants

Women, midwives, and health service managers were deemed sufficiently knowledgeable and with diverse characteristics and roles in maternity care to form the main participants in this study (Makhoul, Nakkash, Harpham, & Qutteina, 2013). Redshaw, (2008) and Devane *et al.,* (2007) propose the inclusion of different groups during evaluation and development of programmes in a maternity setting. The wide participation and multi-data sources created an avenue to build consensus and a common understanding among the different groups of participants as the study evolved (Makhoul *et al.,* 2013). This provided a positive affirmation for some participants and additional insight for others (O'Keefe & Head, 2011). The study did not include specialist doctors such as obstetricians and paediatricians, as there were no specialists at the facility nor any medical doctor attached to the maternity unit at the time of the study. The only doctors who participated in the study are the three who held administrative roles.

3.4.1 Sampling

The study used purposive sampling in the selection of participants to achieve wide participation and maximum sample variation, as is expected of an Appreciative Inquiry process (Whitney & Trosten-Bloom, 2010). The method provided for the inclusion of participants with information on key research areas and diversity (Ritchie, Lewis, Nicholls, & Ormston, 2013). Inclusion for all participants included informed consent for participation and excluded were any person who did not consent.

3.4.1.1 Women

This group comprised women seeking maternity services at the facility. The services included antenatal care, labour and birth, postnatal care, and immunisation of the babies or family planning services. The population of childbearing age in the catchment area is 20 309. Purposive sampling was used with the aim of achieving representativeness (Teddlie & Yu, 2007). The inclusion criteria for the women included the following:

- Seeking maternity care at the facility
- Having received maternity care at least one other time at the facility
- consenting.

The exclusion criteria for women focused on the following:

- Women in the active phase of labour
- Sick pregnant women not able to respond
- Not consenting.

3.4.1.2 Midwives

All the midwives, totalling 32, working at the hospital constituted the study sample. They comprised midwives working in the antenatal clinic, labour and birth unit, the postnatal clinic, and immunisation and family planning unit. The inclusion criteria had the following requirements:

- Must be a registered nurse/midwife or midwife with a diploma as a minimum qualification
- Must be registered by the Nursing Council of Kenya to practice as a midwife or nurse/midwife

- Must have worked in a maternity section of the hospital for at least one year
- Consenting.

The exclusion criteria were:

- Midwifery lecturers supervising students
- Nurse/midwife students
- Not consenting.

3.4.1.3 Health Services Managers

The main inclusion criterion for health service managers was consenting to the study and the fact that they were directly or had previously held administrative positions responsible for decisions regarding maternity services at the facility and the county. The seven were: the medical superintendent, nursing/midwifery officer in charge, hospital administrator, a medical doctor, two county directors of health and one former reproductive health coordinator, a midwife. The county health service managers were selected as they were frequently consulted by the hospital management committee on management decisions.

3.4.2 Study sample

The sample size was defined by the dictates of the Appreciative Inquiry process, which encourages wide participation, ranging from 30 to 3000 participants (Ludema & BARRETT, 2009). Participants are engaged over an extended period with participation of all members of an organisation or a team of group members from an organisation going through the Appreciative Inquiry 4D (that is Discovery, Dream, Design and Destiny) process, over 10-12 two- to four-hour meetings. A total of one hundred and twenty four (124) participants comprising 32 midwives, 85 women and seven (7) health service managers participated in the study (Table 3.1

below). The response rate for midwife and health service managers was 100% as the Appreciative Inquiry framework provides for contact with participants multiple times. During phase one of the study, 58 respondents took part; 31 women, 20 midwives, and 7 health service managers. In phase two of the study, thirty two women participated; 20 midwives participated; of these, 12 had participated in phase one and the seven health service managers. In phase three of the study, 12 midwives participated, of whom 4 were new participants and 10 women participated in this phase of the study. Finally, the phase four sample included 14 midwives and 12 women. All the seven health service managers participated in all the phases of the study.

Table 3.1: Sample Size

Participants	Total number of participants
Midwives	32
Women	85
Health service managers	7
Total number of participants	**124**

Not all the 124 participants took part in the four phases of the study, as illustrated in Figure 3.3.

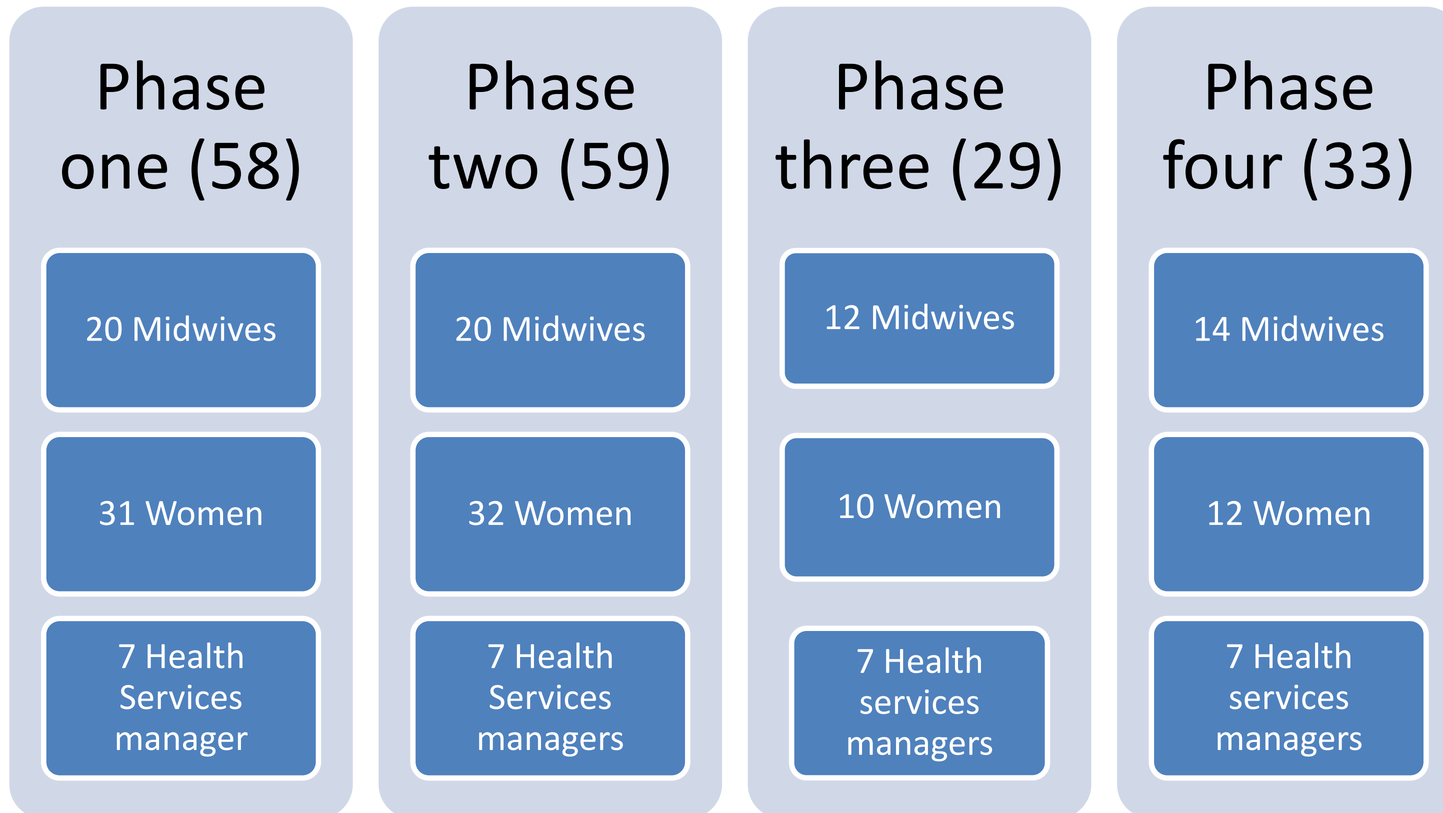

Figure 3.4: Total Number of Participants per Phase of Study

3.5 Procedure for recruitment of participants and ethical considerations

Recruitment of participants commenced after receiving ethics approval from the University of Cape Town's (UCT) Human Research Ethics Committee (HREC) and from the Moi University and Moi Teaching and Referral Hospital's Institutional Research and Ethics Committee (IREC) (Appendices III, IV & V). Permission to carry out the study was granted by the Uasin Gishu County Hospital medical superintendent. Details of the ethical considerations applicable to this study are described in Section 3.5.1 below and 3.5.2 describes the procedure for recruitment of participants.

3.5.1 Ethical considerations

The study complied with the ethical principles enshrined in the Declaration of Helsinki (2013). The declaration requires medical scientific research to conform to certain standards, including respect for human rights and accepted scientific principles. It also requires submission of a well-designed research protocol on the application of the ethical principles during the conduct of study to a research ethics committee. These principles include obtaining of informed consent, achieving autonomy, privacy and confidentiality, all of which were observed in this study.

Due to the participatory and the cyclical nature of the Appreciative Inquiry approach, ethical implications foreseen at the commencement of the study are discussed and, in addition, ethical issues that arose during the conduct of the study are discussed at the point at which they arose as is done in other participatory research like action research (Badger, 2000).

Autonomy/voluntary participation: Participation in the study was voluntary and participants had the right to withdraw from the study at any point in time without any penalty or other consequences. An invitation letter detailing the research was provided to participants (Appendix VII). Badger (2000), highlighting the challenges participants face in a participatory research process, observes that participants feel indebted to continue participating in the study once they have been enrolled. Participants were free to withdraw from the study at any point in in the course of the study; two participants in the first focus group discussion contributed halfway and could not continue to the end, due to other commitments they held. None of the participants expressed discomfort with any of the discussion questions.

Informed consent: Informed consent was signed after participants had received and showed that they had fully understood the information provided about the research at the beginning of focus group discussion or interviews. This information detailed the purpose of the research, criteria for participation, benefits and risks involved in participating in the study, maintenance of anonymity and confidentiality, management of data, and compensation for participation (Appendices VIII). Ongoing verbal consent was obtained from those who participated more than once as the study evolved (Orb, Eisenhauer, & Wynaden, 2001). One participant deferred the signing of the consent at the start of the focus group discussions and left without signing and the data from the participant was expunged from the transcript. Prior to starting the focus groups, all participants were informed that they could leave at any point during the discussion and did not have to participate if they did not wish to. Participants were also asked for permission to audio-tape the interview. All participants agreed.

Confidentiality and anonymity: Focus group discussions and interviews were held in a room free from noise. Prior to the start of the focus group discussions and interviews, demographic information was collected. Only the researcher kept the demographic data and assigned a number that linked to the demographic datasheet, to ensure confidentiality. The participants' names were not indicated in the research reports or transcripts; instead anonymity was assured by assigning each participant a number, as explained in Section 3.7.1.2. Findings have also been reported as group data. Khanlou & Peter, (2005) discuss the challenges to confidentiality experienced in participatory research, as participants get to know the contributions from each member. As such, the researcher, at the start of focus group discussions, informed participants of the importance of collective confidentiality.

Focus group discussion participants were asked not to use the names of colleagues or others during discussions and not to share any identifying information from the discussion sessions. However, there were occasions in which the examples shared were specific to an office, thus making it possible to identify the officeholder through their designated role, as was experienced by (Badger, 2000). During transcription, such data were excluded. All the research records were securely stored and transcribed, with the data password-protected and accessible only to the researcher and the supervisors.

Risks: The social risk was minimal. In the two mixed focus group discussions between women and midwives, information on whether they had interacted before was not taken and thus this was a limitation to the study. The midwives and health service managers knew each other. However, the Appreciative Inquiry approach focuses on the positives, and brings together internal and external stakeholders to discuss together issues affecting them (Whitney & Trosten-

Bloom, 2010; Trajkovski, Schmied, Vickers, & Jackson, 2013). The participants were provided with the contacts of the researcher, supervisors and secretaries to the research committees and urged to report any unethical issues they might have noticed at any stage during or after the study.

Benefits of the study: The discussion process provided the opportunity for reflection on self-awareness, insights, and perspectives on maternity care and on the interactions at the facility. Moreover, the generative process led to a realisation of positive change at the facility. A deeper understanding of the facility was evident since a change in the way of doing things and the outcomes of the process were evident from the discovery phase, as expected of an Appreciative Inquiry process (Khanlou & Peter, 2005). For example, following the study, midwives requested for the purchase of a Doppler machine and a television set that was placed in the labour and birth room for women's comfort. The participants were also able to define the staffing levels required and requested for more staff from the health service managers.

Compensation: There was no compensation for participating in the study. However, the researcher gave participants a standard amount of 500 Kenyan shillings (500) at the end of the meeting in lieu of refreshments that were to be provided during focus group discussions and interviews but could not be provided due to logistical challenges. Five hundred shillings in the setting can buy a bottle of water, tea, snack and pay for bus fare from and to the women's homes. This was not considered a form of coercion as the amount was not considered sufficient to influence the decision of participation in the study (Largent, Grady, Miller, & Wertheimer, 2012).

The midwives created time to participate in the study, despite their busy schedules. This meant that, for a midwife to participate, another midwife had to be present to handle the workload and provide care to women. Implicitly, this doubled the workload for the midwives. Meanwhile, some of them had to attend the focus group discussions during their off-days. Indeed, there were occasions in the study that focus group discussions could not be held and had to be postponed due to increased workload.

Most times, the women participants had to spend an extra one hour at the facility to take part in the study. The health services managers also had to spare time to participate in the study. On some occasions, their lunch hour was used up in focus group discussions. For their part, the health service managers also had to find extra time to attend to managerial issues after participating in the research.

Declaration of interest: The research was undertaken as a fulfilment of doctoral degree programme requirements. The study was partly funded by the National Council for Science and Technology in Kenya. I declare no other conflict of interest.

3.5.2 Identification and recruitment of participants

The researcher began the process of recruitment with orientation and familiarisation at the facility. Meetings were held with the hospital medical superintendent, the facility charge nurse and with midwives working in different areas in the maternity unit. The researcher provided a description of the participatory nature of the study and the importance of wide participation as well as the need for several contacts with participants in the different phases of the study. The hospital medical superintendent and the hospital charge nurse/midwife were eager to participate and provided full support for the research.

During the research period, the hospital charge nurse identified two midwives who acted as research point persons during data collection. Their main role was to assist the researcher in the recruitment of participants and identification of focus group discussion venues. One midwife was responsible for the coordination of the recruitment of midwife participants and the other coordinated the recruitment of women participants for focus group discussions. These recruitment meetings for the midwives and health service managers were held in the month of May 2015.

3.5.2.1 Recruitment of Women

The recruitment of women participants was done through the midwife point person on the morning of focus group discussions. The point midwife assembled a group of 10-14 women who happened to have diverse demographic characteristics and had received services at the facility. The recruitment of women participants was opportunistic Bryman, (2008), as finding women to enrol for the study well in advance was a challenge, as the women came from different locations and the probability of a chance of meeting them all together was minimal. Earlier enrolment of the women, as is required for focus group discussions, was not feasible as there is no register kept of women's contacts and appointment dates at the facility; so the only option was to enrol them on the day they sought services.

The researcher, using the information sheet (Appendix VII), explained to the women the purpose of the study and subsequently invited them to participate in the study. Those women who consented to participate in the study were given more details and written consent to sign. The consent form also required them to grant permission for audio-recording of the data collection sessions in the study (Appendix VIII).

3.5.2.2 Recruitment of Midwives

All thirty-two (32) midwives working at the hospital were invited to participate in the study and details of the study were provided to them (Appendix VII). The midwife research point person organised meetings between midwives and the researcher during unit handover meetings. As was the norm, the midwives had three unit handover meetings at the change of every shift. Consequently, I was able to meet midwives in four different handover meetings in which I requested them to participate in the study. I also informed other midwives who were not present during the meetings about the study during informal visits at the hospital.

During the meetings, participants were provided with information on the intention and purpose of the study, approaches that would be used in the study, and on eligibility criteria for participation, and they were also informed that participation would be on a voluntary basis. Participants were informed that data would be collected through focus group discussions with women, midwives and health service managers. A date was set during the last meeting for the first focus group discussion with the midwives. The midwives on duty and those who were willing to attend discussions on the set dates were invited to participate in the study.

3.5.2.3 Recruitment of Health Service Managers

For health service managers, the researcher enrolled them in the study purpose. A total of seven health service managers, constituting four hospital health service managers and three county health service managers, were approached and they all agreed to participate in the study. Written informed consent was sought from the health service managers at the beginning of first focus group discussion and at the beginning of interviews from county health service managers (Appendix VII).

3.6 Data collection

Data collection was carried out from May 2015 to April 2016.

3.6.1 Methods of data collection/techniques

Data were collected through demographic questionnaires, focus group discussions and interviews. The data collection methods were deemed appropriate for achieving breadth and coverage across the issues of interest, and the depth of coverage within each issue (Ritchie *et al.,* 2013). The feasibility of data collection methods was also considered. For example, it would have been challenging to interview a large group of women. Instead, focus group discussions were considered more appropriate for such a large group. A reflexive journal and field notes also complemented data collection. The flow of questions in the interviews and focus group discussions was guided by Appreciative Inquiry questions and participants' responses in each phase of the study. A discussion guide was used to collect data during FGDs. The discussion guide was developed from the questions in the Appreciative Inquiry process (Bushe, 2012; Cooperrider, Whitney, & Stavros, 2003; Whitney & Trosten-Bloom, 2010). In addition, participants contributed to the Human Scale Development matrix.

3.6.1.1 Demographic Questionnaire

A questionnaire was used to obtain demographic information from the participants. Demographic data were important mainly as they were used to confirm eligibility for the study and were used to compile the participants' profiles. The demographic questionnaire was a one-page document seeking information on items such as age, parity, qualifications and years of experience (Appendix IX and X). The questionnaire was self-administered, and the researcher was available to the participants for clarification.

3.6.1.2 Focus Group Discussions

Focus group discussions were used to collect data from the women, midwives and the hospital health service managers. This is because focus group discussions allow for a mix of participants, a larger group of participants to explore issues and contextual data (Green & Thorogood, 2004) through the naturalistic discussion of experiences (Tobin & Begley, 2004). Since sample size in qualitative research aims at achieving saturation, this may not be so in focus group discussions. Krueger & Casey, (2014) recommends the repetition of focus group discussions with at least three groups of participants, which was done in each phase of the study. Focus group discussions usually involve 6-12 participants discussing a certain topic, together with a moderator. There are challenges with smaller groups as few individuals may dominate and it may be difficult for a moderator to control a larger group. A total of 18 focus group discussions were done during the period, with participation ranging from 4 to 14 participants. The four were with the hospital health service managers. There were only two occasions in which the focus group discussion had more than the recommended 12 participants. Midwives and health service managers identified the venues for focus group discussions.

Stewart & Shamdasani, (2014) have found focus group discussions useful in exploratory research to provide background information on a particular topic of interest. Focus groups enable the obtaining of data from a larger group of people at one go and provides an opportunity for clarification follow up and probing, with different respondents building on other participants' points of agreeing, emphasising or giving a contradicting opinion. Focus group discussions provide an opportunity to obtain rich in-depth data using participants' own words. In addition, the researcher is able to observe participants' non-verbal responses, which provide supplementary information to support the data.

The researcher facilitated all the focus group discussions. At the beginning of focus group discussions with the midwives and women, the participants were paired up in line with what was done by (Carter & Little, 2007) and asked to respond to questions in the focus group discussion guide (Appendix XI). This pairing up was meant to help participants to assist one another in identifying and framing their ideas, values and concerns before presenting them to the larger group. Pairing was also used to create a sense of cooperation, inclusion, and being attended to, heard and respected. Pairing also provided participants the opportunity to learn the unique interests and differences of others (Ludema & Mohr, 2003). The participants then shared their responses to the group in turns until all paired responses were read out. The sharing of stories proved an effective strategy in gathering rich qualitative data. In addition, the round-robin technique was used during focus group discussions to encourage participation by all and to moderate the dominant and reticent personalities.

All group discussions were audio-recorded, except for one session in which participants agreed to record the proceedings on a flip chart. The focus group discussion processes were reviewed regularly. The sessions lasted between 38 minutes and two hours. Generally, focus group discussions with women were shorter than the ones with midwives and hospital health service managers. As indicated in the table below, 18 focus group sessions were conducted throughout the study.

Table 3.2: Details of Focus Group Discussions per Phase of Study

Phase of study	Number of focus group discussions	Specific focus groups
1	6	FGD 1 & 3: Midwives FGD 2 & 4: Women FGD 5: Mixed group of midwives and women FGD 6: Health Service Managers
2	6	FGD 7 & 9: Midwives FGD 8 & 10: Women FGD 11: Mixed group of midwives and women FGD 12: Health Service Managers
3	3	FGD 13 & 15: midwives FGD 14: Women
4	3	FGD 16: Midwives FGD 17: Women FGD 18: Health service managers
Total	**18**	

Six focus group discussions were held in phase one. These comprised Group one (FGD 1), two (FGD 2), three (FGD 3), four (FGD4), five (FGD 5) and six (FGD 6). FGDs one and three were discussions with midwives; FGDs two and four were discussions with women; FGD five was a discussion with both women and midwives; and FGD six was a discussion with hospital health service managers. Six focus group discussions were conducted in phase two. These were composed of group seven (FGD 7), eight (FGD 8), nine (FGD 9), ten (FGD 10), 11 (FGD 11), 12 (FGD 12). FGDs seven and nine were discussions with midwives while FGDs eight and ten were discussions with women. FGD 11 was a discussion with both women and midwives and FGD 12, a discussion with hospital health service managers. In phase three of the study, three focus group discussions were held: two with midwives and one with women. In this phase, focus groups 13 (FGD 13) and 15 (FGD 15) were with midwives and 14 (FGD 14) with women. Data from the health service manages are also included. Finally, in Phase four of the study, three focus

group discussions were held. Focus groups 16 (FGD 16), 17 (FGD 17) and 18 (FGD 18) were with midwives, women and hospital health service managers, respectively.

Table 3.3: Participants per focus group

Focus Group	Women	Midwives	Health service managers
FGD 1	0	12	0
FGD 2	12		0
FGD 3		11 (5 new)	0
FGD 4	12	0	0
FGD 5	7	5 (3 new)	0
FGD 6	0	0	7 (3 interviews)
FGD 7	0	12 (4 new)	0
FGD 8	12	0	0
FGD 9	0	12 (3 new)	0
FGD 10	12	0	0
FGD 11	8	6 (3 new)	0
FGD 12	0	0	7 (3 interviews)
FGD 13	0	12 (All returning)	0
FGD 14	10	0	0
FGD 15	0	0	7 (3 interviews)
FGD 16	0	14 (All returning)	0
FGD 17	12	0	0
FGD 18	0	0	7 (3 interviews)
Total	85	32	7

3.6.1.3 Interviews

Interviews were held with county health service managers who were closely involved at the facility and understood management processes. Interviews with managers were considered necessary to be able to obtain their input and have quality participation, as they could not be easily available for focus group discussions due to their responsibilities. Interviews were conducted at a location of their choice. Two interviews were conducted in the health service managers' offices and one was conducted in a quiet corner of a suitable restaurant. Appreciative Inquiry questions that were used in the different focus group discussions in the different phases of the study were used to collect data during the interviews. All interviews were audio-recorded with the informants' permission.

Interviews provided rich descriptions of best practices in midwifery care. They provided an avenue to uncover and generate new knowledge and multiple perspectives from those who did not participate in the focus group discussions (Legard, Keegan, & Ward, 2003). The one-to-one interaction with participants promoted an undiluted focus on the informants and provided an opportunity for greater understanding of issues through asking questions and seeking clarification.

The interview sessions lasted between 45 and 102 minutes. The trustworthiness of data was enhanced by scheduling a meeting on a day of the participant's preference.

3.6.1.4 Field Notes

The researcher documented in field notes the research process and decisions made during the research immediately after the sessions or within 48 hours of the sessions. A description of the interview environment, participants' behaviour, and occurrences such as spontaneous

interactions between participants, personal accounts of events, discussions and personal feelings were recorded in the field notes (Roper & Shapira, 2000). Field notes helped the researcher to access short-term memory, make reflections and record clarification in the participants' stories, in line with the views of (Cooperrider *et al.,* 2003).

The descriptions made on social interactions and the context of discussions on field notes complemented the interviews and focus group discussions. Field notes also provided insights during the analysis and interpretation of data (Charmaz, 2006) and further descriptive elaboration of the participants' responses (Hammersley & Atkinson, 2007; Montgomery & Bailey, 2007).

3.6.1.5 Reflexive Journal

The researcher used a reflexive journal to record the study logistics and reflections on her own values and interests in the course of the research. The journal also helped the researcher to gain a deeper understanding of issues and the respondents, as well as acting as a platform for constructing meaning (Blustein, Gill, Kenna, & Murphy, 2005). The researcher used a reflexive journal to assess the reasoning and logic that entered into every aspect of the investigation, researcher's own feelings, emotions, thoughts, perceptions, anticipated occurrences and reactions during the research process (Boud, 2001). Reflexion allowed the researcher to remain open to participants' issues of concern, even if the issues deviated from the focus of the study (Pillow, 2003). The reflexive journal provided more insight during data analysis and report writing. A detailed reflexive account has been provided in Section 3.10.3.2 of this chapter.

3.6.2 Methods and procedures for phases One to Four

The study was conducted as per the 4-D Appreciate Enquiry cycle Figure 3.4 that follows.

3.6.2.1 Phase One: Discovery

Participants during the discovery phase were asked to describe the high points or peak experiences (Richer *et al.,* 2010) and explain what contributed to these high points "best of what is and has been" in the institution through the use of affirmative conversations (Whitney & Trosten-Bloom, 2010). In line with AI principles, the researcher used the Appreciative questions in each phase of the study, Appendix XI (Carter, 2006). At the initial stages of the discovery phase, the participants shared what did not work at the facility. They seemed unable at first to describe what worked well and their experiences of what worked well in other similar institutions, as experienced by (Lavender & Chapple, 2004) in their study.

Nonetheless, participants eventually shared the high points and their positive experiences after repeated clarification of the aims of the study and over time through the multiple contacts with the participants. Participants expressed appreciation and value to what brought life to the system and what made the system work. As the study progressed, there was evidence of positive ongoing changes initiated and implemented by participants (Whitney & Trosten-Bloom, 2010).

3.6.2.2: Phase Two: Dream

At the beginning of phase two of the study, the researcher shared a summary of phase one findings with participants. Focus group discussions and interviews were conducted and the researcher recorded field notes and kept a reflexive journal. Participants were asked to imagine a time in the future when people look at the hospital as an exceptional example of a thriving, attractive hospital where healthcare workers and women engage in the hospital's future.

In this exciting future:

1. What will be most significant?
2. What will be true of the maternity services?
3. What would be sustaining the exceptional services?
4. What kinds of systems and structures would be in place?
5. What would you be proud of in this future?
6. What part would you play in this future?

Participants were then encouraged to share their dreams of the organisation. Participants collectively explored hopes and dreams for the kind of midwifery care and maternity services they desired. They boldly expressed big dreams beyond the boundaries of past and present conditions. They shared dreams for alignment around creative images of the organisation's most positive potential and strategic opportunities, innovative strategic visions, and an elevated sense of purpose.

3.6.2.3 Phase Three: Design

Phase three began by sharing the research findings from phases one and two with participants. Building on the discovery and dream phases, the participants identified high impact aspects that were included during the design of the model (Bushe, 2007). The participants' input to the existential and axiological categories of the Human Scale Development framework was also included during the design of the UPENDO-S model.

3.6.2.4 Phase Four: Destiny

The destiny phase started with the sharing of the research findings from phase three, mainly the UPENDO-S model. Participants then developed an implementation plan for the new model.

Carter & Little, (2007), during the destiny phase, also held meetings with participants to monitor the progress of the implementation action plans, during which participants reported on their accomplishments and reflections of what they had learned throughout the Appreciative Inquiry process. Table 3.4 below provides a summary of the study objectives, key activities, study participants and outcomes.

Table 3.4: Activities for Each Phase of Study, Sample, Data Collection, Analysis and Outcomes

PHASE	Objective	Population/ sample	Data collection	Data analysis	Outcomes
Phase One **Discovery**	To describe the current practice in delivery of maternity care	Midwives Women Health service managers	Focus group discussions Completion of human scale development matrices Interviews Field notes Reflexivity	Theme identification and analysis Qualitative description	Themes on best midwifery experiences Positive clinical and maternity experiences
Phase Two **Dream**	To determine desired maternity care	Midwives Women Health service managers	Focus group discussions Interviews Field notes Reflexivity	Theme identification and analysis Qualitative description	Contextual information on expected midwifery care
Phase Three **Design**	To apply data collected to design a model of care	Midwives Women Health service managers	Focus group discussions Create solutions through redesigning innovations and actions	Theme identification and analysis Qualitative description	Design of UPENDO-S Model Provocative propositions
Phase four **Destiny**	To develop actions for implementation of the model	Midwives Women Health service managers	Field notes Focus group discussion Interviews Field notes Reflexivity	Theme identification and analysis Qualitative description	Implementation activities • strategies for implementation of the model

3.7 Data management and analysis

Section 3.7 discusses management of raw data and data analysis.

3.7.1 Management of raw data

This section describes the storage and transcription of data.

3.7.1.1 Storage of Data

All the audio-recorded data were downloaded and stored in a password-protected computer. The recorded focus group discussions and interviews were then transcribed verbatim and typed into MS Word and also stored in the password-protected computer. In addition, the audio-records and transcripts of the focus group discussions and interviews were backed up in a password-protected and encrypted universal serial bus (USB) drive for back-up in case of loss or accidental deletion of data files. Field notes, the reflexive journal, voice recorders, all the paper copies made from the transcripts, other research materials and the USB drive were always stored under lock and the key, only accessible to the researcher, to ensure participants' confidentiality. Only the researcher and the research supervisors had access to the raw data.

3.7.1.2 Transcription of Data

Transcription of data was done within 72 hours after audio-recording by the researcher. The original language of the interview was English with some instances a mixture of English and Swahili. These languages were maintained during the transcription. During transcription, verbal and non-verbal components of the interviews, such as prolonged pauses, silences and hesitation, were captured. The researcher then reviewed the transcripts against original audio records to ensure that all the data were captured and transcribed verbatim. The researcher also reviewed the

transcribed interviews against the audio records and incorporated observations made during the interviews to the verbatim transcripts (for example, a participant was tense or when there was an agreement in unison).

The audio recordings of the focus groups were transcribed verbatim and coded. The methodological theory used to underpin the analysis was not selected a priori, as (Avis, 2003) argues that critical reflection can be hindered. The transcripts were coded and analysed for emerging themes by the researcher individually as illustrated in the sample transcript (APPENDIX XII). All coding and thematic analysis were then shared with the research supervisors to enhance the validity and rigour of the analysis.

The sections of the transcripts that were in Swahili were translated into English prior to analysis. The researcher conducted all the translations, to make the most of the subject matter and linguistic accuracy of the transcripts (Karwalajtys *et al.,* 2010), to take note on illustrations that participants used such as clichés, and expressions containing jargon or slang, to preserve the meaning of terminologies across the transcripts (Lopez, Figueroa, Connor, & Maliski, 2008) and to optimise the reliability of the data (Twinn, 1997).

The researcher conducted a forward-backward translation process (Al-Amer, Ramjan, Glew, Darwish, & Salamonson, 2016). Translation was aimed at preserving the meaning from original data and the participants used English language most of the times in presentation of medical terminologies. Sentences and phrases in Swahili were translated into English and back to Swahili to ensure semantic and content congruence to have translated text as similar as possible to the original transcripts (Elderkin-Thompson, Cohen Silver, & Waitzkin, 2001; Irvine, Roberts, & Bradbury-Jones, 2008; Karwalajtys *et al.,* 2010; Kwok, White, & Roydhouse, 2011; Lopez

Figueroa, Connor, & Maliski, 2008; Temple, 2006). The retranslated Swahili versions of the transcripts were compared with the original ones for accuracy of terminology and phrases. Any corrections made on the retranslated transcripts were also captured in the final English version that was used for analysis.

During the transcription of data, the participants' identities were protected to ensure confidentiality and guarantee their anonymity (Cooperrider *et al.,* 2003). This was done by coding through assigning letters and a number to each participant according to the focus group number and the number of participants in the group. The coding was done in three sequences starting with either an "M" for midwife, "W" for women and "A" for health service managers, followed by a number depending on the number of participants listed as 1, 2 … 11, 12 … and finally FGD 1, 2…, depending on the number of the focus group discussions. An example of coding is M1, FGD 1, denoting a midwife participant and voice 1 in focus group discussion 1. Protection of identity for the three managers followed a similar order: I1, I2, I3 representing the three interview participants. These were used in the reporting of findings in Chapter 4 and in the discussion in Chapter 5. The same will also be used in future for publication or presentations.

During transcription, the researcher took notes of the first impressions of any relevant themes and concepts in summary sheets. These records formed the preliminary themes which were shared with the participants in the next focus group discussion for checking and verification. The summary described the sequence, details, variations and relationships of events in all the transcripts (Camic, Rhodes, & Yardley, 2003).

3.7.2 Data Analysis

The data analysed in this study came from the demographic questionnaires and focus group discussions and interview transcripts. Demographic questionnaires were analysed using simple descriptive statistics to profile participants. Focus group discussions and interview transcripts were analysed using thematic analysis. Field notes provided meaning and understanding during analysis. The reflexive journal guided the researcher to attend systematically to knowledge construction and to expose and validate the research practices and representation (Pillow, 2003).

3.7.2.1 Thematic Analysis

Thematic analysis is a qualitative analysis method commonly used to identify report and analyse data for the meaning produced in and by people, situations and events (Braun & Clarke, 2006; Riessman, 2008). The codes and themes are derived from the content of the data. It involves a search for themes, organising and offering insight into meaning that describes the phenomenon under study (Braun, Clarke, Hayfield, & Terry, 2019). There are six stages in a thematic analysis that fit into the three broad stages of qualitative analysis. These are the reduction or breakdown of the text, the exploration of the text and the integration of the exploration (Vaismoradi, Jones, Turunen, & Snelgrove, 2016):

1. Stage 1: Developing the code manual
2. Stage 2: Testing the reliability of codes
3. Stage 3: Summarising data and identifying initial themes
4. Stage 4: Applying templates of codes and additional coding
5. Stage 5: Connecting the codes and identifying the themes
6. Stage 6: Corroborating and legitimating coded themes

3.7.2.2 Thematic Network Analysis

Thematic analysis was augmented by thematic networks which are described as web-like illustrations that summarise the main themes constituting a piece of text (Attride-Stirling, 2001). The conceptual foundation for thematic networks, guiding principles, structures and specific steps can be traced to other analytic techniques, such as grounded theory (Corbin & Strauss, 1990). Its core structure has significant parallels with the three basic elements of grounded theory, namely, concepts, categories and propositions (Corbin & Strauss, 1990). Concept maps were used to provide a visual representation to enhance the formulation of themes and a better understanding of relationships among the different themes through sorting and organising of different codes into themes (Cruzes & Dyba, 2011).

Thematic network analysis enabled breaking up text, and the unearthing of the themes salient in the text at different levels, starting from the lowest-order premises evident in the text (basic themes), categories of basic themes grouped together to summarise more abstract principles (organising themes), and super-ordinate themes encapsulating the principal metaphors in the text as a whole (global themes) (Attride-Stirling, 2001), p .388). The six steps thematic network analyses are illustrated in Figure 3.5.

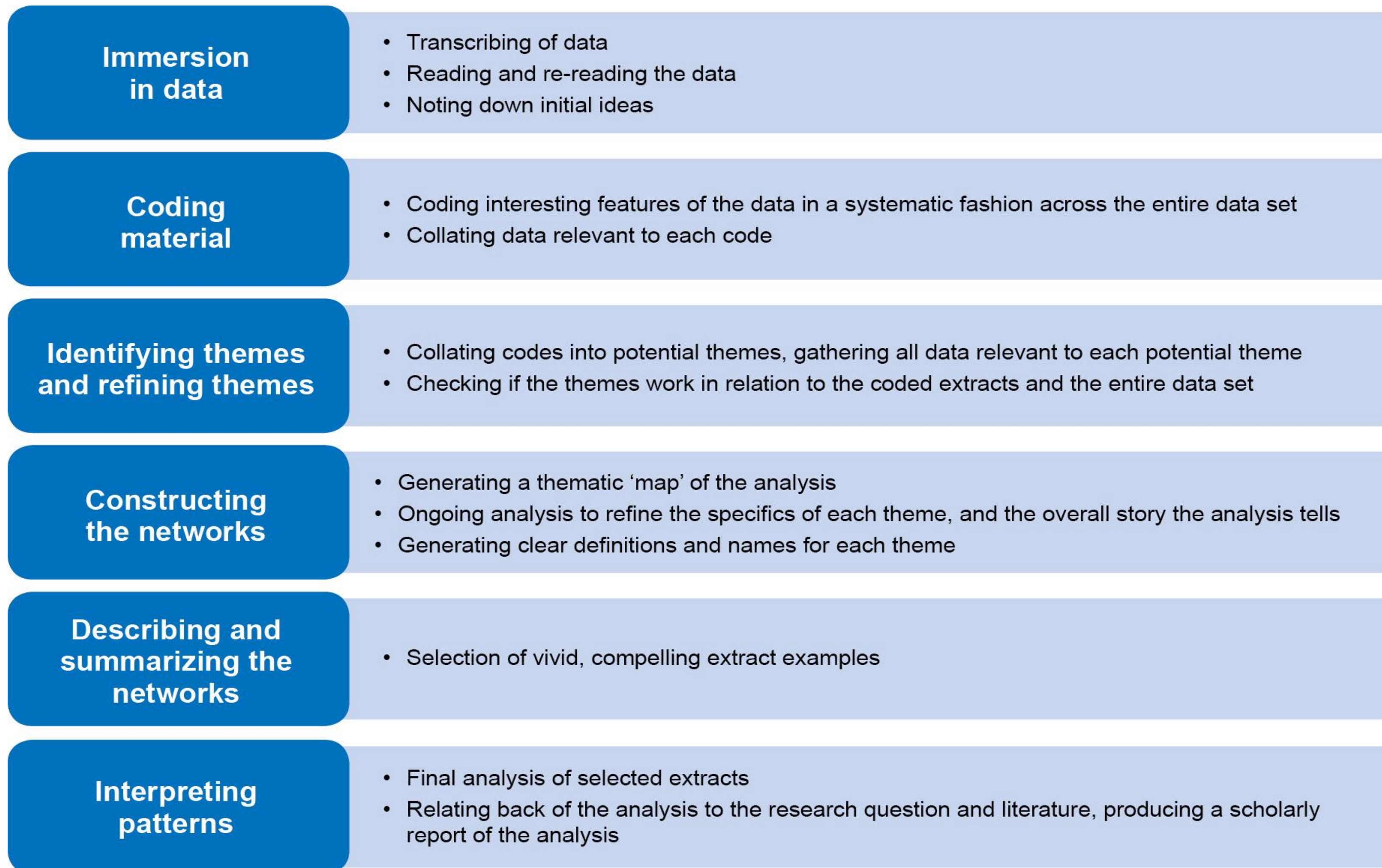

Figure 3.5: Steps in Thematic Network Analysis

3.7.2.3 Immersion in Data

Immersion in the data involved reading through each research transcript several times (Pope, Graham, & Patel, 2001; Rigano & Ritchie, 2003) which enabled the researcher to apprehend essential features, without feeling pressured to move forward analytically (Sandelowski, 1995). Immersion in data was made easy as the researcher collected all the data and did the transcription and, with prior interaction with data, the researcher came in with some initial analytic interests and thoughts. Transcripts were re-read for further familiarity with the depth and breadth of the content, in search for meaning and patterns inherent in the data (Bradley, Curry, & Devers, 2007). Immersion in data also enabled the researcher to gain more insights, make sense of data and learn 'what is going on' (Polit & Beck, 2004; Tesch, Thorsson, & Colliander, 1990). It also enabled the researcher to get the overall impression, and identify emergent ideas from participants based on particular words, phrases or sentences (Bradley, Curry, & Devers, 2007; Polit & Beck, 2004; Tesch *et al.,* 1990).

3.7.2.4 Coding the Material

Interview transcripts were saved in multiple folders in a computer before initiation of coding. The researcher then used one of the saved folders for analysis and retained an original folder. Coding was done both using the NVIVO programme and manually. NVIVO facilitated coding, constant comparison and theory generation. The programme gave the researcher ready access to coded text quotations as it made storage and retrieval of information easy (Weitzman & Miles, 1995).

The researcher engaged in manual coding guided by Appreciative Inquiry questions per phase of the study and the salient features that arose from the text (Attride-Stirling, 2001). Every effort

was made to ensure that the codes had explicit boundaries (definitions), so that they were not interchangeable or redundant. Starting with one transcript per phase of the study, the transcripts were reviewed line by line, paragraph by paragraph and as a whole document to identify emerging ideas until all the transcripts were coded (Bradley, Curry, & Devers, 2007; Thorne, 2000). The researcher then created a table with three columns and inserted the transcribed data. The first column contained the transcript, another column was the codes identified from textual data and the last column was text such as passages, quotations, and issues surrounding the data to minimise loss of context (Alan Bryman, 2016). An example of coding of data is presented in Table 3.5.

Table 3.5: Sample Excerpt of Transcript and Coding

Data extract	Coded for
… a precious baby was delivered alive from a mother a para 6+1with one living child. An asphyxiated baby was extracted via C/S, resuscitation was done, admitted in NBU and discharged home alive and well three days later. So the most exciting thing done was having a Live mother and ba**by go home (M1, FGD 1)**	Precious baby live birth Asphyxiated baby Extracted via C/S Resuscitation Admitted in NBU Discharged home alive and well

3.7.2.5 Identifying Themes

The identification of themes was made through abstraction of themes from coded text segments. The researcher generated a table with different columns using the codes from transcripts per phase of the study with each column containing codes from one transcript. The researcher then highlighted all the codes in the data across the different transcripts from the same and within participant groups (i.e., women, midwives and health service managers). Codes presenting the

same idea and with a distinct meaning were highlighted in the same colour. The researcher then used a cut and paste of all the coded data with the same colour and collated them together to form categories (Appendix XIV). A cut-and-paste method was used to ensure that all coded data were captured and categorised and also to identify the data that did not fit in any category.

The researcher went through each code (or group of related codes) and extracted the salient, common or significant themes in the coded text segments which enabled the researcher to connect the codes and discover patterns and themes in the data (Crabtree & Miller, 1999). Each pile was labelled as initial categories (basic themes) using keywords or phrases from the texts. Basic themes were revised as the process continued. The researcher then went further to corroborate the themes developed (Crabtree & Miller, 1999), p. 170) and scrutinised the data to ensure that the clustered themes were representative of the initial data analysed and then assigned codes. The researcher then identified the similarities and differences between separate groups of emerging themes, indicating areas of consensus in response to the research questions and areas of potential conflict. The analysis focused on discursive themes common across the different participants and different focus group discussions and interviews. The themes that were more common were given precedence, since it made it possible to focus attention on the common, homogenous, popular themes, which was the specific interest of this study (Attride-Stirling, 2001).

The researcher constantly reviewed transcripts and read them together with field notes and compared the contents with the themes developed. The iterative comparative approach (Bradley, Curry, & Devers, 2007) enabled the researcher to arrive at overarching themes which were applied to the data and further refined as new themes emerged per phase of the study. The

interaction of text, codes, and themes in the study involved several iterations before the analysis proceeded to an interpretive phase. In addition, the various issues that were being handled were listed and the specific quotations contained in each theme and the themes that were emerging.

3.7.2.6 Refining Themes

The researcher reread through the original interview transcripts without looking at the codes and the themes and then went through the selected themes and refined them further. The researcher returned to the data and reconsidered all the codes and themes, looking at the relationships between them. Themes were carefully considered and the significance of each theme considered and redistributed as appropriate, considering whether the themes were too small or too large, specific enough to be discrete and broad enough to encapsulate a set of ideas contained in numerous text segments which summarised the text.

A lot of interpretative work occurred during refinement of themes, whereby themes had to be moulded and worked to accommodate new text segments, as well as old ones, with each theme having to be specific enough to pertain to one idea, but broad enough to find manifestations in various different text segments. In situations in which themes did not have enough data to support them, the researcher collapsed the themes into each other and, where they were too diverse, the themes were broken down into separate themes (Gale, Heath, Cameron, Rashid, & Redwood, 2013). Some of the themes were then re-labelled as appropriate. The themes were then looked over as a whole using (Michael Quinn Patton, 1990) dual criteria judging categories of internal homogeneity and external heterogeneity. The researcher ensured that the data within themes were coherent and meaningful and with clear and identifiable distinctions. In situations in which the theme did not fit, the researcher relooked at the codes and the data extracts and

reworked or created a new theme or fitted it to existing themes or discarded them from the analysis.

Detailed analysis of each individual theme was done to identify how it fitted into the broader overall 'story' and to identify what the story was telling about the data, in relation to the research questions and to ensure that there was not too much overlap between themes. The themes were considered in relation to themselves and in relation to the others. Some large and complex themes contained sub-themes which were used to demonstrate the hierarchy of meaning within the data (Braun & Wilkinson, 2003). In this study, in the theme of a dedicated workforce, an educated workforce was considered a subtheme. The researcher ensured that the scope and content of each theme could be described in a couple of sentences. If themes formed a coherent pattern, then further analysis was done from basic themes to organising themes then to global themes.

3.7.2.7 Constructing the Networks

The construction of networks began with the arrangement of themes into similar, coherent groupings. Themes were grouped on the basis of content by which basic themes were grouped together to form organising themes, which then formed global themes (Attride-Stirling, 2001). These different categories were then prepared and illustrated as non-hierarchical, web-like representations referred to as *thematic networks*. The researcher then went through the text segments to verify and refine the networks.

Thematic maps were developed once the researcher was satisfied that the themes adequately captured the contours of the coded data. Throughout this step of the analysis, questions of "what worked well, why, when, how, who and where were continually asked" (Cooperrider *et al.*,

1987). The answers to these questions helped the researcher to discover emerging patterns from the data. These questions provided the overall story of the different themes of the study and provided clarity in the thematic maps developed.

The same iterative process used during analysis was used once thematic maps were developed. The researcher considered the validity of individual themes in relation to the data set, and whether the thematic map 'accurately' reflected the meanings evident in the dataset as a whole in view of Appreciative Inquiry and thematic analysis. During this phase, the coding of additional data within themes that had been missed in earlier coding stages was done. The researcher evaluated whether the thematic map represented the data and in situations that it did not, the researcher went back to coding until satisfactory thematic maps were developed and checked to ensure that there were no more new codes or themes arising from the data. An example of a thematic network on meeting women's expectations is illustrated in Figure 3.6.

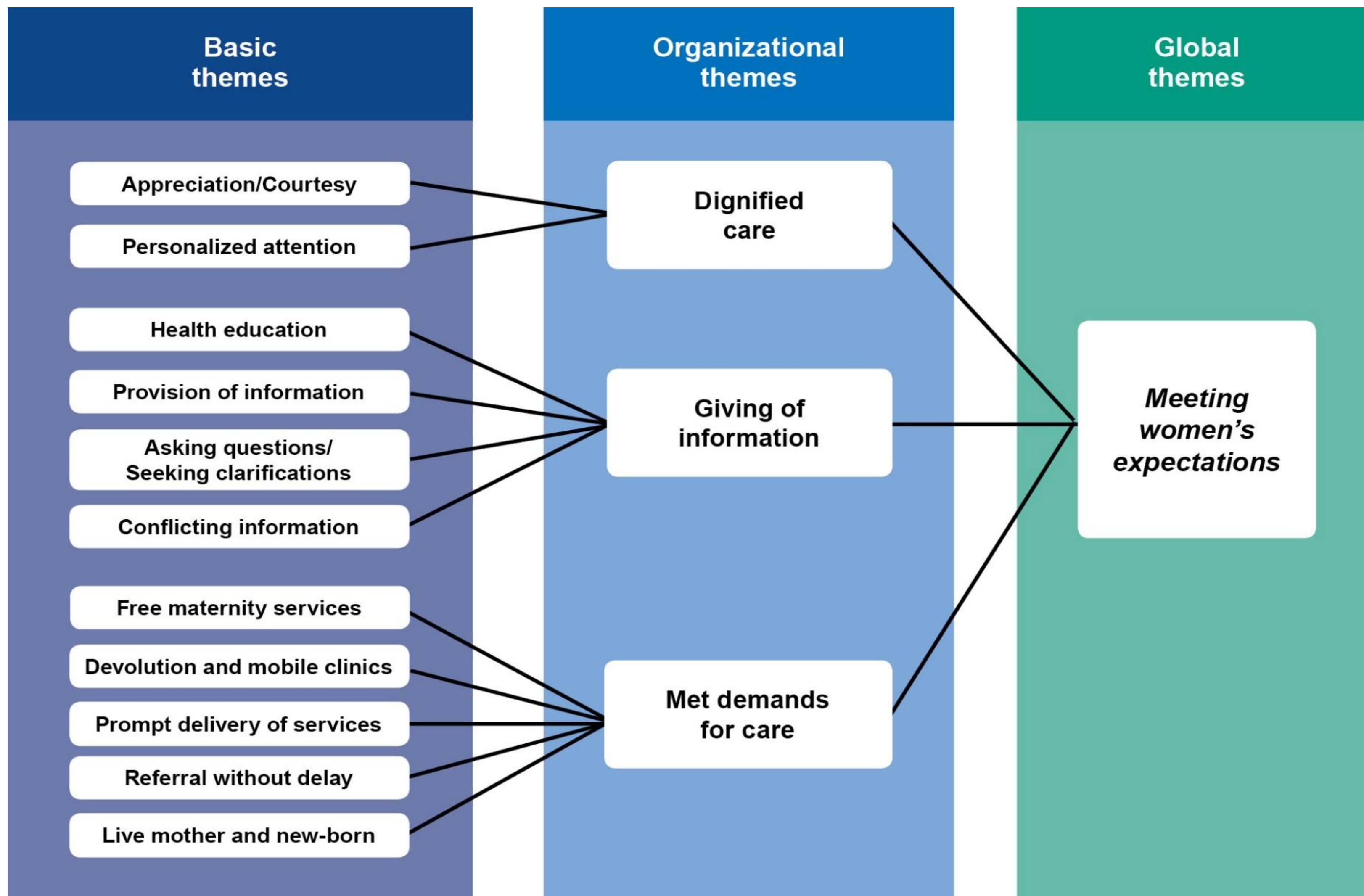

Figure 3.6: Example of Construction of Networks

3.7.2.8 Describing and Exploring the Thematic Networks

Once the networks were constructed, the researcher returned to the original text and interpreted it with the aid of the networks (Attride-Stirling, 2001). The researcher then described each network in turn, using its contents supporting the description with text segments and further exploring the networks and noting underlying patterns that began to appear (Attride-Stirling, 2001). The researcher read the text through the global themes, organising themes and basic themes.

3.7.2.9 Summarising the Thematic Network

The researcher then explored and described networks and the principal themes and summarised the networks to make explicit the patterns that emerged (Attride-Stirling, 2001).

3.7.2.10 Interpreting Patterns

The deductions in the summaries of all the networks were brought together to explore the significant themes, concepts, patterns and structures that arose in the text. An example is provided in Table 3.7.

Table 3.6: Sample Global, Organising and Basic Themes

Global Themes	Organising Themes	Basic Themes
Knowledgeable, skilled and updated midwives	Knowledgeable, skilled, updated midwives	Knowledgeable
		Skilled midwives
		Continuous professional development
	Presence and availability of midwives	Presence and availability
		Staffing at facility
		Staff turnover
Recognised, motivated midwives	Appreciation and recognition	Appreciation and recognition of midwives
		Midwives listened to and their recommendations respected
	High staff morale	Promotion of midwives
		supported midwives
		Well remunerated midwives
	Pleasant work environment	Good work environment

3.7.3 Critique of thematic analysis

The procedure of coding in thematic analysis has been challenged (Coffey, Beverley, & Paul, 1996). Others have criticised thematic analysis as lacking theoretical assumptions (Holloway & Todres, 2003). Thematic analysis is flexible and can be used to extract and interpret data consistent with the theoretical framework, even though it requires a researcher to be clear and explicit about what one is doing thus a major challenge during analysis (Reicher & Taylor, 2005), p. 549).

3.7.4 Ensuring reliability of coding

To ensure trustworthiness in qualitative analysis, verification of the process is achieved through the calculation of inter-coder reliability. In this study, inter-coder reliability was achieved through the involvement of an independent peer. Each audio-recorded interview was replayed and transcribed verbatim by the researcher and double-checked by an independent peer who had just completed his doctoral studies. The independent coder in this study was a university lecturer who had completed his doctoral studies using a mixed methods research approach. Independent coding was done to verify the consistency of data in the transcripts to enhance trustworthiness (Curry, Nembhard, & Bradley, 2009).

In this study, the inter-coder independently coded seven out of 21 transcripts, which represented 30% (two from each category of participants, that is, midwives, women and health service managers and one interview transcript). Miles, (1994) and Lombard, Snyder-Duch, & Bracken, (2002) recommend the use of 10% of the sample of transcripts for testing inter-coder reliability. Codes for each transcript were compared and discrepancies between coders were addressed through discussion and consensus. Overall, the codes were similar except for minor

inconsistencies in labelling and organisation of the codes and sub-codes that were addressed through consensus to arrive at a final coding structure. The percentage of all segments of transcripts coded into the same codes was computed, with a more than 95% coding agreement. With inter-coder reliability established (Burla *et al.,* 2008), the researcher independently coded the remaining transcripts.

Reliability was calculated, as proposed by Miles (1994):

$$\text{Reliability} = \frac{\text{Number of agreements X 100}}{\text{Number of agreements + disagreements}}$$

Consistency and good inter-coder agreement are achieved with an inter-coder reliability score of >70%. An acceptable inter-coder reliability score of 95% was achieved using (Miles, 1994) formula. To demonstrate inter-coder reliability, the calculation for phase one codes was as illustrated below.

$$\text{Reliability} = \frac{\text{82 agreed upon codes X 100}}{\text{82 total number of agreed upon codes + 4 disagreement}}$$

$$= \frac{82 \text{ X } 100}{86}$$

$$= 95.35 = 95$$

3.8 Data presentation

Descriptive statistics were computed to describe the demographic characteristics of participants. The findings of this process were presented as a conceptual model of care developed from the thematic analysis of themes supported by direct quotes. Due to the participatory nature of the study, ongoing presentations were made to the participating facility.

3.9 Dissemination of findings

Finally, this doctoral thesis has been written for presentation to the University of Cape Town for examination. The final research report will also be presented to the Uasin Gishu County Hospital, County health service management team and policymakers. They will also be shared at national and international conferences and published in refereed journals.

3.10 Trustworthiness of the study

(Polit & Beck, 2011) state that trustworthiness is achieved by ensuring credibility, transferability, confirmability and dependability. In this study, the four aspects of trustworthiness were applied as described below.

3.10.1 Credibility

Credibility involves exposure of how data was collected and analysed to address the purpose of the research (Noble & Smith, 2015). Credibility was achieved by the use of rigorous methods of data collection and analysis, prolonged engagement, persistent observation, triangulation and member checks.

3.10.1.1 Data Collection and Analysis

The study utilised the Appreciative Inquiry model and the Human Scale Development framework. Participatory methods, such as Appreciative Inquiry are used to build upon collective goals and personal motivation, encourage participation at all levels of the organisation and connect with the community to tap its creativity and envision a future together (Carter & Little, 2007). Iterative questioning and probing were employed to elicit rich data. A deeper understanding of the phenomenon was achieved in this study through the involvement of women

(service users), midwives (service providers), and health service managers (Durrheim *et al.*, 2006). During data analysis, the researcher reviewed the data several times to ensure that categories and themes made sense, which required perseverance, insight and intellectual rigour to make sense of the findings (Patton, 2002).

Thematic validity was achieved through the sharing of raw data and coded transcripts with the university research supervisors. This afforded the researcher the opportunity to interpret the data from different perspectives. The supervisors evaluated the research process and proposed alternative approaches to data collection and analysis (Graneheim & Lundman, 2004; Shenton, 2004) also lauded the value of dialogue among co-researchers to agree on the way in which the data are labelled. Verification was done through independent coding. The procedure of inter-coder reliability examined the coding consistency of different coders by coding and comparing the findings of the coders. In addition, developed categories were shared with the supervisors for verification. The research proposal and preliminary findings were presented before the Doctoral Quality Assurance Committee and at different conferences for scrutiny, allowing the researcher to further refine the study. During the presentation, the committee critiqued the work that helped in refining the study. Suggestions were provided for areas of improvement, especially in making the research question clear, the methods used and the analysis of data.

The systematic analysis ensured that the developed categories were based on the data collected and that there was a clear link between the results and the data (Graneheim & Lundman, 2004; Polit & Beck, 2004). Authentic citations were also used to increase the trustworthiness of the research and to point out to readers from where or from what kinds of original data categories

were formulated (Patton, 1990). The researcher also ensured that participants were not identified by quotes from the data by assigning participants numbers during coding of data.

3.10.1.2 Prolonged Engagement

The researcher visited the research facility prior to data collection, for early familiarisation of the study setting and to consult appropriate documents, mainly vital statistics at the hospital and staffing records to identify the number of midwives working at the facility and to seek participation from midwives and health service managers (Shenton, 2004). The researcher also sensitised participants about the study before data collection. Sufficient time was allocated for data collection (Barusch, Gringeri, & George, 2011). The researcher involved participants in the different phases of the study, which led to the building of a trusting relationship, rapport and positive interaction (Creswell & Miller, 2000). Prolonged engagement was also achieved through repeated interactions with the midwives and health service managers.

3.10.1.3 Persistent Observation

Persistent observations were facilitated by the process of prolonged engagement (Barusch *et al.,* 2011). During data collection, the researcher made observations on what was happening at the facility and took field notes. This made it easy for the researcher to clarify with the participants some of the aspects observed at the facility and gather more detail (Anney, 2014).

3.10.1.4 Triangulation

Triangulation involves the investigation of a research question from at least two different viewpoints (Patton, 1999). The findings were triangulated across the different participants, namely, the women, midwives and health service managers, to elicit credibility of the themes. The involvement of a wide range of participants with different characteristics, viewpoints and

perspectives was achieved through the inclusion of service providers, service users and health service managers in the study sample to obtain data and theoretical triangulation (Durrheim, Painter, Martin, & Blanche, 2006). Triangulation was also achieved through the use of different techniques and methods of data collection, mainly focus group discussions, interviews and field notes (Michael Quinn Patton, 1990).

3.10.1.5 Member Checks

Member checks were used to determine the representativeness of the information provided. A summary of the key findings generated from focus group discussions was presented to the group at the end of the discussion and to participants in the next focus group discussion to enhance the authenticity of the interpretation (Appleton, 1995). On one occasion, midwife participants wanted the emphasis to be placed on certain points they had given earlier. Live mother and baby stood out as a high moment in maternity care. The changes were effected and included in the findings and taken back to the participants. This process helped the researcher to clarify and verify earlier-given information and also gave the participants an opportunity to give additional information where necessary. A typical example during the study is during phase three of the study when participants requested to be given time to discuss on the aspects that need to be included in the study.

3.10.2 Transferability

Transferability refers to whether the lessons learned from the study context and the study findings can be applied to other similar contexts (Ulin, 2002). In order to ascertain the applicability of the lessons learnt from the current study to other similar settings, sufficient details of the study area and environment have been provided. As such, a detailed description of

the context in which the research was conducted, the methodology used in the selection of research participants, field experiences, and analysis have been provided for the transferability of the study to other similar settings. Details have also been provided on the duration of data collection, the number of sessions held and the length of time each session took, as recommended by (Shenton, 2004). In addition, there was wide participation, as expected of an Appreciative Inquiry approach. Participants in the study number 124, thus meeting the sample threshold of an Appreciative Inquiry process (Ludema & Mohr, 2003). A detailed description of the data analysis process has been given in Section 3.7.

3.10.3 Confirmability

This refers to the extent to which findings can be corroborated by other researchers and can be improved by being reflexive (Carolan, 2003). Decisions made during data collection and any alterations made during this study were recorded in the field notes, as suggested by (Shenton, 2004). Raw data were shared with the research supervisors who provided their views on the data, helping the researcher to understand multiple ways of interpreting the data (Koch, 1995).

In the current study, narrative description was found suitable for presentation of the qualitative evidence from an interpretivist perspective. This approach facilitated the logical presentation of large data as the story unfolded from phase one of the study. It also enabled the researcher to report key relationships between the different data and different phases. The empirical evidence evolved from a set of interview transcripts to a set of concepts to a primary narrative, to a higher-order narrative, and finally to the UPENDO-S model and implementation framework/guidelines. The researcher allowed the participants to contribute freely without giving them her opinion. Details of an audit trail and the use of a dated reflexive journal in which the researcher recorded decisions made in the course of the study are provided in sections 3.10.3.1 and 3.10.3.2 below.

3.10.3.1 Audit Trail

An audit trail was used to ensure the confirmability of the study and document the research decisions related to data management and the reasons therein. The audit trail helps the researcher to track important areas of research and the intellectual and physical processes involved (Carcary, 2009).

3.10.3.1.1 Intellectual Research Audit Trail

An intellectual audit trail is a reflection on how the research evolved throughout all phases of the study. It consists of the philosophical position, considerations of alternatives for evidence collection and analysis, interpretation of the evidence and generation of theory from the evidence.

3.10.3.1.1.1 Philosophical Position

When I began the study, my philosophical assumptions were positivist in nature. This was mainly informed by the fact that most of my past research had been quantitative in nature with an emphasis on statistical analysis and association. At the commencement of my doctoral programme, my research problem was wide. I was interested in identifying problems and finding ways to fix them. As the conceptualisation progressed, through guidance from my research supervisors and wide reading, there was a change of heart to concentrate and build on what worked well in the organisation. This then necessitated the need to dig deeper to identify what works well in organisations. Thus, the positivist approach was not suitable for the study that I sought to carry out. As such, I shifted my philosophical stance for this study to the interpretivist paradigm. To achieve this, I realised I needed to involve those who understood the organisation best to actively participate in the generation of theory.

A deeper understanding could not be achieved by administering questionnaires to a large number of midwives. However, it would only happen through in-depth interaction with a defined group of participants, which was achieved through the involvement of participants in the different phases of the study and allowing them to make decisions and thus the wisdom for Appreciative Inquiry approach supported by Human Scale Development framework. The ontological position of interpretivism is relativism. Relativism is the view that reality is subjective and differs from person to person based on real-world phenomena, as the world does not exist independently of our knowledge of it (Grix, 2004; Scotland, 2012).

Following my extensive reading and training on research methods, I concluded that the interpretivist position was the appropriate foundation for this study. I then explored different strategies that would facilitate the realisation of an interpretivist approach in my study. The interpretivist approach is holistic in nature and attempts to capture contextual depth. It also recognises the difficulty in making research value-free and understanding the social world through physical law-like rules. The interpretivist research paradigm offered the participants the opportunity for an in-depth understanding of the maternity setting and processes.

One approach considered appropriate in the interpretivist research paradigm is participatory research. This explains why I chose to use the Appreciative Inquiry approach and Human Scale Development framework in this study. The participatory approach facilitated an interaction that allowed the respondents to express their individual and collective constructs through focus group discussions and interviews (Guba & Lincoln, 1994). The interpretivist researcher's approach to data collection and management enabled participants to describe how best maternity care would be enabling the researcher a deeper understanding through the Appreciative Inquiry lens in the

interpretation of data. The use of AI in the study proved to be emancipatory as participants were able to initiate positive actions as soon as the study began and, as stated earlier, addressed the issue of power dynamics in the hospital.

In the interpretivist approach, the viewpoint is that realities are socially constructed and are under constant internal influence and are shaped by social, political, cultural, economic, ethnic, and gender values; reality that was once deemed plastic has become crystallised (Guba & Lincoln, 1994), as evidenced in the current study. Interpretivist approaches, such as Appreciative Inquiry, provide for an understanding of the current situation during the discovery phase, using people in the setting/situation to discover the high points in the institution (Whitney & Trosten-Bloom, 2010). The goal is to carry out the study in the natural setting and facilitating participants to be able to come up with solutions for their challenges (Max-Neef, 1991b). Typically, data is produced in the form of narrative (words), which are then subjected to content or thematic analysis to find what meaning arises from the data. The researcher is understood to be the instrument or lens through which data are viewed and also the lens through which data are analysed and interpreted (Topping, 2010).

3.10.3.1.1.2 Alternatives for Evidence Collection

Appreciative Inquiry has been used widely to initiate positive results in many institutions. It was considered appropriate for the development of theory in this study as it entails continuous process with different explicit stages and involves participants throughout the research process rather than the usual prescriptive nature of researches whereby the researcher leads the process. Its appreciative nature of what works was preferred. Other methods, which may be appropriate, such as Grounded Theory and Ethnography have been described above.

3.10.3.1.1.3 Interpreting the Evidence

The categorisation of data facilitated the creation, linking and hierarchical management of data concepts. It also allowed for cross-tabulation of the key issues across different groups of participants. This ensured that the interpretation of the evidence began early in phase one of the study, establishing a foundation for phases two and three. Phase four of the study entailed the development of action plans for implementation of the model. Because of my interpretivist position, interpretation was an iterative process that involved interaction with and reflection on the body of evidence on several levels, as illustrated in Figure 3.7.

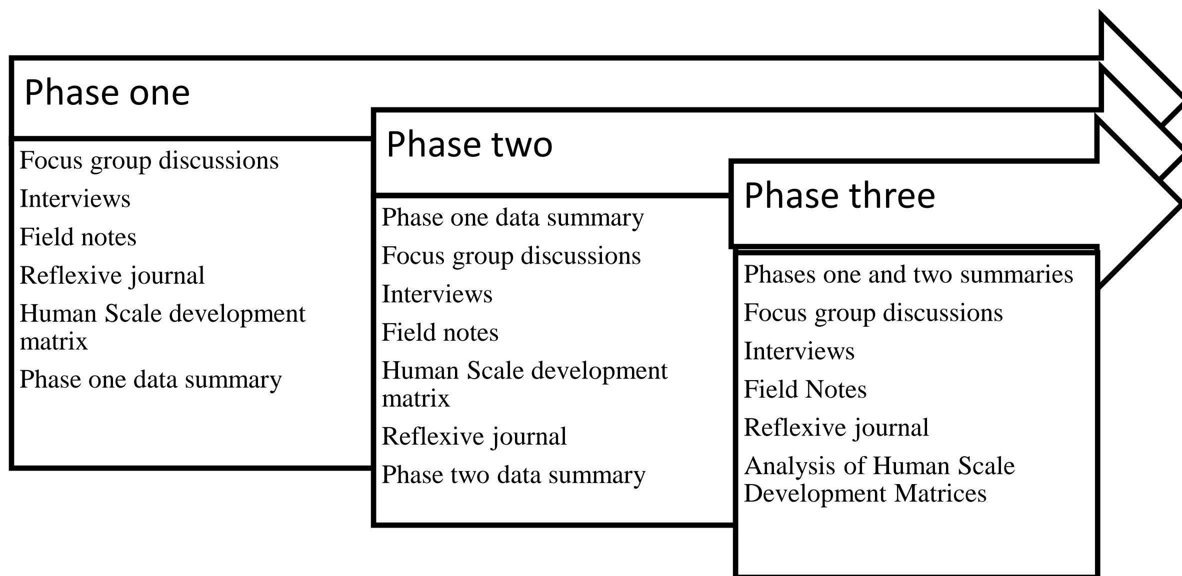

Figure 3.7: Different Phases of Study and Techniques of Data Collection

3.10.3.1.1.4 Generation of Theory from the Evidence

The processes involved in the development of core categories evolved from phase one to phase three of data collection. The central phenomenon that emerged in phase one was followed

through in phase two and phase three of the study (Corbin & Strauss, 1990). In order to discover the core category, the researcher used the iterative process that required going back to data to identify what was most striking/interesting, whether or not the category was more central, and its relation to other categories. Each of the categories was analysed, modified and refined until theoretical saturation was achieved and theoretical statements developed.

3.10.3.2 Reflexivity

Davies, (2012) defines reflexivity as being able to think critically about self and others and interpret behaviour in relation to situations that happen to transform thinking to act differently. It entails bending back "oneself" (Bonner, 2001). Etherington, (2004); Marshall, Fraser, & Baker, (2010) & Davies, (2012) further define reflexivity as the ability of the researcher to look back or inwardly at their own perceptions, thoughts, beliefs, views, experiences and how they influence the research process and interpretation of findings. Reflexivity is used in qualitative research to validate research practices and expose any assumptions and biases that could influence the study (Cutcliffe & McKenna, 2002; Morrow, 2006). It is generally recognised that the nature and findings of a qualitative enquiry are shaped, to a certain extent, by the experiences, worldview and theoretical perspectives of the researcher (Cutcliffe & McKenna, 2002; Green & Thorogood, 2004). To consider this influence, the researcher does self-examination to understand the biases and assumptions that could affect the study (Morrow, 2006). Reflexivity is presented in three sections below as recognition of self, others and reflexivity on the research design.

3.10.3.2.1 Reflexivity as Recognition of Self

This research arose from my desire to understand the kind of maternity care that women received, what guided the provision of such care and what best care would be. This passion developed while I was pursuing my master's degree in midwifery. In addition, my passion was

further triggered while I served as the chairperson of the Nursing Council of Kenya. Holding that office, I was concerned by the instances of reported cases of disrespectful care. I was cognisant of my position as a midwifery lecturer and a midwife in leadership and constantly reminded the participants that the research was purely for academic purposes, and no one would be penalised for any contributions. This was done to encourage the participants to be open in their discussions. Tension reduced as the study progressed between the participants and the researcher as the study progressed. Taylor, (2005) and Richards & Emslie, (2000) recognise that the status of the researcher can influence the type of responses and on the effects of power differentials between the researcher and the participants and emphasizes on importance of being aware of this.

There were instances when I experienced conflict as a midwife practitioner and a midwifery lecturer. For example, in one of the focus group discussions, a woman wanted to know about the effects of intrauterine devices. I refrained from giving my professional views immediately. However, after the session, I took the participant to their attending midwife and informed the midwife that the woman needed responses to some questions on contraception. Although I had the capacity to address the issue that the respondent had raised, professionally, my purpose at that time was to collect data. I could not convert data collection sessions into teaching sessions, as this would have had methodological and ethical implications. Being able to think critically about how I responded to the participants during the study enabled me to reframe my practice as a researcher. I checked my language and was always cautious of my body language (Rolls & Relf, 2006).

In reflecting on the likely influence of my perceptions and experiences, it is perhaps likely that my academic training, professional experience, leadership position and formed opinions and views influenced the research process in some way. Being able to think critically about how I responded to the participants as the study progressed enabled me to reframe my practice as a researcher. I checked my language to conform to Appreciative Inquiry positive questioning and was always cautious of my body language.

3.10.3.2.2 Reflexivity of my Recognition of Others

Involvement of participants in the different phases of the study created some sense of ownership. This ownership, was evidenced by the build-up of energy as the participants shared their achievements, their dreams and their participation in the design and destiny phases of the study. The women, midwives and health service managers participated in the study when they were available. Never at any time did they show any signs of feeling compelled to participate in the study. There were occasions when midwives stated that they were busy and requested for the postponement of data collection sessions. The researcher allowed them to freely express their feelings during the focus group discussions and interviews. They were only redirected when they lost focus or went out of the research topic.

Rolls & Relf, (2006) assert that, in addition to maintaining awareness of his or her own body language, the researcher must remain aware of the participants' body language, which may signify discomfort or distress, as well as reveal added layers of meaning in their responses. I perceived that the midwives and managers opened up when I informed them that the purpose of the research was to develop a model of care. There were occasions when the participants gave

their proposals and asked me to communicate with the county administration. Indeed, I felt pressured at points to forward their grievances to the authorities.

However, I reminded them that the research process was meant to encourage them to initiate actions and construct ways in which they could better interact with the management. With time, they were able to courageously approach the facility health service managers and requested for the purchase of equipment and other materials without waiting to be asked. I only provided a summary of the discussions we had had with the other participants when I held interviews with the health service managers.

The fact that the same group of midwives participated consistently in all the four phases of the research enhanced their sense of ownership of the research. It also helped to increase their energy as they witnessed their inputs being included in the different phases of the study. However, these changes in zest were not noted in the discussions with the women as different women participated in the different phases of the study. Nonetheless, the diversity in participation among the women enabled the researcher to obtain views from a large segment of women who sought services at the facility. There was extensive sharing of a summary of previous group discussions. These checks provided the opportunity for participants to seek or clarify certain issues raised. In most of the data sharing, the participants confirmed that the presented summary of previous findings represented their thoughts.

3.10.3.2.3 Reflexivity on Design of Study

The study utilised the Appreciative Inquiry approach and Human Scale Development framework. I was introduced to these approaches by my academic research supervisors. When I first read about the approaches, they seemed so abstract to me. Fortunately, through the guidance of

supervisors and extensive reading, I managed to grasp how these approaches work in research. I came to realise that the two approaches could provide a structured way to design a healthcare model envisaged by the participants.

The Human Scale Development framework complemented the Appreciative Inquiry. Its matrices enriched the study as it identified the specific needs that were included during the design phase of the study. Without it, the details of each of the components of the model could not be realised. On the other hand, the Appreciative Inquiry approach encouraged the participants to share and contribute freely to the discussions and interview sessions. One challenge noted at the beginning of the study was that the participants shared what did not work, without underlining their best experiences. However, the positive approach of the Appreciative Inquiry seemed to inspire them to freely share their best experiences. The Appreciative Inquiry approach dissolved the existing barriers and gave all the stakeholders a chance to contribute to the transformation of the way maternity care was being provided at the facility. It gave all the participants a voice to co-create a better future for the facility.

The Appreciative Inquiry process ignited a desire for change. The participants showed great interest in seeing improvements. The approach served as a catalyst for them to take action, based on their current capacity. They initiated actions that were within their means, such as the formation of a quality assurance team and making records on the poorly performing areas. They also stated that they were able to request for the purchase of a Doppler machine, television set and linen for the women's comfort during labour and birth. During data collection, I employed the probing technique to obtain more information and views from the women, midwives and

health service managers. Moreover, I collaboratively worked with the participants to design a model of care.

During focus group discussions, I used the round-robin technique to provide the opportunity for all the participants to contribute their views. As the midwives and facility health services managers participated in the different phases of the study, they were able to suggest and implement changes, contributing to the outcomes of the Appreciative Inquiry approach. More of the women who utilised services at the facility were involved in the different phases of the study. This ensured that the voices of a large number of women were heard and also minimised the experience of having a group that was less active during discussions.

I had a unique interest in the area of study. However, I mitigated my influence in the study by taking field notes. I recorded initial thoughts and feelings that directed my focus on the participants' needs, impressions, environmental contexts, behaviours and non-verbal cues in the field notes. I wrote the field notes down immediately after each interview and focus group discussion. Therefore, the participatory nature of the research process and the active involvement of different participants in the four phases of the study helped to sieve out my assumptions and biases in this study. Marshall *et al.,* (2010) recommend that a researcher should make their position explicit to better contextualise understanding. In this study, regarding obtaining consent from intrapartum women, the researcher made additional notes in a diary to capture personal thoughts and feelings of what she observed to reduce the effect of her own experiences of obtaining consent in labour (Marshall *et al.,* 2010). The researcher's own experience, when used in a reflexive manner, may also proffer helpful insights during project conceptualisation that may result in a deeper engagement with the participants and the data.

I kept a reflexive journal to help me track and reflect on my subjective research processes and the reasoning behind my specific research decisions. The contents of the journal were also instrumental in the interpretation of data. I facilitated all the group discussions and carefully articulated the crafted questions in the focus group guide to help the participants tell their positive past, present and future stories. I also thoroughly analysed the phrases and words in their responses. I further sought and received guidance from the research supervisors on the research process (Cooperider, Whitney, & Stavros, 2005; Cooperrider *et al.,* 2003).

3.10.4 Dependability

Dependability refers to the consistency between the data collected and the findings (Guest, MacQueen & Namey 2012). This was achieved in the current study through concurrent data collection and analysis. Field notes were analysed and compared with the data obtained from the discussions for an audit trail (Polit & Cheryl Tatano Beck, 2011). A full report was provided through a detailed description of the data (Talja, 1999). Transcripts were shared with the supervisors, whose contributions were valuable and enriching to the study, to enhance the enquiry audit (Skhosana & Peu, 2009). Details of the research design and its implementation were also provided. Finally, the procedures followed in data collection and analyses were described in Section 3.6 of this document, as suggested by (Shenton, 2004). Dependability was strengthened through the data collection tools to minimise errors of bias (Yin, 2003). Further analysis was carried out using NVIVO 11. Coding was done by the researcher, as well as an independent qualitative PhD researcher.

3.11 Expected outcomes

The dynamic nature of the study led to the initial development of change activities at the facility by the midwives and the health service managers. Some of the changes seen included requests for a Doppler machine and additional staff. Finally, the study developed the UPENDO-S model of care for Uasin Gishu County Hospital, Kenya.

3.12 Summary

This chapter has described the methodology used in the study. It has given a description of the study setting, design and the study participants. The chapter provided the reason for the choice of Uasin Gishu County Hospital as a study site. It also explained why the researcher adopted Appreciative Inquiry and mainly its generative nature and the positive approach to questioning and achievement of change in organisations. The chapter further described how the Human Scale Development framework guided the study. It also described the study sample and the sampling procedures across the four phases of the study. The chapter then provided details of the data collection instruments and procedures, data analysis, presentation and dissemination, and the methods used to ascertain trustworthiness. The chapter also enumerates the expected outcomes and ethical considerations of the study. The decision to use thematic network analysis and how the model was developed was also provided in the chapter.

The chapter also explained in detail the concepts of reflexivity and audit trail, as applied in the study. It also discussed the areas considered critical in an audit trail as applicable to the current study. This chapter further discussed the reflexivity and brought to the fore the researcher's own

perceptions, thoughts, beliefs, views, experiences and practices and how they influenced the research process and interpretation of findings.

4: FINDINGS

4.0 Introduction

This chapter presents the findings from the data collected and analysed in all four phases of the study in line with the Appreciative Inquiry cycle, which are discovery, dream, design and destiny, illustrated in Figure 4.1. The chapter begins with the presentation of participants' profiles (Section 4.1), followed by findings of each of the four phases of the study (sections 4.2–4.5). The chapter ends with a summary of the findings (Section 4.6).

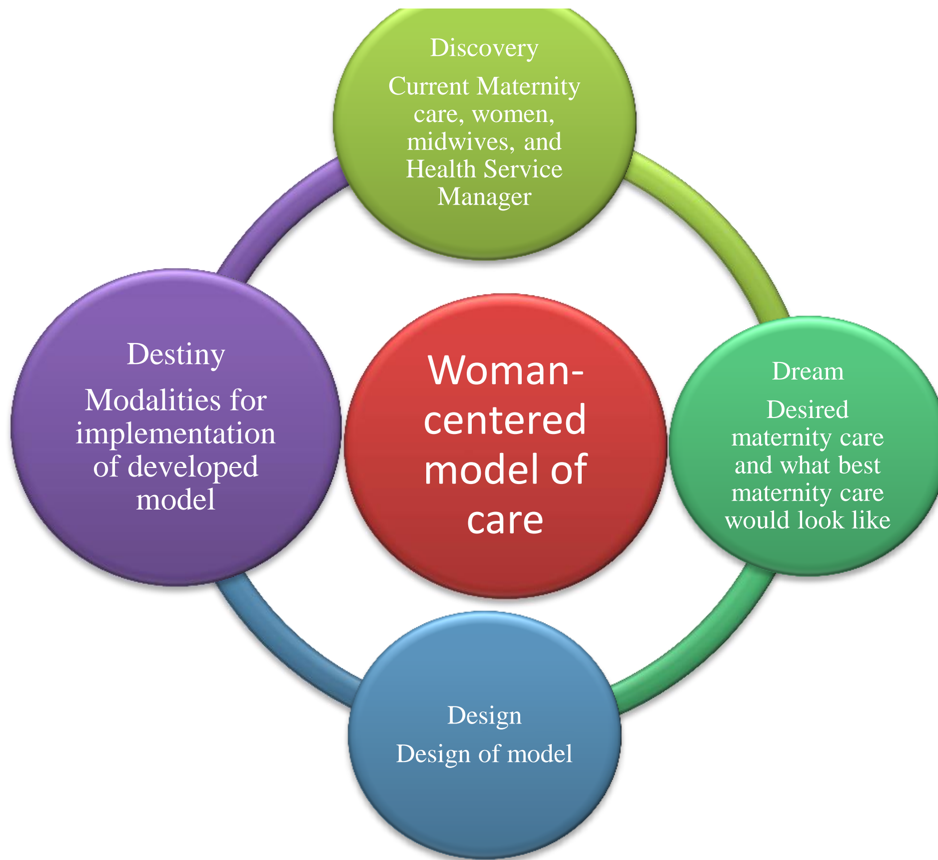

Figure 4.1: The 4-D circular model of Appreciative Inquiry

4.1 Participants' demographic profiles

The Appreciative Inquiry emancipatory paradigm honours participants' contributions and relies on participant's stories and their voices. Altogether 124 participants comprising women, midwives and health service managers were engaged in the different phases of the study.

4.1.1 Women

Eighty five (85) women participated in the study, 67 (71%) of whom were 18-30 years old. Thirty-eight (38) had primary-level education, 23 secondary-level education and 18 tertiary-level education. Forty-five (27; 31.7%) were primiparous, 29 (34.1 %) were seeking antenatal, immunisation and weighing of children services and 27 (31.8%) had given birth at least once at the facility. In this case, they had experienced at least some other maternity services such as antenatal care at least one other time.

Table 4.1: Women participant characteristics

Participants' characteristics	Range	Number (n = 85)
Age	18-20	17
	21-25	27
	26-30	23
	31-35	11
	36 and above	7
Level of education completed	None	6
	Primary	38
	Secondary	23
	Tertiary	18
Parity	0	27
	1	22
	2	16
	3	12
	≥ 4	8
Number of children women delivered at facility	0	58
	1	26
	≥2	1
Service sought by women	Antenatal Care	29
	Birth	10
	Post Natal care	7
	Immunisation	21
	Family Planning	18

4.1.2 Midwives

A total of 32 midwives participated in the study, 26 (80%) of whom held diploma and above as the highest level of qualification. Their ages ranged from 24 to 59 years. None of the midwives had obtained maternity services at the facility for themselves, and thus their contributions were curtailed to their being midwives and not as recipients of maternity services. Their clinical experience ranged from 1 to over 20 years, and 11 (34%) worked in maternity inpatients, antenatal, labour, birth and postnatal units.

Table 4.2: Characteristics of midwives

Participants' characteristics	Variable	Number (n=32)
Age	20-25	2
	26-30	6
	31-35	14
	≥36	10
Gender	Female	30
	Male	2
Education Level	Certificate	6
	Diploma	21
	Bachelor's degree and above	5
Years of experience	1-5	8
	6-10	7
	11-15	5
	16-20	3
	Above 20	9
Current place of work	Antenatal clinic	3
	Maternal child health clinic	4
	Family planning clinic	2
	Labour and postnatal wards	11
	Comprehensive care clinic and PMTCT	6
	Outpatient, gynaecology and counselling room	6
Parity	1	2
	2	8
	3	8
	4 and above	12
	N/A	2

4.1.3 Health service managers

Seven (7) health service managers participated in the study: the hospital medical superintendent, the hospital administrator, the nursing officer-in-charge, the reproductive health coordinator, one medical doctor and two county directors of health. Three managers had a diploma as their highest level of education; four had a bachelor's degree as their highest level of qualification. They each had over six years of work experience.

Table 4.3: Health service managers

Participants' characteristics	Variable	Number (n=7)
Age	25-30 31-35 ≥35	0 2 5
Gender	Female Male	2 5
Level of Education	Diploma Bachelor's degree	3 4
Years of experience	1-5 6-10 11-15 16-20 ≥21	0 2 2 2 1
Current place of work	Health facility County management	4 3

4.2 Phase One (Discovery)

Consistent with the Appreciative Inquiry cycle, phase one of the study was the discovery phase. Six focus group discussions were held: two with midwives, two with women, one mixed group of midwives and women and one with health facility service managers. In addition, interviews were done with three participants: two county health service managers and one midwife who was the reproductive health coordinator.

At the beginning of the focus group discussions and interviews, participants were asked to describe a time when they felt care was at its best at the facility or, alternatively, their past positive maternity care experiences. The participants were initially tense, talked less and kept referring to what did not work at the facility and the facility's inability to meet regulatory bodies'

standards. In reflection, what was difficult may have been uppermost in their minds, or most probably they were more used to talking about what did not work, and they needed to be heard. It may also have been as a result of power differentials between the participants and the researcher (a past member of nurses and midwives regulatory board and a midwife lecturer). Indeed it took a while for participants to shift their responses from those usually given to a manager, to responses for research purposes.

After they had spoken about this for a while, clarification of the purpose of the research was provided and participants were encouraged to refocus on best maternity experiences. They opened up and contributed freely, and the mood shifted from quiet to passionate exuberance as they were elated in sharing their best maternity experiences. Their past positive experiences related to the care, processes, staffing, structures, relationships and outcomes. They described what they considered important in midwifery care, what happened and what facilitated the provision of care.

Women shared positive encounters using phrases such as “felt valued”, “cared for”, “safe”, “welcomed”, and “comfortable”. The high points of their birthing experience came from the hospitality and respectful care received from birth to a live newborn. The women experienced satisfaction when they were involved in decisions regarding their care and when they were given health information. They also appreciated receiving care in a comfortable environment that was clean, private and where confidentiality is maintained. The women respondents also experienced a high point when they provided support to each other.

For their part, midwives expressed positive emotions, using terms such as “was excited”, “was able”, “felt good” and “achieved job satisfaction”. They identified high points as a time when

everything came together or a time when a midwife was able to successfully support a mother to give birth. Midwives further described best experiences as a time when they successfully applied a skill, took risks and went out of the norm, or when they experienced unusual events. Also, a high degree of engagement with women or encounters of a life-changing experience were viewed as good moments. Noted also as high points was when midwives achieved a breakthrough in challenging situations that significantly stretched their professional expertise. Such challenges included having to handle women who had complicated births, struggling and succeeding to save the lives of a mother or newborn and generally achieving good outcomes.

The discovery phase for the health service managers contributed to reflections on their role in maternity care. As they reported, the high points for them came when processes and services worked in harmony and when women were attended to well and when they were able to monitor performance. The health service managers experienced high points when they were able to resolve challenges that arose and were able to support staff in performing their duties and implementing formulated policies. Motivation and satisfaction of staff were also important. The health service managers experienced high points when they participated in the planning and budgetary processes and when they provided strategic directions.

The following global themes were generated from the analysis of data in phase one of the study; “live and healthy mother and baby”, “efficiency and timeous delivery of services”, “targeted responsive interventions”, “responsive communication”, “resources at the facility”, “presence of knowledgeable, skilled, updated midwives”, “informed women, involved in decision making”, “nature of service and facility”, “focused decisive leaders” and “collaboration and partnership”.

Table 4.4: Phase One: basic, organising and global themes

Basic themes	Organising themes	Global themes
Live mother (FGD 1, 2,3,4) Live newborn (FGD 1,4) Baby breathing well at birth (FGD 1, 3,4, I2) Good outcomes from high risk situations (FGD 1, 3,4)	Live births Good outcomes	**Live, healthy mother and baby and good outcomes**
Quick service (FGD 1,3,4) Quick response to emergencies (FGD 3,4) Proximity to a referral hospital (FGD 2,3,4, 6,I2) Access to ambulance/designated transport (FGD 3, 5,6)	Timely service delivery Established referral systems and accessibility	**Efficiency and timeous delivery of services**
Accurate assessment (FGD 1,2,3,4) Change of position (FGD 3,5,I3) Resuscitation (FGD 1,3,4,I1) Management of obstetric emergencies (FGD 1,3,6)	Assessment and provision of care Effective practices	**Targeted responsive interventions**
Appreciation (FGD 1,2,3,4,5,6) Expression of courtesy(FGD 2,4) Assessing needs of individual woman (FGD 2,3,4, I1,I3) Allocating sufficient time for each woman (FGD 2, 4,5) Structured means of providing feedback (FGD 2,3,4,5)	Respectful welcoming Personalised attention Feedback on care	**Responsive communication**
Maternity Unit (FGD 1,3,4) Theatre(FGD 1, 3,5,6) Newborn Unit (FGD 3,4,I1,I2) Laboratory (FGD 1, 3,5) Equipment(FGD 1, 3, 6) Drugs and commodities (FGD 1,2,3,4)	Infrastructure and essential departments Equipment, Drugs and commodities	**Resources at the facility**
Knowledgeable (FGD 1, 2,4,6) Skilled midwives (FGD 1, 3,5,6) Continuous professional development (FGD 1, 3,5,6) Presence and availability (FGD 1,2,3,4) Staffing at facility(FGD 1, 3,4) Staff turnover(FGD 1, 3,4)	Knowledgeable, skilled, updated midwives Presence and availability of midwives	**Knowledgeable, skilled and updated midwives**

Basic themes	Organising themes	Global themes
Information about pregnancy, care of woman & baby(FGD 2,3,4) Danger signs(FGD 1,3,4) Nutrition, breastfeeding, (FGD 2,3,4,5) Information on procedures done and progress (FGD 2,3,4) Women ask questions and seek clarifications(FGD 1,3,4) Women involved in planning their care (FGD 1,2,5) Birth plan (FGD 1,2,3,4)	Health information for women Involvement of women in decisions regarding their care	**Informed women involved in decision making**
Different maternity services (FGD 2,4,5) Mobile clinics (FGD 1,2,4) Free maternity services, (FGD 1, 3,4) Low charges (FGD 1,3,4) Signage and directions at facility (FGD 3,4) Organisation of services at the facility (FGD 2,3,4) Water supply (FGD 1,3,4) Cleanliness at the facility (FGD 1,2,3,4) Poor drainage (FGD 3,4,6) Recognising strangers at the facility (FGD 1, 3,4) Protection from theft (FGD 1,2,3,5)	Accessibility Affordability Organisation and signage Water and sanitation issues Security	**Nature of service and facility**
Planning and budgeting (FGD 2,3,4) Able to make decisions (FGD 1,4,5,6) Resolve challenges (FGD 1,3,5,6) Good relationships between management & staff (FGD 3,4) Involve staff in decision-making (FGD 1,2,3,4) Structured means of providing feedback (FGD 3,4,6) Regular meetings (FGD 2,3,4) Appreciation and recognition of midwives (FGD 3,4,5) Motivation of staff (FGD 3,4) Monitor performance & support supervision(FGD 1, 5,6)	Decisive supportive managers Visionary leaders who recognise and involve staff in decision-making Recognition and motivation of midwives	**Focused leadership**
Collaboration with external partners (FGD 1, 6) Working with community (FGD 1,2,4)	Support from External Partners Involvement of community	**Collaboration and partnership**

4.2.1 Live and healthy mother and baby and good outcomes

Achieving a live birth and good outcomes were critical to all participants.

4.2.1.1 Live births

During antenatal care and the childbirth period, participants stated that they continuously appreciate it when the mother and the baby are well. Their main satisfaction is the wellbeing of the two. They were very much happier when they intervened to ensure the baby was breathing well at birth and the mother well too.

W 8, FGD 2: "…they check the baby and tell you when baby is doing well".

M 2, FGD 3: "… there is a time we felt good and achieved job satisfaction when we saved a newborn and a mother. A mother came in after delivering at home with retained placenta. We were able to diagnose another foetus. We did an ultrasound very fast, it showed presence of a foetus, we rushed the mother to theatre and we saved the lives of the mother and the newborn… mmm … We were able to save the lives of the mother and baby."

4.2.1.2 Good outcomes

Achieving good outcomes from pregnancy and birth is foremost. Even during obstetric emergencies and high-risk situations, midwives put in extra effort to monitor the women to ensure that the process goes smoothly without any problems.

M 5, FGD 1: "so the experience there delivering a primigravida without an episiotomy no tear and the baby was delivered and scored well".

M1, FGD 1: "a moment in the year 2000 … when a precious baby was delivered alive from a mother a para 1+6 with one living child. An asphyxiated baby was extracted via C/S (Caesarean

section), resuscitation was done, admitted in NBU(newborn unit) and discharged home alive and well three days later… the most exciting thing… was having a live mother and baby go home."

M2, FGD 1: "…you see the mother didn't have a living child, may be BOH [bad obstetric history] so a live infant from a mother of bad obstetric history of para 1+6 [a parity of 1+6 indicates that the woman has had seven pregnancies out of which one led to a live birth]*"*.

4.2.2 Efficiency and timeous delivery of services

Efficiency and timeous delivery of services concerns timely service delivery and established referral systems and accessibility.

4.2.2.1 Timely service delivery

This involves the provision of services in a timely manner and quick responses to emergencies. Women appreciated it when they were served immediately they arrived at the facility. This meant that women spent less time at the facility and were able to go home and undertake other routine activities.

W 1, FGD 2: "…we are sent for palpation. There we are served quickly...they don't waste time."

In situations in which midwives were not able to attend to the women, they referred them immediately. When obstetric emergencies occurred, midwives were able to transfer the woman to receive emergency care in time.

W 1, FGD 4: "when I came to this facility to deliver another time, I had a complication and the midwives assessed me and they referred me immediately to another hospital. They told me they would not be able to handle my situation and they referred me (baby coos) I was happy that they did not waste time as they said they could not handle my complication…"

W3 FGD 4:"… took action immediately unlike other places they keep you … then they tell you they can't manage and delay in transferring you…"

There were occasions when women cited experiencing delays in receiving services at the facility. The delay in receiving services caused inconvenience to those women who had asked for permission to be away from work for a few hours. There were concerns that, on some occasions, women give birth on their own at the facilities without any assistance from the health care professionals or others and leave the facility without receiving services at all. Midwives attributed the delays in the provision of services to their being alone at the facility at that time with many women to be served.

W , FGD 4: " …when you come they keep you for long and you have to go back to work and yet you have asked for permission…Need to have more staff, you come and you find you stay for long before you are seen".

W 7, FGD 4: "Yes delivering on her own, not because they were ignoring her but because they were busy attending to others, so when the numbers of midwives are few, mothers deliver on their own".

M 6, FGD 1: "mothers who come to clinic wait for long before receiving services... you find you are in family planning alone and there almost 100 mothers waiting for you alone".

4.2.2.2 Established referral systems and accessibility

Good referral systems and the proximity of a tertiary hospital eased referrals of emergencies and complications.

A2, FGD 6: "… at least referral services are good, because we have a referral facility near our facility whereby when we have challenges like a mother who has a difficult delivery or they have neonatal problems … we are able to refer …immediately and they get support immediately …"

Participants stated that the availability of an ambulance eased the referral of mothers with complications. In cases in which an ambulance was not available, the health service managers were able to make arrangements for prompt transfers.

M10, FGD 3: "when we have challenges in referring mothers because we don't have an ambulance we have used taxis to refer mothers because we don't want to risk the lives of the mother and of the baby."

4.2.3 Targeted responsive interventions

Targeted responsive interventions involve doing accurate assessments and applying effective practices for care and management.

4.2.3.1 Assessment and provision of care

Accurate assessment is critical as it guides decisions regarding the management of the mother and of the foetus and baby after birth. This includes a midwife being able to assess a woman and make a decision as to whether she will give birth without any interventions, as indicated by the midwives in the study. Some of the assessments include checking whether birth occurs without any interventions or would require an intervention such as change of position of the woman, or allow gravity to aid birth and avoid tearing or performing an episiotomy.

M11, FGD 3: "…there is a time that I had an experience with a mother who had a retained placenta ... the mother had delivered at home, said it was retained placenta but was able to diagnose presence of undiagnosed second twin…delivered the second twin well."

M 6, FGD1: "…a primigravida in second stage...I assessed her, she was tight [perineum was tight]…"

Midwives were able to perform assessments and call for help during emergency situations or in situations that they were not able to handle. On many occasions, they received assistance immediately they requested it.

M7, FGD 3: "I was just alone then when I noticed now it was breech delivery, I had never delivered any breech I called for help, I called for a nurse, luckily a nurse paediatrician came in when I was now delivering the head, the head now got stuck, ...we tried we were not able to do it so well. We called for a doctor who responded immediately…"

4.2.3.2 Effective practices

The ability of midwives to apply effective practices and achieve good outcomes was a high point. Midwives were able to apply effective practices during the resuscitation and management of obstetric emergencies such as shoulder dystocia and an undiagnosed breech presentation.

M 6, FGD1: "... We changed position to lateral then raised this leg [points at the left leg] like this and she pushed and delivered without an episiotomy, without a tear."

M3, FGD 1: "But there were others conducting delivery then the mother delivered the head then there was shoulder dystocia and they were calling the doctor to come and assist the delivery, I

stepped in because I had the skill I delivered….mmm. The experience was good. The skill of manoeuvring was successful. I had undergone training on BEMONC."

4.2.4 Responsive communication

Responsive communication relates to respectful welcoming, personalised attention and giving and receiving feedback.

4.2.4.1 Respectful welcoming

Respectful welcoming is demonstrated by appreciation and expression of courtesy. This relates to the way the women were approached and talked to by the midwives at the facility. Women felt welcomed and valued as they were not shouted at. The feeling of appreciation and expression of gratitude certainly made women feel safe and comfortable.

W2, FGD 4: "...I like how they approach people they treat people well…"

W3, FGD 5: "I've been attending FP [family planning] clinic and there is a difference with other clinics. Here they have welcomed me and a warm welcome."

Women experienced satisfaction when midwives were sensitive to their needs and met their expectations. Women stated that they sought the services of traditional birth attendants whom they regarded as being more welcoming and respectful.

W2, FGD 2: "We prefer to go to deliver at home with the help of those women [traditional birth attendants]…because we know the woman assisting us and again…they don't shout at us."

4.2.4.2 Personalised attention

Midwives assessed the needs of each individual woman and allocated adequate time according to their needs. Each woman sought services with specific expectations and needed to be handled as

an individual with unique requirements. Sufficient time was allocated to pregnant mothers who were seeking comprehensive counselling and attention services for the first time. Similarly, any other woman who had special needs was allocated adequate time. However, there were occasions that women felt they did not receive the attention they expected.

W3, FGD 4: *"I had a problem and some issues that were not good on my side…I thank God because of the doctor who attended to me. He has been a counsellor ... counselled me how to live with the situation…"*

W 2, FGD 4: "This discourages us from coming to the hospital…You come here you take time expecting to be attended to well and then you don't get the service you expect. You go away feeling that the facility does not help us since you come when you are sick expecting to get required attention. When you come you go saying I wish I knew. I should have gone somewhere else I should not have wasted my time here ... I would be attended to well."

4.2.4.3 Feedback on care

Participants expressed a need for channels of communication and avenues to provide feedback. There were no structured systems to appreciate care provided or register displeasure.

W3, FGD 5: "…If there is a suggestion box, one will open up and write everything ... about the services".

4.2.5 Resources at the facility

Resources in this context relate to infrastructure and essential departments, equipment, drugs and commodities.

4.2.5.1 Infrastructure and essential departments

The facility was small and could only accommodate a few mothers at a time. It could not meet the demand for labour and birth services for all the women seeking antenatal care at the facility.

A1, FGD 6: "…because you find like if I give a scenario like in ANC you realise you can even have 10 000 clients in a year 1000 per month but when it comes to delivery because of limited space, those who come for deliveries are fewer than those seen in ANC… so you can imagine that kind of a challenge and it just points to expansion of facility."

There was the contention that the facility lacked essential departments such as a theatre and newborn unit. Women who required a Caesarean section and newborns who required special attention were referred to other health facilities.

A 3, FGD 6: "…the facility does not have even theatre. When there is an emergency, we are not able to operate …we find cases where mothers are supposed to undergo C/S [Caesarean section] and you are forced maybe to refer the patient."

Congestion was noted in key areas, such as the laboratories, which posed risks of transmission of infectious diseases as women and children shared the laboratory with other patients seeking services.

W11, FGD 4: "…another thing is about their labs… Their lab is so congested. As you know expectant mothers and babies like those can easily contract diseases …you will find typhoid victims there all kinds of diseases."

4.2.5.2 Equipment

The availability of equipment is critical for diagnosis and provision of emergency services. A well-equipped laboratory ensured the performance of essential tests during pregnancy and birth. However, participants raised concerns about the unavailability of equipment and some critical tests not performed.

A3, FGD 6: "…a mother who had just delivered and the baby had a poor Apgar score … we didn't have the required equipment for resuscitation … You want to perform something but you can't because there is no equipment."

W4, FGD 2: "another thing that is not good is there in the lab; there is a time we were told that the facility could not do a blood group test, so we were sent to go and do the test… I wish they can be able to do all the tests."

4.2.5.3 Drugs and commodities

The availability of drugs, vaccines and commodities was appreciated. However, there were occasions when women were issued with prescriptions and sent to buy drugs from pharmacies outside the facility. In the course of the study, there were occasions the researcher noted that some vaccines were not available and women were being referred to other facilities for the immunisation of their children. When asked to clarify why some vaccines were unavailable, the response from the facility management was that it was a countrywide problem and that the demand exceeded supply.

W4, FGD 2: "… another thing is vaccines. There is no time we have come and told that the vaccines today are not there, come next week. Like Rotavirus vaccine was introduced just the

other day. There is no time you come and told Rotavirus today is not there. At least all the children get the Rotavirus vaccine."

W2, FGD 4: "… they don't have … drugs, when you come, you queue they give you a prescription. When you go to pharmacy the drugs are not there. They tell you to go and buy drugs… sometimes you are from the lab they tell you to go for injection. When you reach there they tell you to go buy the drug and the needle for injection and come back to be injected …"

4.2.6 Knowledgeable, skilled, updated midwives

This entails knowledgeable, skilled, updated midwives and presence of the midwives at the facility.

4.2.6.1 Knowledgeable, skilled, updated midwives

The facility was found to have well-educated, knowledgeable and skilled midwives. Midwives demonstrated expertise in the application of skills during the provision of care and by the way they attended to the women during routine as well as emergency situations. Midwife participants expressed satisfaction when they were able to apply their knowledge and skills during difficult situations.

W3, FGD 4: "… they [midwives) know what they are doing …so I've felt that they are knowledgeable …They give you proper advice."

M12, FGD 1: "…came with history of retained placenta … On palpation, I realised that there was a 2nd twin which the mother was not aware … we listened … the foetal heart was there … looking for the presentation … I queried transverse lie … on V.E [vaginal examination],… sent

the woman for ultrasound which confirmed that it was a transverse lie … I was excited that I was able to diagnose a transverse lie!"

Midwives stated that continuous professional development was critical, as it was used to update and polish their knowledge, skills and attitudes. Midwives appreciated training on basic emergency obstetrics and neonatal care. Midwives stated that they frequently experienced emergencies from mothers who give birth at home. On reflection, emergencies from unplanned home births, especially when a woman came in with a retained placenta, undiagnosed second twin, postpartum haemorrhage, stretched midwives' professional expertise and, when they handled such unexpected emergency situations successfully, they experienced satisfaction.

M11, FGD 3: "… during my BEMONC [basic emergency obstetric and newborn care] training … so now I was much confident of delivering that placenta …the mother had delivered almost four hours ago … On arriving I put an IV [intravenous] line; I put Oxytocin and tried to manoeuvre the placenta and delivered the placenta."

M 11 FGD 1: "… This mother came from home, had delivered at home and placenta got retained that was after my BEMONC training so now I was much confident of delivering that placenta which was successful….when the mother came in I just asked she said she delivered at home at around three almost four hours ago. On arriving I put an IV line; I put oxytocin and tried to manoeuver the placenta".

4.2.6.2 Presence and availability of midwives

Availability of midwives at all times at the facility was appreciated. Indeed women always found a midwife any time they visited the facility. They observed that, even if they were not in the vicinity, they were busy attending to a woman somewhere.

W2, FGD 2: "…and the midwives you can't enter at least and say this time they are not there… you know we have gone to many places and sometimes you arrive and stay for quite a long time before you see the nurses …they do their work at the right time at the right place."

There was a shortage of midwives at the facility resulting in midwives attending to large numbers of women. There were occasions when a midwife was allocated the entire six-hour shift to care for about five to six mothers in labour on her own. Staff shortages some days prompted managers to suspend their managerial tasks and step in to provide operational services. Besides, midwives had multiple roles to perform, ranging from making book entries, receiving and passing on information by telephone, attending to relatives, as well as performing their core business of caring for women.

W6, FGD 5: "…we see they get tired, sometimes you find one midwife…there is a lot of work, writing on books and others have to do assessments on us and they get tired… "

M9, FGD 3: "… that you would want them to at least balance we have enough staff and are distributed elsewhere… you realise that this distribution of personnel is not balanced…"

Concerns were raised over high turnover of midwives arising from frequent transfers from one facility to another, contributing to low morale. The issue of frequent transfers also interfered with the provision of care and was thus a hindrance to achieving continuity of care.

A1, FGD 6: "…uncertainty of staff as they report every day on duty, they're not certain that they will be there tomorrow or in another facility… staff turnover is very high and you can even be transferred without any posting order, no procedure…"

4.2.7 Informed women, involved in decision making

The theme "informed women, involved in decision making" relates to health information provided to women and the explanation of procedures done to them and using the information to make decisions on their care.

4.2.7.1 Health information for women

During visits to the hospital, women were provided with health care information on pregnancy, how to care for themselves and their newborns during pregnancy and after birth, danger signs during the childbirth period and other critical areas related to pregnancy and childbirth.

W1, FGD 2: "[We were] taught about danger signs in pregnancy, nutrition, breastfeeding, birth plan, all those things ... given to women…explained to how many weeks the pregnancy is…importance of folic acid helps in the development of the brain and the nervous system …good teachings assist us."

W4, FGD 4 "I liked the service at ANC. The nurses are polite and they're very nice. They teach us on nutrition, how to take care of the baby, danger signs in pregnancy. They give you information. They tell you what to do when you are expecting and when you come for the service and most hospitals don't do that."

Verbal information was complemented with maternal and child information booklets useful for birth plan preparation. The health information sharing provided an opportunity for both the woman and the midwife to learn from each other.

4.2.7.2 Involvement of women in decisions regarding their care

Provision of information to women on procedures performed on them, their condition and being given an opportunity to ask questions or seek clarifications, contributed to satisfaction. This is important because women would like to be active participants in their care and also give consent.

W3, FGD 4: "I've been attending FP clinic and there is a difference with other clinics… but I thank God because of the doctor who attended to me. He has been a counsellor also, and has counselled me how to live with the situation, ... also they give correct information about FP, and also they attend to you the way you are with the situation ...you understand better your condition…"

W7, FGD 4: "…they just tell you to open your legs when you are in labour. They insert their fingers and just tell you ... you are still far."

High points occurred when women made decisions about their preferences. Women experienced joy when they had opportunities to make decisions on place and positions of birth.

A2, FGD 6: "…in ANC (antenatal care), we have the mothers' booklets…indicate where she would want to deliver so they write down…"

4.2.8 Nature of service and facility

Nature of service and facility relates to the accessibility of services, organisation and signage and affordability of care. It also relates to water, sanitation and security at the facility.

4.2.8.1 Accessibility

Provision of different maternity services, mainly comprehensive antenatal, labour and birth, postnatal and family planning services contributed to satisfaction among the different

participants. Other services appreciated include counselling and testing for HIV/AIDS services for which women reiterated the importance of early diagnosis and treatment.

W1, FGD 2: "in front there, blood pressure is done, weight, told whether your pressure is okay or not…we go for palpation…twenty weeks you are given de-worming drugs free of charge, folic acid."

W2, FGD 2: "very important to us women especially when you are pregnant…Very good to know our HIV status as expectant mothers…the early the better…"

In addition, services had become more accessible through devolution of health services and the use of mobile medical clinics. An example of the mobile clinics is the *Beyond Zero* initiative, a project initiated by Kenya's First Lady, Hon. Margaret Kenyatta, in 2014 the purpose of which was to improve maternal and neonatal health. The project operates mobile vans for delivery of antenatal care, labour and birth, immunisation and cervical cancer screening services.

M5, FGD 1: "Beyond zero campaign good thing …Two or three of this vans we will reach more people."

4.2.8.2 Affordability of care

The majority of maternity services and commodities were offered free of charge at the point of care, including nutrient supplements such as vitamins and folic acid, mosquito nets and deworming drugs. In addition, mothers give birth at no charge at the health facilities thanks to the free maternity care policy in Kenya. Where mothers are required to pay, such as for laboratory services, charges are subsidised.

M10, FGD 3: "Maternity service is free right now, I see it helps, we are happy… we have everything now in maternity ... women are given mosquito nets ... deworming drugs ... supplements free of charge."

W9, FGD 4: "Affordable care. Even if they charge, their charges are minimal."

4.2.8.3 Organisation and signage

Organisation and signage relate to overall arrangement and order of services and provision of directions within the facility. The participants commended the level of organisation. The compliments are perhaps because of the way the various services were arranged, the signage put in place and the customer service desks which provided directions and made it easy for women to locate, access and receive the services conveniently.

W5, FGD4: "I think what I liked most about this place is that it is organised and for those who are going for ANC they have a place to enter and those who are going for FP they also have their places."

4.2.8.4 Water and sanitation

Consistent water supply was considered critical and concerns related to inconsistent water supplies were expressed as there were occasions when the facility ran out of water.

W4, FGD 4: "…there is also water problem… sometimes there is no water in the taps and if you want to take a shower after delivery you can't".

Issues of poor sanitation and drainage were raised. There were few toilets at the facility and these were shared by a large number of people. The toilets were cleaned only in the morning and, as a result, remained dirty for most of the day. As a result, some women could not use the toilets and

preferred to wait and relieve themselves at home. Midwife participants also cited instances where women were sent to collect urine specimens for analysis but failed to do so, citing dirty toilets. Dirty toilets can be a source of infection as pregnant women need to empty their bladders often.

W 5, FGD 5: "…water everywhere even you don't know whether it is water or urine women just persevere until we go back home…"

4.2.8.5 Security

Good security was considered important as it provided a feeling of safety. This occurred with vigilance and enabled the identification of strangers whose missions were unknown. In addition, adequate safety measures to prevent theft and other incidents related to insecurity contributed to high points.

W8, FGD 4: "in case in the side of facilities, security is available so that they can protect and prevent from stealing..."

4.2.9 Focused decisive leaders

This regards decisive supportive leaders who recognise and involve staff in decision-making and motivate and reward staff.

4.2.9.1 Decisive supportive managers.

Decisive supportive managers can plan for activities, budget and make decisions such as staffing, equipping and supply chain management at the facility. Such managers create an enabling environment and build relationships with staff and are able to resolve disputes. They strive to ensure cordial relationship between management and staff. Leaders who provide necessary support and guidance to the staff so that they are competent to make decisions and resolve any

challenges that arise. However, participants wanted to be involved in planning and be informed of the priorities the leaders have for the facility.

A2, FGD 6: "as administration we have been able to plan and support midwives any time issues are raised, we are able to support them immediately through the office of the medical sup [superintendent] …"

A 4, FGD 6 : "in this facility we have sat as management and we have pointed out these things we have even scaled it up with the County management those policy level makers but you see the thing is the answer they give us is kind of like it's not an immediate one …we wanted some renovation to be done at least to create even more space in maternity but you are told we're not even interested in renovating that place because they have a long term plan to put up another structure for health elsewhere …".

4.2.9.2 Visionary leaders who recognise and involve staff in decision-making

There was an appreciation of health service managers who were visionary and astute in decision-making. Such leaders have structured feedback mechanisms through regular meetings between them and staff and schedule visits at service delivery points. On my reflection on this, participants needed to be heard and be given a chance to make certain decisions.

A2, FGD 6: "…in midwifery we can improve if we had somebody with a vision of health in our county we don't have somebody with that vision, they're just for their own selfish good, they're just there…so there are these positive initiatives that staff come up within their areas of work … on how to improve maternity care but the only challenge is that the recommendations are not implemented."

A3, FGD 6: "bottom-up approach of management whereby the decisions come from us…but now we have a situation whereby the decisions are made from up and they are forced down throat…some of these decisions are not friendly … for the short time I've been here, I've not had a forum where I can give my views or where I can say what I'd like to be improved because even that forum is not provided for ..."

Monitoring the performance of staff and identifying areas of success as well as areas of improvement and challenges staff face is appreciated. This they achieve through support supervision at areas of work.

M6, FGD 3: "… when they do supportive supervision, they're able to learn what we're going through and support us on the same."

4.2.9.3 Recognition and motivation of midwives

Participants were also concerned about staff recognition and reward systems. They observed that midwives felt unappreciated, their contributions were ignored, especially when they gave suggestions for improvements in certain areas. Organisations would go a long way in motivating their employees if they are listened to, appreciated, recognised and commended for good work; this is possible through simple gestures such as 'Thank you'.

M 2, FGD 3: "… staffs give suggestions to management but we do not get feedback ... they should implement our suggestions and if they cannot they should tell us…"

A2, FGD 6: "…even they don't recognise the good work. Being told you are doing good work keep it up is motivation enough …"

M5, FGD 1: "something they need to improve is how they treat staff. Nobody listens to us they don't even say we have done good work. We are demoralised."

4.2.10 Collaboration and partnership

This is associated with receiving support from external partners and working with the community to realise the provision of quality health care.

4.2.10.1 Support from external partners

Support from external partners played a big role in the improvement of the facility. Some external partners funded activities such as renovation of the facility and sponsored staff for continuous professional development. Even though partnerships play a significant role in maternal care provision, these partnerships ought to be sustainable and devoid of risks of dependency.

A1, FGD 6 " so our strength and our motivating factor has been like the partners, they have been supportive to health services even maternity side has been actually getting like 100% support from our partners…"

4.2.10.2 Involvement of community

Involvement of the community in the management of the facility ensured that the needs of the general public were considered and that the care provided was responsive.

M3, FGD 1 "also involvement of community in hospital board is good. They tell us their needs and help in decision-making at the facility".

4.3 Phase Two (Dream)

Phase two is the dream phase of Appreciative Inquiry cycle. Findings presented are from six focus group discussions (two with midwives, two with women, one with a mixed group of midwives and women, and one with health service managers) and three interviews with county health service managers. Participants were encouraged to dream guided by the question:

> *Imagine a time in the future when maternity care is at its best in our facility; assuming that all the required resources are available. People look at our hospital as an exceptional example of a thriving, attractive hospital where health care workers and women engage in the hospital's future: in this exciting future, what will be most significant?*

Participants described their views of an ideal maternity setting during which some perceived the dreams to be too ambitious while others expressed the feeling that "dreams are valid". Their dreams were summarised into the following themes: "achieving good maternal and neonatal outcomes", "excellence in service provision", "identity, compassion, dignified, respectful care", " informed women", "choices and cultural sensitivity", "knowledgeable, professional, updated midwives", "recognised, motivated midwives", "continuity of care", "establishment of linkages and stakeholder involvement", "good governance and leadership", "maintained infrastructure with essential departments and clinical resources" and "improved hospital processes and facility".

Table 4.5: Phase two: global, organising and basic themes

Basic themes	Organising themes	Global themes
Live mother and baby(FGD 7,8,9,10,11,12,I1) Reduced morbidities Mortality free	Live mother & baby Reduced morbidity and mortality	**Live mother and baby, achieving good maternal and neonatal outcomes**
Comprehensive care (FGD 7,8,9,10,11,12,I1) Quality, exceptional services (FGD 7,8,9 ,I1) Ensure mothers receive care they require and avoid delays (FGD 7,8,9,10,11,12,I1) Basing care on condition of woman and protocols, policies (FGD 7,8,9,10,11,12,I1)	Comprehensive quality care	**Excellence in service provision**
Application of evidence-based practices/ best practices (FGD 7,8,9,10,11,12,I1) Increased hospital deliveries(FGD 7,8,9,I1) Interventions towards prevention of HIV/AIDS(FGD 7,8,9,10,11,12,I1)	Effective interventions	
Recognition, identity for women(FGD 7,8,9) Prioritisation, attention to women(FGD 12,I1) Women receive care that they require(FGD 7,) Satisfied woman/happy(FGD 7,8,9,12,I1)	Identity in women	**Identity, compassionate, dignified, respectful care**
Good reception (FGD 7,8,9,10,11,12,I1) Orientation of women at facility(FGD 7,12,I1) Compassionate friendly(FGD 7,8,9,12,I1) Ensuring privacy(FGD 7,8,9,10,11,12,I1) Maintaining confidentiality(FGD 7,8,9,10,I1) Tokens/gifts for mothers(FGD 7,8,9,10,I1)	Compassionate, dignified, respectful, care	

Basic themes	Organising themes	Global themes
Health information for women(FGD 7, 10,11,12,I1) Childbirth classes for women(FGD 7, 10,11,12,I1) Women informed on procedures done on them(FGD 7, 10,11,12,I1) Consistency in provision of information(FGD 7, 10,11,12,I1)	Health information Information on procedures done and condition	**Informed women**
Women make choices (FGD 7, 10,11,12,I1) Birthing choices and options (FGD 7, 10,11,12,I1) Male involvement (FGD 7, 10,11,12,I1) Birth companion (FGD 7, 10,11,12,I1) Taboos associated with pregnancy(FGD 7, 10,11,12,I1) Traditional practices related to pregnancy(FGD 7, 10,11,12,I1)	Choices for women Culturally sensitive care	**Choices and cultural sensitivity**
Highly qualified, knowledgeable (FGD 7, 10,11,12,I1) Skilled, updated, experienced (FGD 7, 10,11,12,I1) Continuous professional development (FGD 7, 10,11,12,I1) Opportunities for training (FGD 7, 10,11,12,I1) Maintain professionalism (FGD 7, 10,11,12,I1) Registered by the midwives Council (FGD 7, 10,11,12,I1)	Knowledgeable, skilled, updated midwives Midwives uphold professionalism and regulated	**Knowledgeable, professional, updated midwives**

Basic themes	Organising themes	Global themes
Appreciation and recognition of midwives (FGD 7,8,9,I1) Midwives listened to and their (FGD 7, 10,11,12,I1)recommendations respected(FGD 7,11,12,I1) Promotion of midwives Motivated supported midwives(FGD 7,8,I3) Well remunerated midwives(FGD 11,12,I1) Good work environment (FGD 7,8,9,12,I1)	Appreciation and recognition High staff morale Pleasant work environment	**Recognised, motivated midwives**
Deployment and placement of staff(FGD 7,I1) Good staffing at the facility(FGD 7,8,12,I1) Rationalisation of staff(FGD 7,8,9,I2) Continuity of care(FGD 7,8,9,10,11,12,I1) Provision of care in the community(FGD 11,12,I1)	Adequate staffing and apposite deployment Continuity of care	**Continuity of care**
Working with external partners(FGD 7,8,9,10,11,12,I1) Establishing collaborations(FGD 7,8,9,10,11,12,I1) Involvement of community and political (FGD 7,8,9,10,11,12,I1)leaders(FGD 7,8,9,10,11,12,I1)	Partnership and collaborations Community and political leadership involvement	**Establishment of linkages and stakeholder involvement**

Basic themes	Organising themes	Global themes
Ability to make decisions and act(FGD 7,8,9,10,11,12,I1) Managers who understand their roles(FGD 7,8,9,10,11,12,I1) Provide leadership(FGD 7,8,9,10,11,12,I1) Focused, committed managers(FGD 7,8,12,I1) Approachable managers(FGD 7,10,11,12,I1) Supportive environment(FGD 7,8,9,10, I1) Supportive management (FGD 7,8,9,10,11,12,I1) Shared governance(FGD 7,8,9,10,11,12,I1) Participation forums(FGD 7,8,9,10,11,12,I1) Encourage participation in meetings	Proactive leaders Responsive leaders Participation and consensus building	**Good governance and leadership**
Essential departments(FGD 7,8,9,10,11,12,I1) Spacious facility(FGD 7,8,9,10,11,12,I1) Modern maternity with coded calling system(FGD 7,8,9,10,11,12,I1) Functional maintenance unit(FGD 7,8,9,10,11,12,I1) Well-equipped facility(FGD 7,8,9,10,11,12,I1) Availability of drugs and vaccines(FGD 7,8,9,10,11,12,I1) Good storage and maintenance of supplies(FGD 7,8,9,10,11,12,I1)	Maintained modern infrastructure with essential departments Availability and maintenance of clinical resources	**Maintained infrastructure with essential departments and clinical resources**

Basic themes	Organising themes	Global themes
Integration of services(FGD 7,8,9,10,11,12,I1) Flexible clinic hours(FGD 7,8,9,10,11,12,I1) Reduced waiting time(FGD 7,8,9,10,11,12,I1) Good working systems and environment of care(FGD 7,11,12,I1) Established referral structures and systems Affordable care(FGD 7, 10,11,12,I1) Separation of maternity services (FGD 7, I1) Signage and directions(FGD 7, 10,11,12,I1) Availability of finances(FGD 7,8,9,11,12,I1) Continues water supply(FGD 7,8,9,10,12,I1) Maintenance of hygiene(FGD 7,10,11,12,I1)	Increased efficiency and improved service delivery	**Improved hospital systems and processes**
Use of information technology(FGD 7,8,9,I1) Proper recording and record-keeping(FGD10) Digital records(FGD 7,8,9,10,11,12,I1)	Improved health information systems	
Structured feedback mechanisms(FGD7,12,I1) Continual communication(FGD 7,8,11,12,I1) Suggestion boxes(FGD 7, 10,11,12,I1) Exit interviews(FGD 7, 10,11,12,I1)	Improved communication and feedback mechanisms	

4.3.1 Live, mother and baby, achieving good maternal and neonatal health outcomes

This theme is concerned with the provision of safe care and use of effective interventions to have a live and healthy mother and baby and realise improvement in maternal health through reduction in maternal and neonatal morbidities and mortalities.

4.3.1.1 Live mother and baby

A healthy mother and baby are important outcomes of pregnancy. This will, in turn, lead to joy and celebrations by families and their providers, as is expected in childbirth.

W12, FGD 8: "we will be having mothers delivering and going home with their babies. No mortality."

W2, FGD 8 "… increase in hospital deliveries… increased number of hospital deliveries live mothers and babies…"

M4, FGD 7: "…have a live mother and baby…it feels good to have a live baby and safe mother."

4.3.1.2 Reduced mortality and morbidity

Participants were categorical that the outcomes of pregnancy and childbirth should not be morbidities or mortalities. The desire of participants in the different focus group discussions is reduced morbidities and zero mortality rates. The dream will be realised through improved service delivery leading to improved health and good outcomes.

M 1, FGD 9 "good working systems, zero maternal and neonatal mortality".

M4, FGD 7: "…there will be no maternal or newborn deaths … it feels good to have a live baby and safe mother."

4.3.2 Excellence in service provision

Excellence in service provision would be achieved through the provision of comprehensive quality care and application of effective interventions.

4.3.2.1 Comprehensive quality care

Quality care entails provision of comprehensive care, ensuring the provision of quality exceptional services and ensuring mothers receive the care they require without delays. It also entails basing care on guidelines and policies and the condition of the woman. The desire for participants is to have women receive required care and all procedures done on them in time such as complete antenatal profile care during the first antenatal visit.

A3, FGD 12: "… we will provide comprehensive antenatal care, good delivery care, postnatal services … investigations like when to measure haemoglobin levels, like they do HB [haemoglobin] *at first visit and then done during labour or every subsequent visit regardless of the initial one…because even urinalysis ideally should be done four hourly in labour."*

M 12, FGD 9 "we will observe SOPs (standard operation procedures) to provide quality care when doing procedures isn't it."

M6, FGD 9: "we will continue to offer free maternity services and there will be good policies guiding provision of free maternity care."

4.3.2.2 Effective interventions

The participants foresee a future in which care provided will be safe and, with effective interventions applied, leading to an increase in women seeking hospital births. There will be an application of evidence-based practices in provision of care to the women. Some of the interventions include integration of HIV/AIDS services with maternity care.

M1, FGD9: "M 1: we are applying evidence-based practices ... we shall provide pain relief during labour… food for labouring women, use technology to provide care."

A3, FGD 12 "then also they thought they'd be utilising in future a lot of evidence-based practice which will lead to reduction in morbidity and mortality."

4.3.3 Identity, compassionate, dignified, respectful care

The theme entails identity in women and provision of compassionate, dignified, respectful care.

4.3.3.1 Identity in women

The promotion of the mother identity helps to instil in women that pregnancy and birth are normal physiological processes and help others to realise that women need support to undergo this process successfully. This will be achieved through paying attention to women and prioritisation of their needs and receive the care they require.

W3, FGD 10: "they refer to us as patients but we are not sick. I will like them to refer me as a mother because pregnancy is not sickness."

M3, FGD 9: "…these women are not sick, so we shall provide the services they seek. Pregnancy is a normal thing. It is not sickness."

4.3.3.2 Compassionate care, dignified, respectful care

Compassionate care involves good reception, the orientation of women at the facility, giving women priority, attention, and friendly care that allows women to experience happiness and achieve satisfaction. Orientation of women at the facility is for familiarisation and ease of movement, especially when they come in during labour. Women gave attention to other women through gestures such as surrendering a seat for a pregnant woman and those with small children. Another aspect is there will be tokens and gifts for mothers to facilitate more comfort during and after birth.

W1, FGD 11: "promote a culture that is open ...supportive of relations ... trust ...sense of value and respect for others ... I anticipate I will come here during my delivery ...I hope to be treated well by the nurses, I don't get harassed."

W 12 FGD 10 "I think here protection so far so good is better because at least people even other people consider a pregnant woman. You will find a person saying let me stand up for this lady. We can't complain protection is quite good, we get a seat ... mothers protect each other. They will continue to care about each other. Giving someone a seat and space. Considering someone in need."

W3 FGD 10 "…if you feel yours is not so needy give first priority like those with young babies of less than a month who are there give them a space first."

The respondents dreamt of a future in which privacy and confidentiality would be maintained by screening off examination couches and covering women during examination with minimal exposure of the area being examined. Privacy will also be achieved by minimisation of the number of people in a room during the examination. This is probably because, on some

occasions, there were a lot of students rotating at the facility. They also dreamt of a future in which confidentiality would be maintained; there would be no unauthorised sharing of women's information and reports would be handed over in a private location or room or by the women's bedside.

M4, FGD9 "...maintain privacy, secured room with a lock...Privacy is to make sure that the client is not exposed ... doing examination lock the room no one is coming in".

M5, FGD9: "...you give the report and everybody is listening we usually breach the privacy of the patient that in future we need to have rooms...having a nursing station...every bed will have a screen, nursing station exclusive."

4.3.4 Informed women

The dream phase envisions having women who are well informed on pregnancy and childbirth and receive consistent information on their condition and procedures performed on them and are able to make decisions about their care.

4.3.4.1 Health information for women

Provision of health information to women was thought to be an enabler for decision-making. The information should be provided in an orderly way and through structured means such as childbirth classes so as to capture all aspects related to pregnancy, childbirth and the postnatal period, as well as breastfeeding and family planning and also include all women seeking maternity care.

M1, FGD 11: "During the ANC [antenatal care] visits educate them tell them we encourage you to come with your husband teach them about the care of pregnant mother labour

preparation…birth plan, involves many things, even transport birth plan includes even being ready with the clothes for the baby…"

W 1, FGD 11 "I think on the side of the family planning, the midwife will analyse all the methods of FP to someone who is new or coming for the first time and the nurse should be able to introduce all those methods and be able to counsel the clients about the methods, the consequences and the side effects of those methods of FP …".

A1, FGD12 "that's the only day mothers will get an opportunity to be provided with knowledge supposed to be in our programme… we need to programme…happens sporadically…not in the programme …will strengthen and improve services in maternity, …can be done daily basis or even twice should be daily if you break you can miss some mothers, missed opportunity for mothers."

4.3.4.2 Information on procedures done and condition

This entails having a conversation to ensure that the women are informed and understand procedures carried out on them, have knowledge of the drugs administered to them and on their general status. It also entails women being able to ask questions and get clarifications. The different participants reiterated the need for the provision of accurate information consistently and avoiding or minimising provision of conflicting information from different providers.

W10, FGD 10: "…midwives should inform us on anything they do to us…tell us what drugs they are giving us like during immunisation…they should tell us the injection the baby has been given…am very curious, I have to ask what is it for? …you are told this injection is for this and the other one is for that…not just injected."

M8, FGD 9 "Still reassure the patient... Reassure the mother when you are performing all those procedures or give information ... You're doing well; you're not progressing well because of ABCD…So that the mother knows the things that have been done on her and the results and what she needs to do and so-operative."

4.3.5 Choices and cultural sensitivity

This will be achieved by giving women choices and ensuring culturally sensitive care.

4.3.5.1 Choices for women

The participants dreamt of a future in which women would be given choices on the place and position of birth and other critical decisions at the moment of birth. It also involves women being able to make decisions on the involvement of their partners and birth companions. This is because, in some contexts, as the women participants stated, men/husbands play a big role in decisions regarding pregnancy and birth in households, including decisions on place of birth and are sometimes responsible for paying for costs related to seeking maternity services.

M7, FGD7: "... allow mothers to deliver in their own styles ... adopt position of their choice at birth like ... women to choose knees down, squat."

W3, FGD 10: ... also the choice of a place to deliver is not just for the mothers… our husbands should be involved."

4.3.5.2 Culturally sensitive care

Participants expressed a need for the provision of culturally sensitive care. In this regard, health service providers would understand women's culture, be sensitive to taboos associated with pregnancy and birth and caution women on harmful cultural practices. Women were asked to carry baby clothes to the hospital as part of birth preparation when in labour. In some cultures,

baby's clothes were only bought after the birth and not before the baby was born. This was probably because participants felt that the hospital could provide the clothes for newborns immediately after birth.

W3, FGD 11: "... They need to respect people's culture. You know in our culture, you are not supposed to buy clothes before a baby is born and you see they tell us to come with baby clothes to hospital. Maybe they should be having clothes in the hospital that the baby will wear when born."

4.3.6 Knowledgeable, professional, updated midwives

This entails having competent, knowledgeable, skilled, updated midwives who uphold professionalism.

4.3.6.1 Knowledgeable, skilled, updated midwives

The participants stated that they dreamt of a facility staffed with midwives who are highly qualified, knowledgeable, skilled and experienced. Through opportunities for training and continuous professional development, respondents stated that midwives would provide updated care. This is probably because, for staff to grow professionally, they need some training to improve their knowledge and skills and for personal development.

M 1, FGD 9: "...Because delivery involves a midwife ... We'll have to go to the technical knowhow, the skills. So deliveries will be by a skilled provider"

M 3, FGD 7: "... presence of well qualified, knowledgeable midwives, skills with current update"

M 4, FGD 9: "... then midwives will have gone to school and we will have highly educated, skilled staff"

M2, FGD 11: "...where everyone is updated…all the midwives should be updated through CPD [continuous professional development]*."*

4.3.6.2 Midwives uphold professionalism and regulated

They expect that the midwives will uphold professionalism. Such midwives apply their knowledge and skills and are altruistic, ensuring that women receive compassionate respectful care. Women want to have midwives who will attend to them promptly and minimise socialising while mothers are waiting to be attended to. Participants expect to have midwives who are regulated and uphold the code of ethics of the profession.

W 3, FGD 8, "currently nurses do not attend to clients well. Sometimes they enter into the room and sit and talk or talk on phone for a long time and not attend to us. Why can't they attend to clients first then go and talk their stories later".

M7, FGD 7 "I have the knowledge and skills…have the correct qualifications and belong to… midwives professional council ... so registered at the council as a midwife ... it's sort of there's a sense of belonging somebody said eel…sense of belonging to the profession yes, so when you belong… you do your things professionally…confident and ... self-esteem is just enough…"

4.3.7 Recognised motivated midwives

Recognised motivated midwives will be achieved through appreciation and recognition, high morale and a pleasant work environment.

4.3.7.1 Appreciation and recognition

Participants dreamt of a time when midwives will be appreciated and recognised for the work they do. They expected midwives to be listened to and their recommendations considered. They felt that, when staff recommendations are taken seriously, the staff will feel safe and contented. Midwives dream as a result of recognition they will be part of policymaking decisions.

M 5, FGD 9: "... you know nurses can make things move its only that we are not given opportunity. Midwives voices will be heard"

M5 FGD 7: "…appreciation of staff even telling them you have done well… ok even thank you."

A1, FGD 12: "…another thing our staff will be motivated. We will motivate them through capacity building."

4.3.7.2 High staff morale

Important too in boosting staff morale is promoting staff after they have worked for some time, promoting those who excel at work and providing an environment where staff are settled and relaxed. In addition, their dream is for good remuneration of staff working at the maternity unit and to have the staff provided with special allowances. The participants expect that staff will be motivated through the different measures mentioned.

M2, FGD7 "good staff package paid according to the job… enjoying the benefits…"

4.3.7.3 Pleasant work environment

A pleasant work environment for midwives will be an environment with mutual understanding and working systems. Input from midwives would be considered in such an environment.

M3, FGD9 "relaxed environment …no tension …everybody will want to work here good working systems."

M11, FGD9: "we are having good working relationships among ourselves among other healthcare providers and also good relationships between ourselves and our own clients."

M9, FGD7 "midwives can make things move …not given opportunity to realise our dreams."

M1, FGD7 "we are policymakers as midwives."

4.3.8 Continuity of care

Continuity of care is expected to be achieved through adequate staffing and apposite deployment of midwives.

4.3.8.1 Adequate staffing and apposite deployment of midwives

Participants dreamt of a facility with adequate midwives in all areas and during all shifts to allow for monitoring of women and provision of quality care. This will be achieved through the equitable deployment of midwives to different maternity settings. Having adequate number of midwives will also facilitate supervision of students by experienced midwives during clinical rotations.

M7, FGD 7: "…client provider ratio be 1:2 for close monitoring as in 2 clients and 1 provider for … monitoring and care."

A3, FGD 12: "Another issue with staffing is that staffing is not an issue for the entire county; the only problem is right placement of staff. If you go pick those midwives who are underutilised elsewhere and be brought here that problem will be solved…"

W3, FGD 11: "Maybe when there's a check-up and then when the student nurse cannot hear the heartbeat or things like that so then there is no one around to confirm it is not good. Students should not be left to work alone."

4.3.8.2 Continuity of care

The current arrangement facilitates continuity of care with a woman likely to meet the same midwife any time they seek services. The participants desire an extension of these services to the community where some maternity services can be provided at a woman's home or in the community. This is probably because health service providers will be able to assess the environment where women live and advise them accordingly.

W8, FGD 10: "actually it will be better if midwives would be coming let's say they set a day maybe say such and such a day we are coming to such and such an area.... mothers wait then weigh your children in the house… this will reduce congestion."

4.3.9 Establishment of linkages and stakeholder involvement

This theme involves building partnerships and collaborations and involvement of the community in decision-making and activities at the facility.

4.3.9.1 Partnership and collaborations

The theme partnership and collaborations entail working with external partners and building of collaborations. The participants aspired to network and collaborate with different stakeholders to achieve the vision of their facility. They stated that external partners would be able to support certain activities, such as having a comfortable environment for women seeking services by constructing shades and benches.

M 4, FGD 7: "… we will network and collaborate with stakeholders to achieve our vision…"

A2, FGD12: "…we can do through our partners …it's not something that will need much that's not going to be very costly …through partners we can do something small …the partners we can convince even for the shade and the benches."

4.3.9.2 Community and political leadership involvement

Participants also envision involving the community in decision-making. They also stated that political leaders would be engaged in the formulation of good health care policies.

W2, FGD 10: "Involvement of ... community members in decisions of the hospital."

M1, FGD 9: "talk to the politicians to make good policies and increase funding for maternity."

4.3.10 Good governance and leadership

This theme is concerned with proactive responsive leaders who embrace participation and consensus-building. This kind of leadership is expected to guide the realisation of the vision for an ideal facility.

4.3.10.1 Proactive leaders

Participants dreamt of a future where they will have leaders who understand their roles and provide leadership. Leaders, who are focused, committed and are able to make decisions. Such leaders are able to identify areas of improvement, and liaise with different departments to initiate actions for implementation and mitigate challenges.

A2, FGD 12: "I will be providing leadership and requesting for staff you know when you talk about staffing, it's enough midwives per shift, frequent CMEs [continuous medical education] for update, capacity building, and encouraging teamwork."

M2, FGD 9: "we will be liaising with DHMT [district health management team], reproductive health coordinators and county HMTs [health management teams] to ensure proposals have been fulfilled to maintain the service and to achieve excellent services …"

4.3.10.2 Responsive leaders

The respondents also envisaged that there would be a respected chain of communication across all sections of the entire facility. The anticipation is to have leaders who are approachable. Midwives felt frustrated whenever they communicate to management and across departments and receive no feedback. Thus, the desire to have managers who are sensitive to employee needs, understand and listen to their concerns.

A2, FGD 12: "Unless there's another way of communication otherwise if it's writing letters and visiting them, we've done of course we cannot go to the governor…we start from the executives … written so many letters … we have challenges … Our dream will be action once a request has been made".

4.3.10.3 Participation and consensus building

An important aspect of participation and consensus building is the involvement of staff in decision-making. Such involvement could be achieved through forums in which managers and staff discuss different issues. In the forums, the health service managers would empower and support facility managers to plan and implement decisions. Midwives envisaged a time when they would have opportunities to be supervisors and managers and therefore be in a position to design and implement policies. Responsive leaders are expected to create mechanisms to receive feedback from women through well-established feedback mechanisms.

A3, FGD 12: "… there is provision for maybe something from policy-making department to be joining us in meetings so that they can get the feeling of the concerns … we will need some support from the county."

A4, FGD 12: "… we need somebody who's so fast in getting to hear our views and of support… people who can move things actually implements suggestions … Supportive management. You see now if the management was supportive, they would buy the things that are not there like these things you've said that we need equipment."

4.3.11 Maintained infrastructure with essential departments and clinical resources

This theme relates to maintained modern infrastructure and working systems, with clinical resources to include equipment, drugs and commodities.

4.3.11.1 Maintained modern infrastructure with essential departments

This relates to physical infrastructure, essential clinical departments and functional maintenance units. The facility will be well designed with all the essential clinical departments such as a functional surgical theatre and a well-equipped laboratory installed with an automated communication system. They expect to have a functional maintenance unit. Participants dreamt of a modern maternity unit with the capacity to accommodate a large number of women and a large waiting bay with a good relaxing ambience. On reflection, women spend a lot of time at the facility when they attend the clinic and thus desire to have a comfortable sitting area as they wait to receive services. This facility will have designated areas for mothers and babies. The participants also desired to have a facility with a cafeteria. A cafeteria will be helpful to women

and those accompanying them who have travelled far and have to eat and will also be helpful to staff.

W2, FGD 10: "create more labour wards for mothers to deliver ...sufficient enough to hold mothers at least say twenty-five (25) at a time."

M3, FGD 11: "...there is no place for staff to eat food...in the future we will have a staff cafeteria, even a place where staff will sit down and have tea... right now we take tea here in front of mothers."

Comfort will be assured through the provision of care to women in a serene mother baby-friendly environment that is spacious and has good ambience. The expectation is to have a bigger waiting bay where women can relax as they wait for care.

W11, FGD 10 "when we come to the clinic, we take time to relax here... as a mother we run up and down to be honest, we move a lot from one place to another being a working mother you are expected to deliver at work, ...baby is here when you arrive at the hospital you realise that I need to sit and relax...you realised that there's congestion, ...then maybe the place is not even conducive, So a bigger room, a bigger waiting bay clean surfaces that we can even put down the baby... a place for mothers and babies to be a bit separate ... then children side to have a baby like colourful area..."

W 1, FGD 10 " ... maybe a place for mothers and babies to be a bit separate not as it is now you know now is a bit congested. I was saying mothers and babies are going the other side then pregnant mothers going the other side then children the other side have a baby like colourful area you know such like thing it will be a better place."

W2, FGD 11 "…our children will be playing with toys floor will be clean…children will not pick any illness or anything."

4.3.11.2 Availability and maintenance of clinical resources

Participants visualised a facility that is well equipped to facilitate the provision of care and facilitate early accurate diagnosis. Drugs and supplies were considered key to the provision of effective maternity services. Participants wanted a record of all drugs and supplies to be kept and the stock maintained and to ensure that orders are made in advance to ensure consistent supply. They also dreamt that there would be good storage and maintenance of supplies.

A3, FGD 12: "…the hospital will have necessary equipment for ANC [antenatal clinic], *labour, postpartum…fully equipped maternity wing with an ultrasound machine, a Doppler machine ... we will have structures that will enable us diagnose early foetal distress, we shall have diagnostic equipment."*

M2, FGD 7: "…drugs will be available ... essential drugs and vaccines, the facility will be well-stocked ... Stocktaking ... proper storage …if you mix and in case of emergency you don't have to start looking for things ... arrangement of the whole store ... arrangement of supplies."

4.3.12 Improved hospital systems and processes

This theme relates to increased efficiency and improved service delivery and improved communication and feedback mechanisms.

4.3.12.1. Increased efficiency and improved service delivery

The research participants dreamt of a facility with increased efficiency, good working systems and a caring environment, flexible clinic hours, reduced waiting time, integration of maternity

services with other services, good referral systems and structures with functional ambulances. In this future, there will be coordination between the referring and receiving facility. With improved hospital processes and facilities, the participants stated that women would have more confidence in the hospital with a good reputation, leading to increased demand for maternity services. In the end, the hospital will serve as a reference centre of excellence.

M5, FGD 11 "…many mothers will be coming to deliver at our hospital; we shall fly high like eagles."

M6, FGD 7: "…we will be a reference centre it's like go there and compare, people will come to benchmark from us…it will be a model hospital; you know reference centre is …a model."

A3, FGD 12: "Where to refer…don't just refer anywhere…referring from a lower to a higher specialised facilities and also we have their contacts… referral forms… so which also means responsive documentation during referral."

Another aspect in improved service delivery will be clear directions and signage and well-designed flow to facilitate women access of services and minimise delays, leading to a reduction in waiting time.

W1, FGD 11 "…focusing on signs for direction so a client knows where services are offered … It should be like a supermarket, one-stop-shop when I want a shoe, I'll just see the Bata point (example of a shoe shop in a supermarket*) … also desk for customer care whereby they could give direction."*

Participants desire a consistent water supply and a clean and safe environment. Maintaining cleanliness at the facility will require collective responsibility and the introduction of a cleaning

schedule and close supervision. In addition, their desire is to have good plumbing, adequate toilets and effective waste disposal and sanitation.

W5, FGD 11: "…there will be a place for washing hands… Alternatively if they cannot put the tap right away they put the jerry can thing put the tap so that someone just re-fills it…"

4.3.12.2 Improved health information systems

Participants dreamt that in the future, advanced information technology would be embraced to facilitate efficiency and ease of delivery of services. This will also ease documentation, storage, accessibility and retrieval of records.

M7, FGD7: "…digital records …there at family planning, MCH (maternal child health) …if I want to take history of ANC (antenatal care); I just open her profile by pressing on a button …"
M3, FGD9: "with computers we do not need observation charts; we can record in a computer immediately after performing observations…"

4.3.12.3 Improved communication and Feedback mechanisms

Provision of feedback by the women to the midwives and health service managers was critical in maternity services. Structured feedback mechanisms, such as the use of suggestion boxes and exit interviews for women who receive services at the facility, were important to identify areas of good performance as well as address concerns.

M3, FGD11: "there will be suggestion boxes to give feedback… one for both complaints and compliments ... one will write everything that she didn't like about the services there."

4.4. 0 Phase Three (Design)

Phase three is the "design" phase of the Appreciative Inquiry cycle. In this phase, three focus group discussions were held, two with midwives and one with the women respondents. Data from the interviews with health service managers are also included. Phase three began by sharing the main findings from phases one and two, which set the foundation for further discussions. Participants took time to reflect on their dreams and experiences that generated high points and identified key aspects to be included in the model. During the first focus group discussion with midwife participants, there was a consensus that the proceedings be recorded on a flip chart. At the end of the session, participants still asked to be given more time to reflect on what more needed to be included. Their inputs were analysed and included in this dissertation as *"Ms, FGD 13"* data. Participants also reviewed the statements constructed from the Human Scale Development nine axiological and four existential matrices.

4.4.1 Phase Three Themes

After going through the Appreciative Inquiry process, participants expressed excitement during the "design" phase as they discussed aspects to be included in the model. This culminated in the following themes: "building of relationships", "effective communication", "identity and personalised responsive care", "defined roles, teamwork and professionalism", "experienced focused leaders", "spacious comfortable well-maintained facility with adequate resources", "professional regulated motivated midwives", "maintained health information systems", "good outcomes", "continuity of care" and "improved effective systems".

Table 4.6: Phase three themes

Basic Themes	Organising Themes	Global Themes
Cooperation (FGD 13,14,I3) Love for one another(FGD 13,14,15) Appreciation of each other (FGD 13,15, I1)	Demonstration of hospitality	**Building of relationships**
Free environment of sharing and airing views (FGD 13,14) Embracing ethnic diversities(FGD 13,14,15,I2) Partner involvement(FGD 13,14) Cultural sensitivity(FGD 13,14,I2,I3)	Respect for diversity and cultural sensitivity	
Good communication (FGD 13,14,15,I1)	Good communication	**Effective communication**
Structured communication mechanisms(FGD 13,15) Installed feedback mechanisms(FGD 13,I3)	Structured feedback mechanisms	
Individualised attention (FGD 13,14,15) Ensuring privacy(FGD 13,14,I2) Maintaining confidentiality (FGD 13,14,15)	Personal attention and dignified care	**Identity and personalised, responsive care**
Health information to women(FGD 13,14) Information package for women (FGD 13,14,15,I1)	Informed women	
Clear definition of roles(FGD 13,14,15,I1) Professionalism(FGD 13,15,I2,I3)	Defined roles and professionalism	**Defined roles, teamwork and professionalism**
Teamwork (FGD 13,15,I1,I2) Collegiality(FGD 13, I2,I3)	Teamwork and collegiality	
Trained in leadership(FGD 13,14,15,I3) Flexible and embrace talent (FGD 13,I3) Continuous professional development on leadership (FGD 13,14,I3)	Leaders with management skills	**Experienced focused leaders**
Scheduled regular meetings(FGD 13,I1,I3) Supportive supervision(FGD 13,15,I1,I2)	Supervisory visits	

Basic Themes	Organising Themes	Global Themes
Spacious facility(FGD 13,14,15,I3) Warm environment (FGD 13,14, I1,I3) Ensure adequate supplies and equipment (FGD 13,14) Ensure availability of drugs (FGD 13,14,I3) Clean environment(FGD 13,14,15,I3) Good ventilation(FGD 13,14,15,I3) Availability of water consistently(FGD 13,14)	Spacious warm maintained environment Availability of equipment, supplies and drugs Good sanitation and consistent water supply	**Spacious comfortable facility with adequate resources**
Knowledgeable, skilled providers(FGD 13,15,I3) Professional(FGD 13,14,15 ,I3) Regulated midwives(FGD 13,I2,I3) Good midwife woman ratio(FGD 13,15) Human resource policies(FGD 13,14,15,I3)	Knowledgeable, skilled, regulated Adequate staffing and human resource policies	**Professional, regulated motivated midwives**
Use of information technology (FGD 13,14) Maintaining records electronically (FGD13,15)	Use of information technology Maintenance of health records	**Maintained health information systems**
Well mother and baby(FGD 13,14, I2) Live mother and baby (FGD 13,14,15,I1)	Well mother and baby Live mother and baby	**Good outcomes**
Continuity of care(FGD 13,14,15,I3) Continuous presence of midwives(FGD13) Presence of different cadre of staff and specialists(FGD 13,I1,I2)	Continuity of care Continuous presence of midwives supported midwives	**Continuity of care**

Basic Themes	Organising Themes	Global Themes
Provision of good service (FGD 13, I3) Prompt provision of care (FGD 13,14,15) Well-designed flow of women (FGD 13,I2) Use and observe SOPs (FGD 13,I2,I3) Achieve ISO certification (FGD 13,15) Provision of services all day 24 hours (FGD 13,14,I3)	Timeous delivery of services	**Improved effective systems**
Community outreaches (FGD 13,14,15) Working ambulance (FGD 13,14,15,I1) Defined referral structures (FGD 13,I2,I3)	Strengthened referral systems	

4.4.1.1 Building of relationships

The theme building of relationships relates to the demonstration of hospitality, respect for diversity and cultural sensitivity.

4.4.1.1.1 Demonstration of hospitality

Demonstration of hospitality will be expressed through good reception, cooperation, appreciation and love for each other, respect and courtesy. Midwives brainstormed on ways they demonstrated hospitality, and they stated that they had initiated the creation of a customer care desk.

Ms, FGD 13: "*good customer care, provision of dignified care, we attend to clients in a friendly manner and good attitude towards clients…"*

W 11, FGD 14: "Sometimes those coming to antenatal clinic for the first time and arrive late; they need to be told in a good way importance of coming early and no need of shouting at them. They need to talk to the mothers in a good way instead of shouting at them".

4.4.1.1.2 Respect for diversity and cultural sensitivity

Respect for diversity will be expressed through sensitivity to the needs of the women and their culture. In addition, it will be achieved through individualised attention to women who give birth at the facility and creating a free environment for airing views.

Ms, FGD 13: "…culturally acceptable care [voices of the mothers] listening to mother's view regarding their cultural practices and encourage mothers to practice what is not harmful to their health and that of infants."

According to the participants, contribution to Human Scale Development existential matrices of protection, affection and participation and the building of relationships will be achieved through positive criticism, recognition, reassuring, praising, smiling, explaining, using kind language and creating rapport. It also involves the expression of love, good morals, caring attitudes, kindness, gentleness, being supportive, social, understanding, good listener, good etiquette, and being emphatic.

4.4.1.2 Effective communication

Effective communication will be achieved through good communication and effective feedback mechanisms.

4.4.1. 2.1 Good communication

Participants recognised that responsive communication is necessary. This can be achieved through structured communication channels for the free flow and exchange of information and obtaining feedback. Participants expressed the need to have effective media or means for communication through the installation of phones for ease of communication and consultation between different departments at the facility, internal networking and structured communication through memos.

Ms, FGD 13: "...Availability of a communication pool with extension to all departments. Internal networking (install) phones in hospitals for easy verbal communication to avoid officers moving from place to place for help in terms of advice ... Relay of information to all staffs effectively to make work easier. Use of memos, reports, meetings, noticeboard."

4.4.1.2.2 Structured feedback mechanisms

Structured feedback applies to feedback among midwives, with other health care providers and with health service managers. It also entails feedback with women and other external stakeholders. Use of suggestion boxes and exit interviews were seen as a means to obtain feedback from women on the care they receive.

Ms, FGD 13: "…suggestion box, patient feedback and other channels effectively".

4.4.1.3 Identity and personalised, responsive care

Personalised, responsive care relates to personal attention and dignified care and informed women.

4.4.1.3.1 Personal attention and dignified care

Participants expressed the need for midwives to take time to listen to the women's needs. They also expected to be treated well, not shouted at and be communicated with effectively. Critical in dignified care is maintaining privacy and ensuring confidentiality.

Ms, FGD 13: "…Privacy and confidentiality individual counselling to mothers to help to overcome social stress."

M 9, FGD 14: "a private place that you can tell the doctor your problems. You know when we are many in a place; we are not able to tell the doctor our problems so it is good when there is some privacy".

4.4.1.3.2 Informed women

Participants expressed the need for defined packages such as brochures and information communication materials on services provided at the facility. Provision of information on the

progress of a pregnancy, labour and procedures done on women was re-emphasised. Providing information is critical as it empowers women to make decisions on their health and care. It also instils in them confidence and trust in their bodies. Outreach services were also found to be an important means to provide health information.

Ms, FGD 13: "women able to make decisions, women have confidence in their bodies and able to birth naturally... Individual counselling to mothers to help to overcome social stress."

M2, FGD 15: "good communication to the mother on the progress of labour, provide comprehensive report to clients and communication of findings to clients…"

4.4.1. 4 Defined roles, teamwork and professionalism

This theme entails defined roles and professionalism and promoting teamwork and collegiality.

4.4.1.4.1 Defined roles and professionalism

Defined roles and professionalism requires each midwife and other healthcare professionals to understand their roles clearly and to uphold professional standards and codes of ethics during provision of care.

Ms, FGD 13: "Professional, uphold professional code of conduct, respect women and work within their scope of practice".

4.4.1.4.2 Teamwork and collegiality

This requires each team member to take up their role with commitment, cooperation and a positive attitude, even in times when the workload is high. It also involves an environment where everyone has an opportunity to share his or her views freely and respect other's opinions and embrace collegiality.

Ms, FGD 13: "good interpersonal relationship, with supportive peers and collegial relationship…teamwork… have cooperation among co-workers, and cultivation of a non-discriminative environment …have love for another…"

4.4.1.5 Experienced, focused leaders

Experienced focused leaders are leaders who are visionary and can make decisions and support staff to ensure the provision of quality services.

4.4.1.5.1 Leaders with managerial skills

The theme is concerned with having leaders with the requisite management skills, clear strategic priorities and who are supportive to team members. Such leaders have good values, are appointed competitively and on merit, vetted and trained in leadership. Leaders who are appointed based on capability and can perform tasks such as planning, budgeting, organisation, delegation and supportive supervision. Leaders who update their leadership skills are focused and have clear priorities communicated to the team members. They value staff and utilise participatory approaches in decision-making. Midwives felt that they understood the system well and were in a position to contribute to areas of improvement based on what they have been doing best.

Ms, FGD 13: "visionary, transformational leadership, committed to God and the people …Trained in leadership/ Continuous professional development on leadership, vetting of leaders before appointment, avoidance of political influence in appointment of leaders".

4.4.1.5.2 Supervisory visits

Regular meetings and support supervision are critical in measuring performance and ensuring that challenges are resolved. According to findings from the Human Scale Development category

of interaction, a midwife should interact and associate freely in a safe environment with supportive colleagues and supervisors. In such an enabling and caring environment, a midwife is expected to be self-driven, uphold high standards of morality and exercise a reasonable degree of independence and be able to make decisions, plan care, make choices in the interest of women and follow laid-down procedures, rules and regulations.

Ms, FGD 13: "support supervision by internal and external supervisors and holding regular monthly meetings…empower and support staff to make decisions that influence how they run the facility and allow for funding decisions kept close to practice."

4.4.1.6 Spacious, comfortable facility with adequate resources

Spacious, comfortable facility with adequate resources deals with a spacious warm maintained environment, availability of equipment and continuous supply of drugs and commodities and good sanitation and consistent water supply.

4.4.1.6.1 Spacious, warm maintained environment

A spacious, comfortable facility entails a modern maternity unit with all essential departments and the capacity to accommodate a large number of women. The departments include labour and birth units, theatre, laboratory and newborn units. Such infrastructure should be adequate to provide for a large waiting bay, a separate place for mothers and babies, a changing area for babies, a clean and neat playground and a restaurant for staff and women. Another important aspect is ensuring the maintenance of infrastructure and renovations being done when necessary.

Ms, FGD 13: "...expand facility through construction to accommodate the necessary departments and provide more space to accommodate more clients, spacious working

room…identify an area that can be established to be a theatre to be able to perform caesarean section and manual removal of placenta."

4.4.1.6.2 Availability of equipment, supplies and drugs

Adequate resources entail a facility that is well equipped with the necessary laboratory, diagnostic and resuscitation equipment. A facility with good storage of supplies and maintenance of stock to ensure that there is a consistent supply of drugs and commodities. It is also supported with systems of tracking and ordering of supplies ahead of time before they are exhausted.

Ms, FGD 13: "…availability of modern equipment and other working resources, availability of supplies and drugs, e.g. iron/folate supplements."

According to findings from the Max-Neef axiological category of interaction, necessary resources are required for optimal performance, namely, equipment, materials and supplies, monitoring and reporting tools, partographs and adequate staff. With the necessary tools, midwives will be able to provide care and assist with births.

4.4.1.6.3 Good sanitation and consistent water supply

Another important aspect is ensuring good sanitation and proper waste disposal. This is because participants felt that there was a need to segregate waste and dispose of it appropriately. Participants stated that maintenance of hygiene would be achieved through making hand washing facilities available, cleaning toilets regularly and having a cleaning schedule.

Ms, FGD 13: "consistent supply of running water, functional incinerator, availability of cleaning equipment and good ventilation…prevent cross-infection through hand washing;

donning protective wears and disinfection…clean toilets regularly and check hourly to ensure toilets are clean

M1, FGD 15: "maintain cleanliness, observe infection prevention practices and maintain high standards of hygiene…"

According to the research findings and in line with the Max-Neef model, health care interactions should happen in a clean, good, conducive work environment, be it in the wards, clinics, community centre or the woman's' homes.

4.4.1.7 Professional regulated motivated and supported midwives

This theme relates to having midwives who are knowledgeable, skilled, updated and regulated. It also entails adequate staffing and the use of human resource policies to guide deployment.

4.4.1.7.1 Knowledgeable, skilled, regulated midwives

The study indicates the need for competent midwives who demonstrate proficiency in the application of skills to achieve accuracy. A midwife who updates knowledge and skills through continuous professional development to remain competent to provide care and attend to obstetric and neonatal emergencies. The participants further stated that a midwife should be able to explore, interpret findings, provide solutions, review and learn. The participants also stated that midwives ought to demonstrate an understanding of their roles and aspects of women's health by performing accurate assessments and examinations, providing quality care, good documentation of findings, writing reports, reflecting, obtaining information, making decisions, conducting research and providing health information to women.

Ms, FGD 13: "continuous professional development through seminars, workshops and scientific conferences…targeted to areas of specialisation to help nurses' competency, career development and clinical practice."

Data from the Human Scale Development axiological matrix of understanding, illustrate that a midwife should be educated, competent, innovative, creative and non-judgmental. In the category of creative, a midwife is required to be experienced, observant, curious, optimistic and confident and have a zeal for work. Creativity is also achieved through luck and challenges that drives change. Creativity requires a midwife to identify opportunities to sharpen skills.

The study also recognises the need for a well-regulated midwife who is protected by law and has the autonomy to practice as a midwife and demonstrate expertise in his or her work. In the Human Scale Development axiological category of protection, a person is legally defined as a midwife because they have the right competencies to practice as a midwife, is accountable and licensed to practice. The very identity of midwives entails belonging to a professional association and being registered by a regulatory body.

M2, FGD 15: "Control of midwifery practice, clinical autonomy and recognition of midwife's clinical competency…providing them with practice licence as well as legal and policy framework."

4.4.1.7.2 Adequate staffing and human resource policies

Another aspect of resources is staffing. Participants stated the need for adequate staffing at the facility to ensure a good midwife to woman ratio. They stated that a midwife is a member of a team of other health care providers with expert clinical skills such as medical doctors, obstetricians and gynaecologists who will perform specialist and other non-midwifery roles.

M5, FGD 15: "…adequate midwives during each shift…good client-provider ratio… to facilitate close monitoring of women in labour and also provisions for supervision of students by qualified staff."

Ms, FGD 13: "knowledgeable, skilled staff, specialists such as gynaecologists… should be available as per service need…definition of roles of different professional and effective communication between the officers…midwives, other health workers and staff, administration, community, community leaders and women will work together to achieve quality care."

W 5, FGD 14: "another thing apart from pregnancy services, there should be a doctor to see sick mothers. Like today I am going and nobody has asked me whether I have any other problem….you know you could be pregnant but also one could be having other problems they want to express but no opportunity to. Like today I have a headache and nobody asked me anything"

The participants further stated that staff would be well supported with human resource policies that clearly define procedures for handling staff such as transfers from one facility to another and competitive remuneration. This, they said, will help minimise high staff turnover. They further stated that the facility's workforce would be provided with opportunities for growth, recognition and reward for outstanding performance to boost morale.

FGD 13: "motivated staff provided with opportunities for growth, good remuneration recognition and acknowledgement for outstanding job done and reward good performance."

According to data from the Human Scale Development matrices, a midwife is an active team member and should be willing, available, observant, friendly, positive, cooperative and

motivated. This midwife will exhibit participation through sharing of tasks, reporting on duty as scheduled, communicating effectively, criticising, consulting, discovering and participating in team activities.

According to findings from the Max-Neef axiological category of interaction, midwives interact with various people at work, professional and social forums, conferences, meetings and at the regulatory body. The participants stated that there would be a room where staff can take a break to re-energise before going back to work.

The participants also said it was important to plan for breaks or idle times. They said that such breaks would help midwives to be more creative, to explore, improve their passion and curiosity and be able to manage time.

4.4.1.8 Maintained health information systems

This entails the use of information technology and maintaining electronic records.

4.4.1.8.1 Use of information technology

The study further proposes the use of information technology to ensure efficiency. Participants stated that there was a need to design various electronic tools to be used for planning, organising, implementation, record-keeping and monitoring and evaluation purposes at the facility.

Ms, FGD 13: "use of electronic gadgets like computers, mobile phones in patients cares…tele-medicine… Communicate to the client/patient even at home using phones .e.g. remind him/her TCA or even any other management like drugs…Evaluation and monitoring services rendered using the reports stored in the computer ... Guides also on how to plan, organise and implement to achieve the goals set by the department or facility".

4.4.1.8.2 Maintenance of health records

Maintenance of health records was found to be important for continuity of care. Participants reiterated the need to have women's records kept well for monitoring and future reference.

Ms, FGD 13: "…design various record tools, including reporting tools, referral forms, and ensure good record-keeping".

4.4.1.9 Good outcomes

This relates to having a well and live mother and baby.

4.4.1.9.1 Live mother and baby

What came out clearly in the different phases of study was the outcome of a live mother and baby. Participants stated that the main goal for maternity care is a live baby and a healthy mother.

Ms, FGD 13: "…good handling of emergencies or something like that or prompt… have good outcomes … exciting when mother and baby are well".

4.4.1.10 Continuity of care

Central to woman-centred care is continuity of care which is dependent on adequate staffing and appropriate deployment of midwives.

4.4.1.10.1 Continuity of care

Central to the building of relationships is when the midwife and woman are known to each other in the continuity of care arrangements and can build trust with each other.

Ms, FGD 13: "…Client/patient care is continuous, can refer to the better-improved services or even to the community, society through the social groups, e.g. women's group, community health workers, youth".

4.4.1.10.2 Continuous presence of midwives and other staff

Participants expect to have a continuous presence of midwives at the facility and minimisation of frequent transfers of midwives from one facility to another. Continuous presence also requires the facility to have an adequate number of midwives and other health care providers to support them.

Ms, FGD 13: "... Adequate staffing ... Punctuality, reporting on time and leaving on time and staff are always present on duty."

4.4.1.11 Improved effective systems

Improved effective systems include timeous delivery of services and strengthened referral systems.

4.4.1.11.1 Timeous delivery of services

This theme relates to the efficient delivery of services through the prompt provision of care, well-designed clear flow of women and use of protocols and guidelines. The study proposes provision of maternity services 24 hours a day, seven days a week and outreaches at the community to achieve continuity of care.

I 2: "from the entrance, I should have a direct way… mean entrance route and exit. An area where an ambulance can come in without obstruction and offload with a reception area…"

Ms, FGD 13: "starting and ending clinic in good time, providing 24-hour service and flexible clinic hours… ensure prompt service delivery through use of queues and first come first serve basis to improve on waiting time so mothers can be satisfied and seek services…client/patient care is continuous, can refer to … to the community, society through the social groups, e.g. women group, community health workers, youth."

M 4, FGD 15: "because of the rules MCH/FP clinics run only weekdays, but you find that even our mothers work and weekend is the only time they find to come to the clinic. So I feel I support her that we should be having those clinics if there's a way that they can make it run over the weekends and even after five so that we capture mothers who work the other days".

The study identified that protocols and guidelines would guide the provision of care. Data captured using Max-Neef matrices also indicate that a midwife must abide by the standard operating procedures, guidelines, policies and procedure manuals of the facility.

Ms, FGD 13: "organisational structure, implementation of targeted measures and continuous monitoring and evaluation…design and avail guidelines and standard operational procedures in different areas of work…develop strategic and operation plans and initiate ISO certification measures for the facility."

4.4.1.11.2 Strengthened referral systems

Participants observed that strengthening of existing referral systems requires good management of women before and during referral, availability of functional ambulance that is well equipped and staffed by personnel who can handle emergencies, effective communication and good interpersonal relationships between the staff at the referring and receiving facilities.

Ms, FGD 13: "good referral system in place, well-documented referral forms…availability of ambulance services and a driver within the hospital, ambulance fully equipped with first aid equipment, e.g. oxygen…referral nurses or paramedics trained on how to do resuscitation should always be in the ambulance."

M3, FGD 15: "well-defined pre-management before referral, the referral officer should know / or should be conversant with the patient he or she is referring."

4.4.2 Development of the model

All the global themes from phase one to phase three were looked at and then similar themes grouped together that culminated to the components that formed the model. After arranging the first letter of all the components, UPENDO was coined. At first, the model was presented without the S and participants felt that supportive leadership is a key element and pillar and aspects of leadership that had been included in the organisation of care were separated and stood independently. This then resulted into the coining of the mnemonic UPENDO-S, which represent: User-friendliness, Person (woman)-focused care, Excellence in evidence-based practice, Networking, Dedicated supported midwives, Organised care and Supportive leadership. The term *UPENDO* means 'love' in the Swahili language. Participants deliberated on the representativity of the term UPENDO-S and reached agreement that it was representative.

4.4.2.1 User-friendliness (U)

User-friendliness 'U' is the first pillar of the UPENDO-S model. The components of User-Friendliness emerged in the three phases of the study. It entails personalised, responsive care,

live and well mother and baby, efficiency and timeous service delivery, effective, responsive communication and compassionate, respectful care.

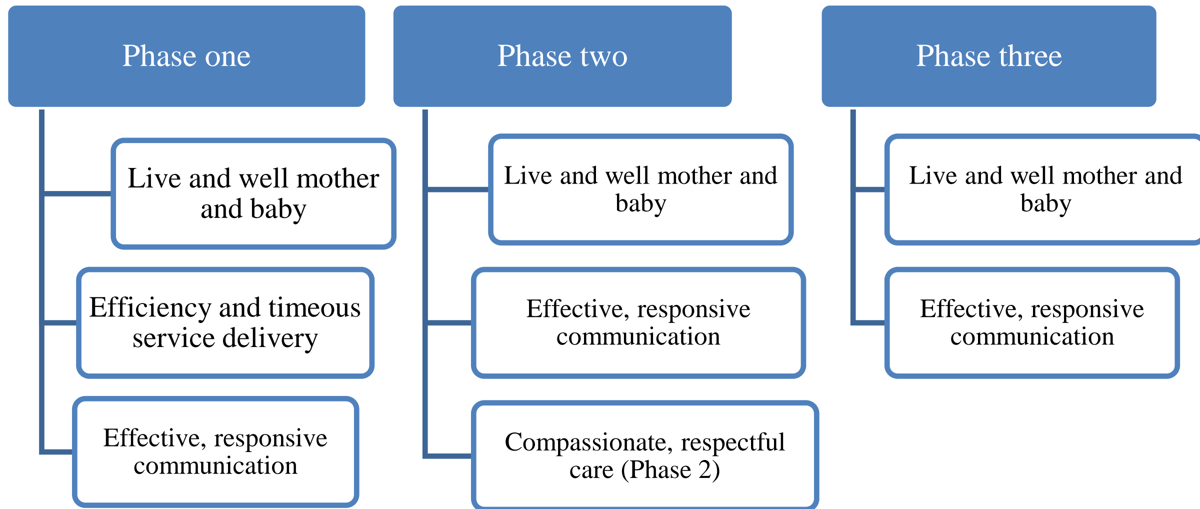

Figure 4.2: Illustration of themes in the category of User-friendliness.

A living and well mother and baby is the ultimate outcome during pregnancy and childbirth. Key to in user-friendliness is personalised responsive care with the woman receiving the care she requires. User-friendliness requires efficiency and timeous provision of care. The model proposes this can be achieved by ensuring that services are available at the facility, astute design of systems to reduce waiting time and speedy referral in occasions that services cannot be provided. User-friendliness can also be achieved through provisions of directions and signage at the facility to ease the accessibility of services.

Flexible clinic hours to include the provision of maternity services after 5 pm on working days and over weekends and public holidays are also part of efficiency. Efficiency will, in the long run, lead to excellence in the provision of care thereby improving the reputation of the hospital,

increasing demand for care, and leading to the hospital being a model facility that serves as a centre of excellence. User-friendliness also entails provision of services at a place considered convenient by the woman, including at her home or in the community and includes use of mobile clinics.

Another aspect of user-friendliness is responsive communication through structured verbal and written communication channels such as customer care desks and brochures to communicate on services available. Another aspect of responsive communication is receiving feedback from women, colleagues and managers.

Finally, provision of compassionate care in user-friendliness would be achieved through the provision of dignified care, expression of appreciation and courtesy, presence of friendly providers, comfortable environment of care and orientation of women to the facility. User-friendly care also ensures comfort, privacy and confidentiality for women.

4.4.2.2 Person (woman)-focused care (P)

The P in the UPENDO-S model stands for a person (woman)-focused care. Person (woman)-focused care considers women central to maternity services. Identity of the woman is critical as it recognises a woman undergoing normal physiological processes and not as a patient with an illness. The woman’s individuality is embraced and personalised and responsive care provided. Understanding of the woman requires building of relationships and providing women with information to enable them to direct decisions on their care and support cultural sensitivity. Cultural sensitivity entails midwives being able to identify cultural practices upheld during pregnancy, discouraging women against harmful cultural practices and supporting useful ones.

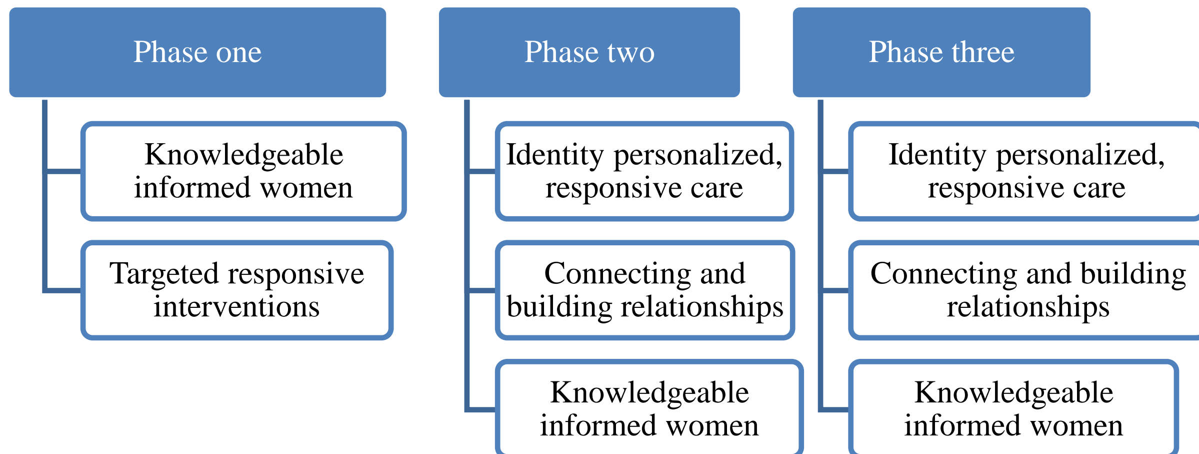

Figure 4.3: Illustration of themes in person (woman)-focused care category.

4.4.2.3 Excellence in evidence-based practises (E)

The E in UPENDO-S stands for excellence in evidence-based practises. This entails continuity of care, good maternal and neonatal outcomes, targeted responsive interventions, application of evidence-based practices and excellence in service provision.

According to the model, excellence in the provision of care involves the provision of a wide range of services, including comprehensive care based on protocols, the condition of the woman and observation of standard operating procedures. Excelling in evidence-based care will lead to favourable outcomes such as an alive and well satisfied mother and alive and well baby.

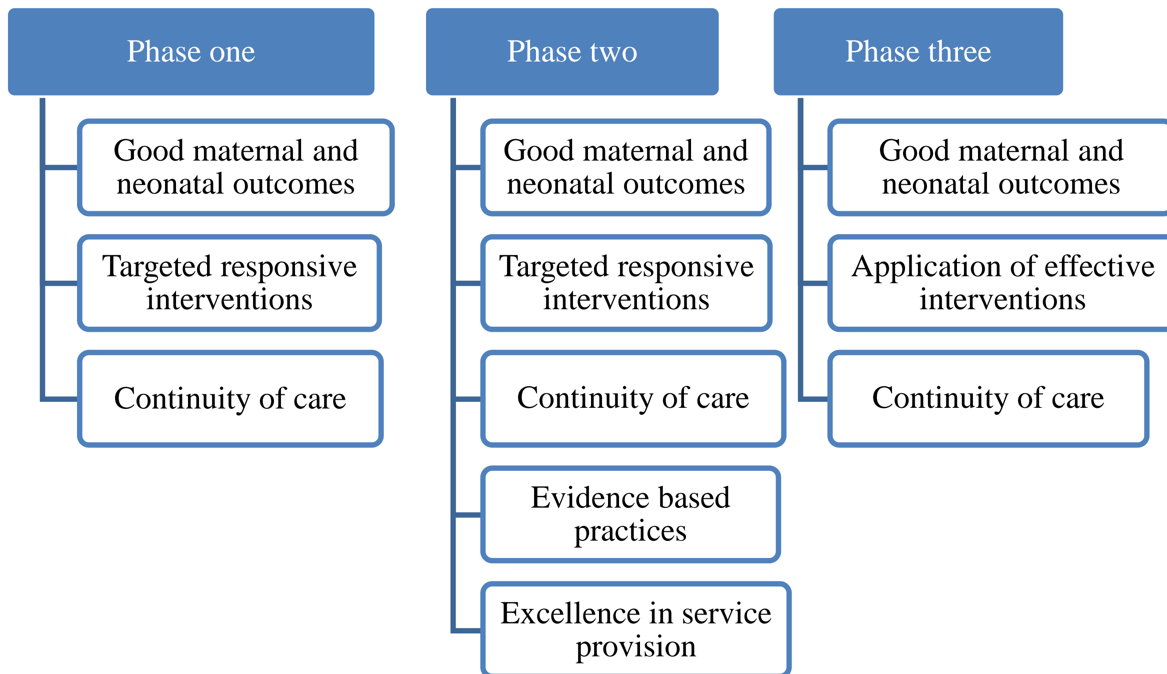

Figure 4.4: Illustration of Excellence in Evidence-Based Practices

4.4.2.4 Networking (N)

The N in UPENDO-S stands for networking and involves collaborations, networking, the formation of linkages and stakeholder engagement, the involvement of the community and political leadership in decisions related to maternity care.

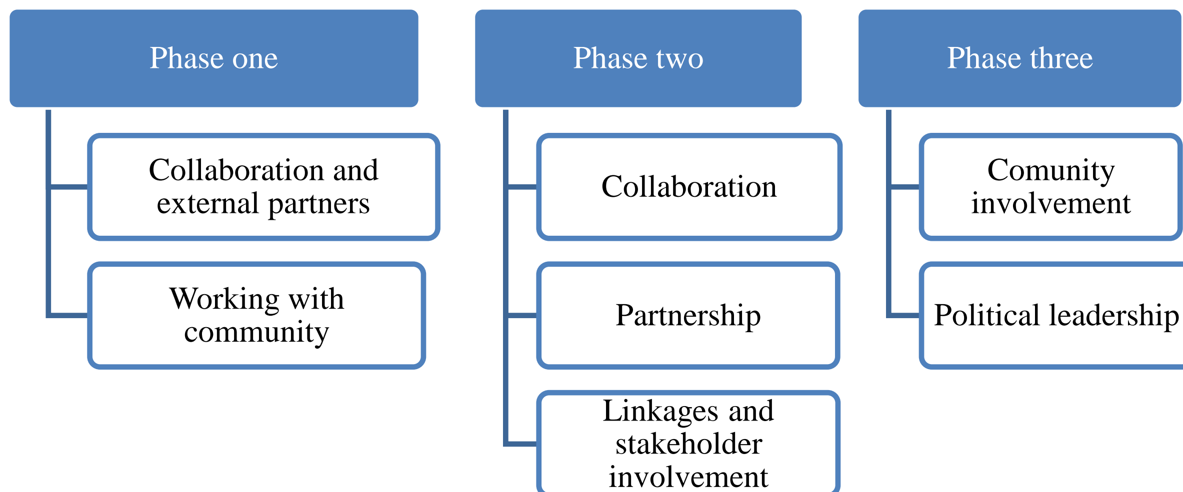

Figure 4.5: Illustration of networking

4.4.2.5 Dedicated supported midwives (D)

Dedicated supported midwives, the D in the UPENDO-S model, is derived from midwives who have knowledge and skills, are up-to-date and are supported and protected to maximise their skills. The model emphasises competencies and clearly defined roles and responsibilities. Through regulation, midwives can uphold professionalism and practice within defined professional codes of ethics and standards. It is important to ensure that midwives are well remunerated and deployed and units are adequately staffed. It also proposes motivation and minimisation of frequent transfers of midwives and use of implementation of human resource policies and codes of ethics in managing issues related to human resources. The model also proposes rationalisation during deployment of staff and consideration of the workload in a certain unit and balancing of staff according to the workload. It also proposes the inclusion of other health care providers, such as obstetricians and gynaecologists, to support midwives.

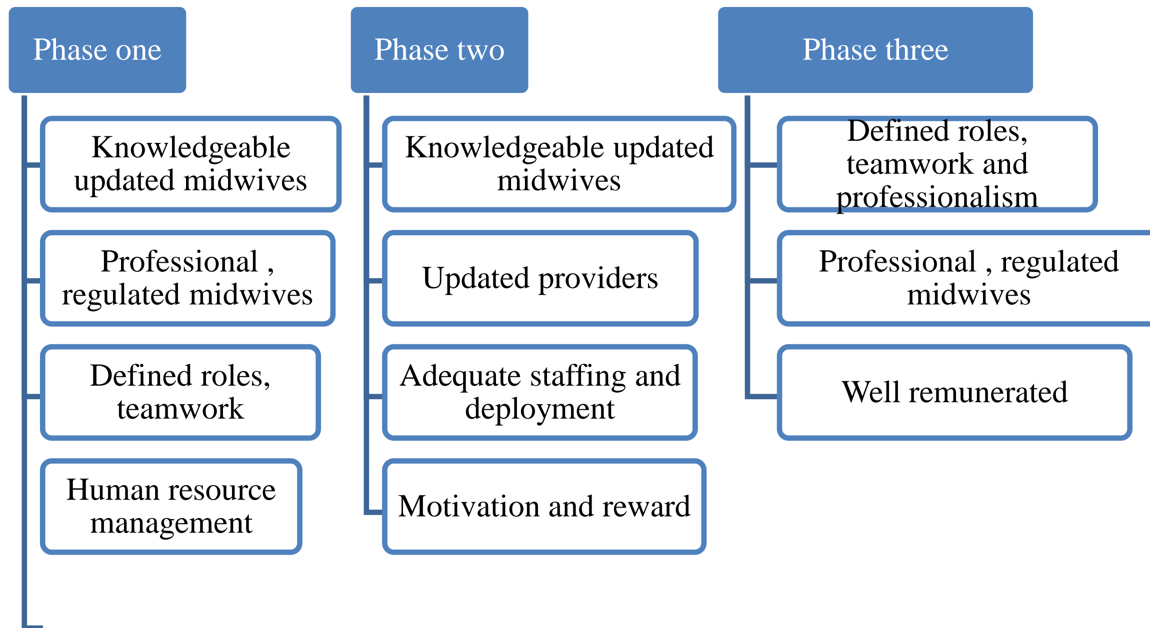

Figure 4.6: Illustration of a Dedicated Midwife Workforce

4.4.2.6 Organisation of care (O)

The O in the model stands for organisation of care. Important in the organisation of care is maintained infrastructure and essential departments, maintained clinical resources, improved hospital processes and effective systems, maintained health information systems and well-defined nature of service at the facility as illustrated in Figure 4.7

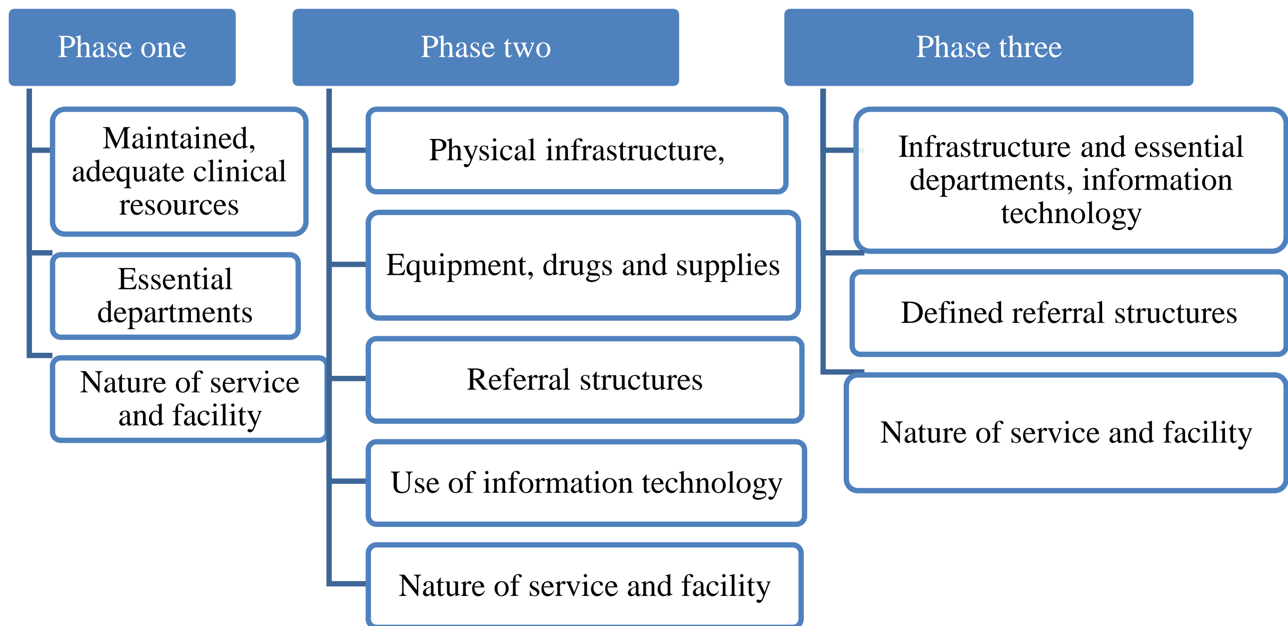

Figure 4.7: Illustration of Organisation of Care

The model advocates adequate infrastructure and essential departments. This is supported by the use of information technology for planning, organisation, provision of care, documentation and for record-keeping at the facility. Another aspect in the organisation of care is establishing good referral systems, which include good management of women before and during referral, availability of functional ambulances and effective communication and good interpersonal relationships between the staff at the referring and receiving facilities.

The nature of service and facility relates to consistent water supply, maintenance of high standards of hygiene and good sanitation. Finally, security is critical in an organised facility for precautionary measures and prevention of theft.

4.4.2.7 Supportive leadership (S)

The 7th component of the model is supportive leadership (S). Supportive leadership involves having experienced focused, visionary/transformational leaders, supportive leaders with a capacity to make decisions. Such leaders participate in facilitative supervision, shared governance and embrace employee participation in decision-making. The different aspects of supportive leadership are illustrated in Figure 4.8.

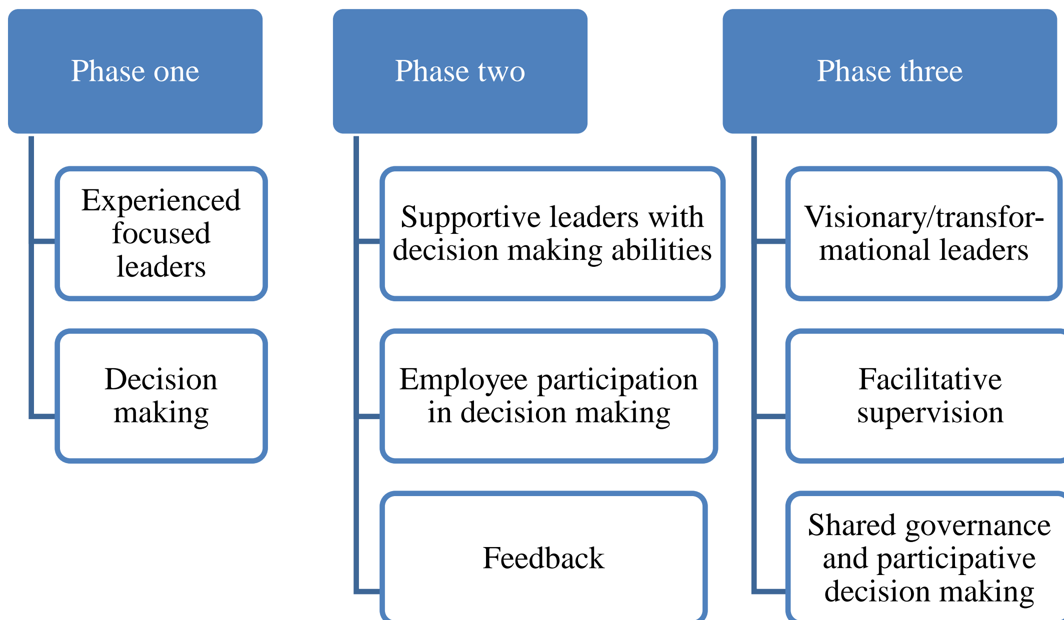

Figure 4.8: Illustration of the evolution of Supportive Leadership

Supportive leaders, according to the model, should be able to plan, budget, set priorities and use funds generated from the facility well. Planning, according to the respondents, entails organisation of the general physical systems of the facility, designing organisational structures, policies and guidelines. According to the study, it also includes having designed measures for monitoring and evaluation. Such leaders also participate in supportive supervision. They can

understand, care and listen to staff concerns and can make decisions, identify and respond well to areas of staff needs.

Another aspect in supportive leadership is shared governance through the establishment of forums for sharing between management, staff and the community. Supportive leaders encourage participation in meetings; ensure communication and implementation of actions.

A diagrammatic representation in the shape of a wheel illustrates the importance of the different parts working in harmony and propelling each other to rotate. Similarly, like any other wheel, uncoordinated rotation results in disconnection. The elements of the UPENDO-S wheel are shown below and illustrated in Table 4.7 and Figure 4.9.

Table 4.7: UPENDO-S components and contributing global themes

Components	Contributing Global Themes
User-friendliness	Live and well mother and baby (phases 1,2,3) Efficiency and timeous service delivery (Phase 1) Effective, responsive communication (Phases1, 2, 3) Compassionate, respectful care (Phase 2)
Person (woman)-focused care	Identity personalised, responsive care (phases 2,3) Connecting and building relationships (Phase 2, 3) Knowledgeable, informed women (phase 1, 2,3) Targeted response (Phase 1) Choices and options (Phase 2) Cultural sensitivity (phase s 2,3)
Excellence in evidence-based practice	Continuity of care (Phase1, 2, 3) Good maternal and neonatal outcomes (Phase1, 2,3) Targeted responsive interventions (Phases 1,2,3) Evidence-based practices (Phase 2) Excellence in service provision (Phase 2)
Networking	Collaboration and partnerships (phase 1) Establishment of linkages and stakeholder involvement (Phase 2) Community and involvement of political leadership (Phase 3)
Dedicated supported midwives	Knowledgeable, skilled updated midwives (phase 1,2) Recognised, motivated midwives (Phase 1, 2,3) Well remunerated (phase 3) Professional, regulated midwives (phase 3) Defined roles, teamwork and professionalism (phase 3)
Organised care	Maintained infrastructure and essential departments (Phase 2) Maintained, adequate clinical resources (Phase1, 2) Spacious Comfortable facility with adequate resources (phase 3) Improved hospital processes and effective systems (phase 2, 3) Maintained health information systems (phase 3) Improved effective systems (phase3) Nature of service and facility (phase 1)
Supportive leadership	Good governance and leadership (phase 2) Facilitative, supportive supervision (Phase 1, phase 3) Inclusive decision making (phase 2,3) Planning and budgeting (Phase 1,2,3)

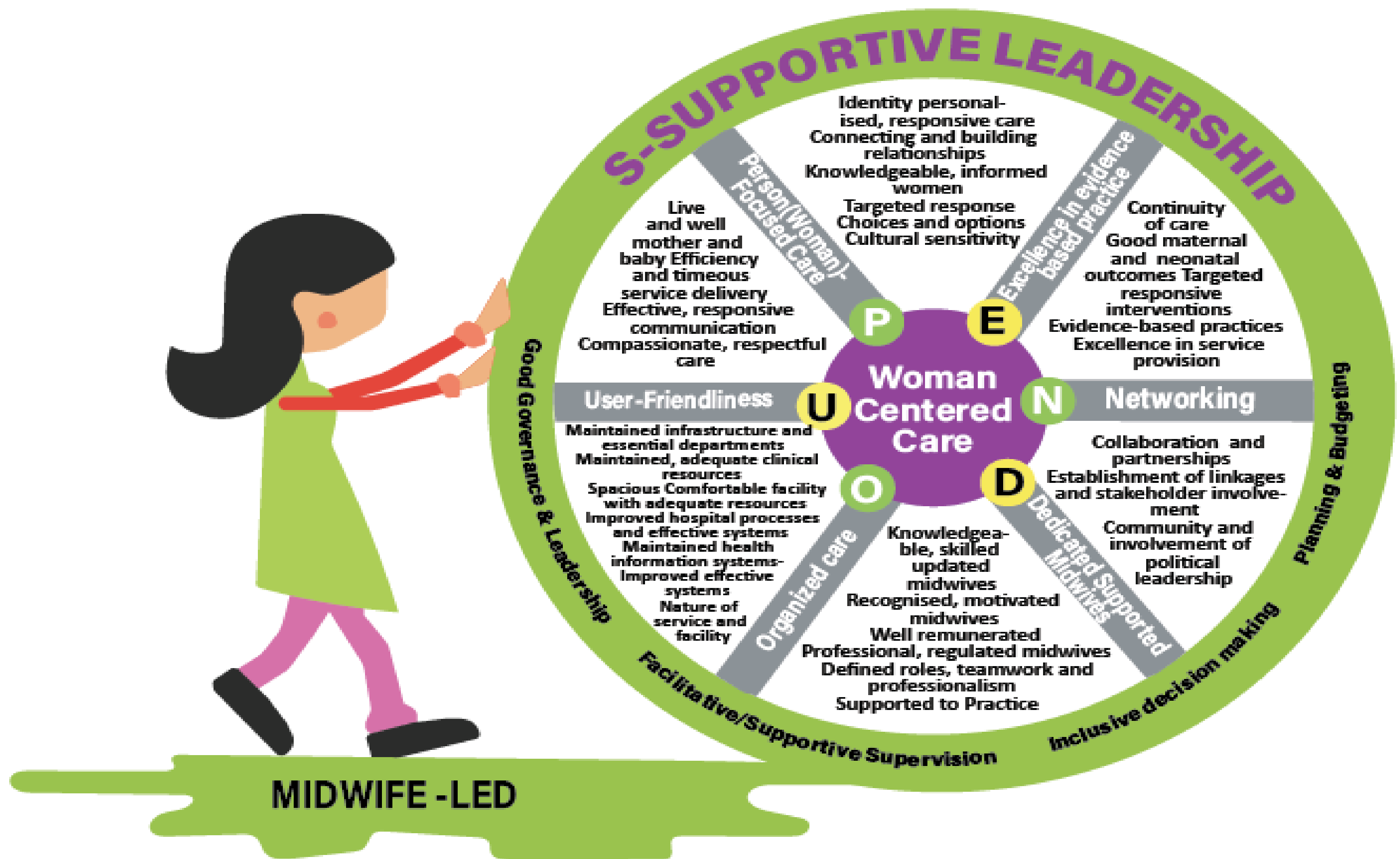

Figure 4.9: UPENDO-S Model

4.4.3 Development of provocative propositions

Provocative propositions were developed for each component of the model, as illustrated below.

Table 4.8: UPENDO-S model domains and provocative propositions

Domain	Provocative proposition
User-friendliness	Maternity services will be provided at the woman's convenience and women will take the lead in decisions regarding their care.
Person (woman)-focused care	Women will be informed and the main decision-makers in their care and be able to choose the kind of care they want and even decline care The focus of maternity care will be on the woman and midwives will allocate sufficient time to meet the needs of each individual woman and recognise them as women experiencing a normal psychological process and not as patients.
Excelling in evidence-based care	Provision of maternity care will be based on evidence-based practices and guided by policies and guidelines Continuity of care will be implemented and culturally sensitive care provided
Networking	Through networking with external partners including the community, professional bodies, non-governmental institutions, provision of responsive maternity care will be realised
Dedicated supported workforce	Midwives take ownership of their own practice and commit to continuously improve their skills
Organisation of care	The facility will be equipped adequately, there will be use of information technology and a clearly defined referral systems that is followed
Supportive leadership	Health service managers will perform monthly support supervision, organise forums with staff and involve them in decision-making

4.5 Phase Four (Destiny)

Phase four is the destiny phase in the Appreciative Inquiry cycle. This phase was used to propose activities for the adoption and implementation of the UPENDO-S model. Three group discussions were held, one with the midwives, one with the women and another one with health service managers. The model was drawn on a flip chart and displayed on the wall for reference during discussions. After the focus group discussions with the midwife participants, they requested that the model remained on the wall so that they could refer to it as they implemented it.

The UPENDO-S model was designed after looking at the data from the three phases critically. Each phase of the Appreciative Inquiry built up to the next phase. Change was evident in each phase of the study, as is expected in the Appreciative Inquiry process. There was a defined force of progress, change, abstraction and liberation.

During the presentation of the model, some participants felt that the term UPENDO-S was local and they deliberated on the suitability of the acronym. A consensus was reached that the term was representative and illustrated the purpose of maternity care.

M4, FGD 16: "… I'd say this is a nice word because it's local and when an outsider comes, we will explain to them what it is … so when one says 'UPENDO' he feels part of us…term encourages familiarisation and adopting and acceptance to culture."

There was a consensus that the term UPENDO-S demonstrates love for one another. As it is the meaning of the word in Swahili, the local language in Kenya, the term was considered representative.

M2, FGD 16: "This is excellent; we have done good work…UPENDO is to love. It's having a good relationship… Loving is an action… it's a doing… UPENDO love is in the midst."

The research participants were asked to suggest activities for the implementation of the UPENDO-S model. Six implementation strategies emerged: collective responsibility and accountability, the inclusion of women in implementation, planning and budgeting, documentation and communication, benchmarking and monitoring and evaluation. This is summarised in Table 4.9.

Table 4.9: Implementation strategies

Implementation Strategy	Activities
Collective responsibility and accountability	Constitution of implementation team Involvement of all maternity departments Involvement of all health service providers Involvement of politicians and community
Inclusion of women in implementation	Inclusion of women in certain facility meetings and activities Formation of community organisations to participate in maternity services
Planning and budgeting	Development of a work plan Budgeting Prudent utilisation of resources
Documentation and communication	Development of documentation tools Analysis of data Reporting systems Effective communication
Benchmarking	Benchmarking with institutions that have models Sharing best practices
Monitoring and evaluation	Constitution of quality improvement team Clinical audit and feedback Evaluation of outcomes

4.5.1 Collective responsibility and accountability

The initial step in the implementation of the model involves extensive sharing of the model for awareness among different stakeholders. This is because the implementation of the wheel would require involvement of staff, women, health service managers at different levels of service delivery and other stakeholders such as community health workers and political leaders.

M7, FGD 16: "A team comprising members from each department. First meeting convened by a named person … [named point person] is the team leader because he has at least something in his mind we can help design …"

M6, FGD 16: "Or we can go the political way, can involve the politicians. Politicians can push for good policies."

4.5.2 Inclusion of women in the implementation of the model

Women were considered to have a role in the implementation of the UPENDO-S model. These would be through structured organisational forums, meetings and activities.

W6, FGD 17: "We can form an organisation. Let's say every month, at least once a month during a weekend … we can also assist mothers in the ward so you can make arrangements of women coming together."

M8, FGD 16:"meetings with women you can get more information from people when they come in. If it's a weekend. Most are available then you can get more ideas from them and see the way forward."

4.5.3 Planning and budgeting

The participants stated the need for a clear work plan and structures for implementation of the model. In this regard, the implementation of the model requires budgeting and prudent utilisation of resources.

M9, FGD 16: "…look at the core values of the organisation, all of us have agreed on this wheel. We implement it so that when you come today and you come two months down the line like ISO Certification you will get the system is like that. We will find that the wheel is functional."

I 1: "So the wheel could be there but implementation may not move faster because of resource limitation, it could also be issues of staff, it will also be issues that there are too many things to meet at the same time…"

4.5.4 Documentation and communication

The research participants stated that documentation was vital in the implementation of the UPENDO-S model. It was agreed that there was a need for elaborate documentation, which required the design of tools to capture data to aid in decision-making.

M2, FGD 16: "Modify reporting systems…provide clear recommendations…Report on achievements…We will identify someone to work on the tool and other members and in charge to assist in the development of the tool..."

I 1: "I think also when we are generating a tool, we are talking of evidence …evidence-based is from the records, the number of clients we see versus the HR [human resource] and the work done, … They should be able to do basic analysis or if they are good at analysis, they can go further to significant associations or not but by just basic quantitative analysis they can obtain a

lot of information…Analysis of records to guide decisions such as staffing levels…documentation of work done…Analysis of data to demonstrate workload.”

M2, FGD 16: “… we started a book for postnatal testing at six weeks which was not done previously… we have integrated postnatal testing and PCR testing. The book we basically use for documenting the number tested...”

Communication was considered as inclusive of the defined system for relaying information and having structured content. This would require structured communication channels within and outside the facility. One of the ways would be through design of a communication package detailing services provided and resources available at the facility.

M4, FGD 16: “If there is information centre and a customer care desk. It is easy for clients to ask for information as people are usually many and they don’t know who to ask where one should start from or where one should go…”

W7, FGD 17: “…provide information to the community on services provided and inform them that there are adequate staffs.”

4.4.5 Benchmarking

Implementation of the UPENDO-S model would be boosted by benchmarking with other institutions that use models of care. This was as a result of the aspiration to be a centre of excellence that other health institutions could benchmark from.

M6, FGD 16: “Benchmarking in best-performing health institutions locally and globally…Midwives who provide direct care to be provided with opportunities to benchmark.”

I 1: "… we are committed to having a Centre of Excellence in this county to be copied by others."

4.5.6 Monitoring and evaluation

Monitoring and evaluation are also critical to ensure the provision of quality care under the UPENDO-S model. Mechanisms for monitoring and implementation of the model had already been initiated in other sections. Monitoring and evaluation would be achieved through mutual assessment and feedback from the staff, which is crucial in fostering the implementation of the model.

M2, FGD 16: "… our department or our section, we have formed a quality improvement team where we choose an indicator that we are not performing very well, so we're using scientific approach on how to improve on that indicator…"

I 1: "at higher level, the CHMT [County Health Management Team] will improve on monthly review of performance … and then as a team we decide what next we have to do to improve…in addition, the facility managers should also review facility-related indicators."

A2, FGD18 :"…we should evaluate each other; score our performance and talk freely to ensure that we are able to change. We should take feedback positively… We should be able to improve in areas that we are not doing well. We shall try to do it with a clear mind that it is for organisational interest not for individual interest…"

4.6 Chapter summary

This chapter has presented the results of this study across the four phases of the Appreciative Inquiry cycle. The first phase of discovery examined the prevailing situation of services at the facility. The research participants gave their views around seven global themes: alive and healthy mother and baby, “responsive communication, nature of service and facility, resources at the facility, knowledge and information, inclusive decision-making and collaboration and partnership. The discovery phase elicited that the high points occurred when there were good outcomes of pregnancy that led to a live and healthy mother and baby, when there was responsive communication and when mothers received all the services that they were seeking at the facility. The availability of resources and knowledgeable midwives, women and health service managers contributed to high points. Inclusive decision-making and partnering with external partners and the community are also critical. The study identified the need of women and midwives to partner to achieve normal birth with support from other health care providers and accessibility of referral systems in case of emergencies and high-risk situations.

The second phase of the study was the dream phase of the Appreciative Inquiry cycle where the research participants envisioned what best maternity care would look like. Their dreams were summarised in the following themes: achieving good maternal and neonatal outcomes, connecting and building of relationships, improved hospital processes and facility, competent, motivated providers, collaboration and networking, and considerate managers. Their views provided a basis for comparing the existing situation with what would be the ideal at the facility. This comparison would then inform the design of a model to bridge the gap between the existing and desired situations.

In the third phase of design, the researcher worked with the research participants to design a model for providing ideal services at the facility. During phase three of the study, the following themes arose: the building of relationships, experienced focused leaders, spacious comfortable maintained facility with adequate resources, timeous delivery of services and updated motivated providers and women. The design phase then culminated in the UPENDO-S model of service delivery. The model defines the nature of services and ways of delivery in the best of circumstances. As an acronym, the model stands for User-friendliness, Person-focused care, Excellence in the provision of care, Networking, Developed midwifery workforce, Organisation of care and Supportive leadership.

The last phase of this study, the destiny phase, looked at the implementation strategy of the UPENDO-S model. It gave rise to the following: collective responsibility and accountability, defined value for women and empowerment, planning and budgeting, documentation and communication, benchmarking and monitoring and evaluation.

5. DISCUSSION

5.1 Introduction

Chapter 5 discusses the findings and is organised into sections that discuss participants' profile (5.2), components of the UPENDO-S model of care (5.3), modalities for implementation of the model (5.4), strengths and limitations of the study (5.5) and chapter summary (5.6).

The study set out to discover how best maternity care can be delivered, which culminated in the development of the UPENDO-S model of care. The UPENDO-S model provides a philosophical basis for the provision of maternal and newborn health care in the study setting. It provides a framework in which midwives can advance their practice in promoting women's dignity, autonomy and enhance their understanding of their *raison-d'etre* (Thompson, 2004).

5.2 Participants' profiles

Women, midwives and health service managers participated in the study. Participant's experiences and interaction with maternity services provided a rich source of data that guided the development of the model. The participatory nature of the Appreciative Inquiry and Human Scale Development framework promotes inclusion of consumers of the service (women) and the people who work in the area (midwives and health service managers), as they understand the environment and what is required for the system to perform optimally to build on what works well in the system (Guillen-Royo, 2010; Whitney & Trosten-Bloom, 2010).

The women participants were seeking antenatal care, immunisation and growth monitoring for their babies, postnatal, birth and family planning services. The majority were in the age group

21-30 years, an active childbearing age, as indicated in the Kenya Demographic Health Survey (KDHS 2014). However, in high resource countries, there is a shift from the norm with increased age at first pregnancy and reduced fertility which Graham terms as an obstetric transition (Graham *et al.,* 2016). The obstetric transition brings new demands in existing health infrastructure with the risk of an increase in obstetric complications and chronic diseases such as diabetes (Graham *et al.,* 2016).

The women in the study were either primiparous or having their second babies. This finding is consistent with the Kenya Demographic Health Survey report that the majority of women who seek maternity services, especially antenatal care, are primiparous and first-time mothers (Kenya Demographic Health Survey (KDHS), 2014). Even though the majority of women were having their first or second babies, the fertility rate in Kenya is 3.5. Graham *et al.,* (2016) report that increased fertility rates cause strain on maternal health services basing on the review of the aggregate data from different parts of the world.

Over half of the women had primary and secondary level education, with 23% having tertiary education. Four of the women had not completed primary education and had dropped out in class seven or eight. However, all the women were able to read, understand and provide informed consent. Explanations about the study were provided to participants in English and Swahili to ensure that participants understood the purpose of the study. Uasin Gishu County hosts several multi-ethnic populations and houses several institutions of higher education and, as a result, has a large population of people with secondary and post-secondary education. Graham *et al.,* (2016) describe the effects associated with maternal education. Women with lower levels of education are more prone to maternal morbidity and mortality due to their health-seeking behaviours. In

addition, they are also economically disadvantaged and end up receiving poor services due to a lack of agency to their health and wellbeing (Graham *et al.,* 2016).

All the midwife participants had a diploma and above as their level of education and were registered and licensed to practice as midwives. Midwives' years of experience varied and spanned across different public and private maternity settings. Thompson, Fullerton, & Sawyer, (2011) emphasise that midwives with several years of practice can interrogate practice, identify areas for improvement and have the autonomy to practice.

Health service managers included facility managers and county managers with varying demographic characteristics. All the health service managers were either diploma or degree holders and with over six years of work experience in health administration. Thus, their experience was vital in the development and implementation of the model.

5.3 Discussion of components of UPENDO-S model

The development of the UPENDO-S model was an adventurous journey. The journey commenced with uncertainty among participants who described how things could have been better at the facility if they were done differently. The same scenario was experienced by (Lavender & Chapple, 2004) in their study among 126 midwives of various cadres through 15 focus group discussions that explored their views on birth setting, models of care and philosophy of care in England using the Appreciative Inquiry approach, where midwives used the focus group discussions to express their frustrations and cited lack of forums for sharing their views on areas of concern during their practice. However, as the study progressed, the mood changed and

there was sharing of what worked well at the facility, culminating in the development of themes that built up to forming the UPENDO-S model.

The development of the UPENDO-S woman-focused model is timely as there has been a push for woman-centred care and recognition of pregnancy as unique for each woman (WHO, 2016). It is also a time when the ICM is advocating woman-centred care, recognition of midwifery as a profession and midwives as lead providers for the provision of maternity care (Thompson, Fullerton, & Sawyer, 2011). This is supported by the World Health Organisation (WHO) endorsement of midwives as lead maternity care providers who deliver positive pregnancy and birth outcomes (Sandall, Soltani, Gates, Shennan, & Devane, 2013). Davidson, Halcomb, Hickman, Phillips, & Graham, (2006) described a model of care as

> *an overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, EBP and defined standards. It consists of defined core elements and principles and has a framework that provides the structure for the implementation and subsequent evaluation of care.*

The UPENDO-S model, as guided by the Max-Neef framework, takes into consideration the socio-economic, cultural and political factors that influence healthcare. Guillen-Royo, (2010) emphasises that sustainable change can be realised when cultural, political, social and economic issues are addressed. Graham *et al.,* (2016) associate socio-economic demographic factors with maternal health outcomes. Women with low socioeconomic status are more vulnerable and prone to receiving poor quality care leading to increased morbidity and mortality. These inequalities in maternal health are a major hindrance to the achievement of sustainable development goals.

William Farr in 1876, termed maternal death as a “deep, dark continuous stream of mortality … how long is this sacrifice going to continue?”

Homer *et al.,* (2014) in the study that identified the effect of scaling up midwifery interventions and care provided by midwives in 78 countries state that the social determinants of health to include women’s status, inequality, education and water and sanitation influence maternity outcomes. In their review, they identify interventions that can mitigate poor outcomes arising from social determinants, mainly being improved water and sanitation, better antenatal, labour and birth care, improved nutrition, improved knowledge and information and greater access to high-quality case management of diseases such as pneumonia, diarrhoea and malaria.

Koblinsky *et al.,* (2016) highlight five priority areas in maternal health according to the World Health Organisation. These are provision of responsive quality maternal health services that meet the local needs and emerging challenges, universal coverage for quality maternal health services to all women, strengthening health systems by optimising the health workforce and improving facility capability and resilience, financing for maternal–perinatal health and acceleration of progress through evidence, advocacy and accountability.

The Primary Health for All model (WHO-UNICEF, 1978) prioritises five areas, the childbearing woman, her family and community, intersectoral collaboration, equity in health care provision, effective, culturally acceptable, affordable and manageable services and integration of promotive, preventive, curative and rehabilitation services. The components of the UPENDO-S model (user-friendliness, person- (woman)-focused care, excellence in evidence-based care, networking, dedicated supported midwives, organisation of care and supportive leadership) resonate with the WHO model for maternal health and the primary health “health for all”.

Table 5.1. A similarity between UPENDO-S components WHO priority areas in maternal health and primary health for all

UPENDO-S COMPONENTS	WHO 5 PRIORITY AREAS IN MATERNAL HEALTH	PRIMARY HEALTH FOR ALL
User-friendliness,	Accessible and universal coverage of quality maternal health services	Affordable and manageable services
Person(woman)-focused care	Responsive quality maternal health services	Effective, culturally acceptable,
Excellence in evidence based care	Financing for maternal–perinatal health	Equity in health care provision preventive, curative and rehabilitation
Networking		
Dedicated supported midwives	Optimising the health workforce and improving facility capability and resilience	Intersectoral collaboration
Organisation of care		
Supportive leadership	Evidence, advocacy, and accountability	

5.3.1 User-friendliness (U)

User-friendliness entails alive and well mother and baby, responsive communication and compassionate, dignified and respectful care. ten Hoope-Bender *et al.,* (2014) reiterate that design of maternity services must be responsive to women's needs and the policies developed must take into consideration distribution of health workforce to meet the needs of women.

5.3. 1.1 Alive and well mother and baby

Since the ultimate goal of pregnancy is alive and well mother and baby, even during obstetric emergencies and high-risk situations, midwives put in extra effort to monitor the women to ensure that the process goes smoothly and that a desirable outcome is achieved. Graham *et al.,* (2016) in their review recognise that poor maternal and newborn health is a concern in many countries illustrated by the high lifetime risk of maternal mortality of 36 in sub-Saharan Africa contrasting with 4900 in high-income countries. This divergence poses a risk to overall population health and achieving sustainable development goals, especially in goal three in the target of reduction of maternal mortality ratio to 70 per 100 000 live births. This is almost certainly because midwives' philosophy is that pregnancy and childbirth is a natural process and their conviction is to support the normal processes of labour and birth.

Homer *et al.,* (2014) recognise that any morbidity affecting a woman does not only affect her but affects her children as well as the broader community. This is because poor maternal health outcomes associated with pregnancy and birth can lead to long term psychological and other effects such as violence and divorce and the importance of the identity of a woman as a whole.

5.3.1.2 Responsive communication

Responsive communication is achieved through the free flow of information and giving and receiving feedback with clear and defined channels which can either be verbal or written. Feedback can be obtained through suggestion boxes, feedback surveys, compliments/complaints registers and exit interviews (Haggerty *et al.,* 2003). Rance *et al.,* (2013) report that women evaluate the quality of care depending on their interactions with health care providers and those who listen and respond to their concerns are appreciated and highly rated.

External communication is also considered in the UPENDO-S model. This can be through the provision of information on available health services using brochures, other information educational materials and community meetings and activities.

5.3.1.3 Compassionate, dignified and respectful care

Compassionate, dignified, respectful care involves demonstration of appreciation and courtesy through good reception and approaching women with sensitivity and kindness. d'Ambruoso, Abbey, & Hussein, (2005) in a study that did 21 indepth individual interviews and two focus group discussions in Acrra Ghana identified courteous, human and professional treatment from health professionals as very important.This requires nurturing midwives to inculcate desirable attributes of kindness, consideration and compassion. Women choose to utilise clinically expert care when they feel respected and emotionally safe. Izudi & Amongin, (2015) noted that women who experience a good reception during birth were more likely to seek postnatal services. Professor Mahmod Fathalla (an Egyptian obstetrician),

> *The question should not be; why do women not accept the service that we offer? but why do we not offer a service that women will accept?*

Women in the study reported that they preferred to deliver at home with the help of traditional birth attendants because they knew the woman and did not shout at them. Pell *et al.,* (2013) in their study in Kenya, Tanzania and Ghana, affirmed that women avoid the hospital and do not share their problems when they are treated harshly and instead seek unskilled care in their births and subsequently miss essential services like immunisation for their children. Rotich, (2011), in a study done in Nairobi, Kenya, reported that women attended antenatal care only once during pregnancy, not for monitoring purposes but to obtain a card to present during labour to avoid

reprimands and chastisements from health workers, undermining the purpose of antenatal care for monitoring progress of pregnancy. Afghan refugee women in Australia did not appreciate providers who were unfriendly, rude and uncaring (Shafiei, Small, & McLachlan, 2012).

The UPENDO-S model recognises hospitality through appreciation of women who birth at the facility with tokens to encourage them to birth at the facility. Campbell *et al.*, (2016) and Koblinsky *et al.,* (2016) recommend routine audits on the provision of care, routine use of interventions and on the provision of respectful maternal health-care services to ensure that every woman can give birth without risk to her live or that of her baby. Renfrew *et al.,* (2014) in their analyses focused on women's preferences and reported that women consider good quality clinical care, improved communication, education, information and respect important. They further state that midwives provide safe maternity care through education, information and health promotion, assessment, screening and care planning and promoting normal processes and preventing complications in the context of respectful care that is tailored to needs and works to strengthen women's capabilities.

5.3.1.4 Accessibility and efficiency

User-friendliness also entails the provision of services at a place considered convenient by the woman, including at her home or in the community and the use of mobile clinics. It also entails flexible clinic hours and provision of maternity services after working hours and during weekends and public holidays. The model upholds timely access to emergency childbirth, which is influenced by the availability of emergency transport, and location of woman before onset of labour. Campbell *et al.,* (2016) shed light on the need for coverage of skilled birth attendants and antenatal care. The contact between health professionals and women and their babies provides an

opportunity for management of uneventful pregnancies, labour and birth and prevent, detect and treat complications appropriately.

Phiri *et al.,* (2014), in their study at Kapiri Mposhi and in rural Malindi, found that perceived distance tends to reduce the likelihood of childbirth in clinics or other facilities. They noted that accessibility is affected by lack of flexibility, scheduled monthly follow-up appointments and the high number of visits required, costs associated with the visits and large distances to health facilities. In the UPENDO-S model this can be achieved through the integration of maternity services, such as antenatal and family planning services, with other routine outpatient services as proposed by (Lang'at & Mwanri, 2015) in their study in Malindi.

Different efforts have been put in place to make maternity services accessible in Kenya. One way is through the provision of free maternity care, which was made policy in June 2013 by the Kenyan Government. However, Lang'at & Mwanri, (2015) report challenges related to free maternity care in their study carried out in Malindi Kenya, that relate to delays in the reimbursement of funds by the government to the facilities, stock-outs of essential commodities at the facilities, increased workload amidst staff shortages and lack of consultation and sensitisation of key stakeholders. Provision of free maternity services in South Africa realised improvement in access and uptake of the services (Harrison, 2009). The UPENDO-S model identifies the use of mobile clinics to improve the accessibility of maternity services. Mobile clinics in Kenya have been embraced through the Beyond-Zero initiative introduced by the First Lady. In addition, accessibility can be achieved through provision of services at a place considered convenient by the woman, including at her woman's home or in the community.

Efficiency in service delivery involves the timely provision of services at the facility, ensuring that women receive the services they seek the quick attention to emergencies and prompt referral without delays. It entails astute design of systems to ensure that women are served on a first-come-first-served basis. Efficiency in service delivery is a motivator for women to make decisions to seek postnatal services in hospitals (Duong, Binns, & Lee, 2004). Efficiency and effectiveness lead to exceptional performance and excellence in provision of care in the long run, thereby increasing the trust that women have and the demand for care at the facility which, in turn, contributes to a centre of excellence and a model facility (Sandall, Soltani, Gates, Shennan, & Devane, 2013).

Not being able to access services and receive adequate care is one of the reasons that have been identified as a cause of death among women in low- and middle-income countries (Thaddeus & Maine, 1994). Van Lerberghe *et al.,* (2014) identified that improvement has been realised in Morocco and Indonesia through improved knowledge, communication and provision of transport to access specialised services.

5.3.2 Person (woman)-focused care (P)

Person (woman)-focused care considers the woman as pivotal in maternity services. In this regard, the focus is on identity for women, personalised, responsive care, connecting and building relationships, knowledgeable, informed women, choices and options, privacy and confidentiality, and culturally sensitive care. Person (woman)-focused care is enshrined in the Kenyan constitution (Constitution, 2010) where the rights to health care are clearly outlined. A study by (Renfrew *et al.,* 2014) states that people-centred care recognises people’s legitimate right to, and expectations for, equitable, high-quality, safe and respectful care as a global health

priority and should be put at the heart of the movement to improve maternal and newborn care. Afulani, Kirumbi and Lyndon (2017) in their study in western Kenya through eight focus group discussions among postnatal women, identified supportive care, effective communication, responsiveness and dignified care to contribute to quality care.

Van Lerberghe *et al.,* (2014) report on the emphasis placed on "person-centeredness and people-centeredness" by researchers, health service managers across the world, press and judiciary systems. The study by ten Hoope-Bender *et al.,* (2014) brings forth the focus on primary health care in the past decade that promotes people-centred care. There has been a focus on life-saving interventions and an increase in coverage which has in the past led to tensions between health care providers over disrespect, abuse and abandonment of care. These ten Hoope-Bender and colleagues term as symptoms of deeper health system problems rather than measures of poor quality (ten Hoope-Bender *et al.,* 2014).

5.3.2.1 Identity for the woman and personalised, responsive care

The UPENDO-S model recognises the woman as a mother and not a patient seeking a cure. This sets the stage for interaction promoting birth as a natural physiological process and recognises the woman as the lead in the management of her care leading to a positive experience (Finlayson & Downe, 2013). Williams, Lago, Lainchbury, & Eagar, (2010) in their study done in Australia, reported that women appreciated it when they were recognised and treated as individuals. This, according to the model, requires the midwife to take time to understand the women and appreciate their individuality. Homer *et al.,* (2014) place emphasis on understanding the individual needs of women and commitment to the promotion of normal birth and consideration of social-cultural processes during pregnancy and childbirth.

Haggerty *et al.,* (2003), and Engel, Prentice, & Taplay, (2017), recommend that midwives dedicate time to pay personalised attention to listen to woman's concerns, perform comprehensive assessments and provide holistic care. This, according to Finlayson & Downe, (2013), enables the midwife to identify other needs of the woman apart from pregnancy.

5.3.2.2 Connecting and building of relationships

Connecting and building relationships between women, midwives and other health care providers is critical to achieving satisfaction (Walsh, 2007). Hunter *et al.,* (2008) state that the quality of relationships with caregivers has an impact on women's experience of childbirth, and describe that

> …women's experiences and caregiver's experiences are interwoven and interlinked like threads in a tapestry.

The building of relationships can be achieved through continuity of care arrangements where the woman and the midwife become known to each other. Through continuity of care, the woman gets to build a relationship with a known midwife and increase satisfaction for both, reducing burnout in midwives (Creedy, Sidebotham, Gamble, Pallant, & Fenwick, 2017; Fenwick *et al.,* 2018). However, the participants did not express an understanding of continuity of care.

Dietsch & Mulimbalimba-Masururu, (2011) in their study in Western Kenya, identified the main reasons why women chose to access traditional birth attendants (TBAs) is because they knew them, received continuity of care from them and trusted them, they had built woman/TBA relationships/partnerships with one another.

5.3.2.3 Knowledgeable, informed women

A knowledgeable, informed woman can make decisions about her care. Women who are informed have confidence and trust their bodies and can seek care and make decisions regarding their health and that of their newborn and can accept or decline care (Izudi & Amongin, 2015; Renfrew *et al.,* 2014; Rotich, 2011; Rotich & Wolvaardt, 2017). Through the provision of accurate information, the woman is directed to make sound decisions, putting into consideration the social and cultural context.

There are different ways of providing information to women through structured antenatal classes, maternal child information booklets and during contact with the woman during assessment or performance of a procedure. Provision of information includes informing women on the health procedures carried out on them, as well as giving full reports and explanations of findings and giving women an opportunity to ask questions and seek clarifications. Pell *et al.,* (2013) in their study in Kenya, Malawi and Ghana, advance the use of structured ways such as scheduled childbirth classes or group antenatal care for the provision of structured and consistent information. Magoma, Requejo, Campbell, Cousens, & Filippi, (2010) identify the ANC period as an opportunity to provide health information on various aspects, including care of the woman and newborn and possible pregnancy complications.

Group antenatal care has been introduced in America in the last decade. The groups are organised so that women of a similar gestational age are seen in a small group of 8 to 12 women and facilitated by a range of health care professionals including midwives, obstetricians, health visitors and midwifery support workers. Women share experiences and learn together, providing

education and health promotion opportunities. The visits are longer, lasting for around 90 minutes and are scheduled ten times during pregnancy (Walker & Worrell, 2008).

Hunter, (2006) reiterates that, traditionally, the midwifery and nursing professions impart knowledge through oral communication and to embrace woman-centred language, there is need to create written information on the profession's legitimate knowledge and ways of knowing.

> *If we are going to listen to women, we need to help them create a language that is meaningful to the speaker. Our challenge is to honor and use our own knowledge of caring and holism. It is crucial to bring this knowledge into the main arena of childbirth as a worthy science that complements and works with other paradigms through creation of a common language and model of caring for health care providers (L. P. Hunter, 2006).*

Rotich & Wolvaardt, (2017) in their study among postnatal women in Kenya found that women experienced satisfaction with care when they were provided with information and explanations about procedures done on them and when they were provided with opportunities to ask questions. Exchange of information between the woman and the midwife provides a platform for the woman to be understood and enabled to make culturally sensitive decisions that do not have a negative impact on the woman or her unborn baby. Van Lerberghe *et al.,* (2014) affirm that there is an increasingly high well-informed women, with expectation of the provision of accessible, affordable care provided by skilled providers who are effective, safe and compassionate. This is supported by health service leaders who are of high standing and committed to the provision of quality care.

5.3.2.4 Choices and options

The model upholds choices for women. It gives choices to women during pregnancy and childbirth on the place of birth, position of birth and other critical decisions at the moment of birth as well as other life and health needs. Women-centred care models promote choice, control and continuity as women recollect their labour and birth experiences in relation to the choices and control they had over the details of it (Johnson, Stewart, Langdon, Kelly, & Yong, 2003). Women in the study used the term “welcome” which (Phillips, 2000) describes as an empowering term in visitation guidelines that promote women to make their own decisions, unlike words such as “allowed to be present” or “limited to the following number”.

Choices also entail enabling women to make decisions on whether to involve their partners/husbands during childbirth. This is because, in some contexts, as the women participants stated, men/husbands play a big role in decisions regarding pregnancy and birth in households, including decisions on the place of birth, and are sometimes responsible for paying for costs related to seeking maternity services. Men/husbands make decisions regarding pregnancy and birth in households, including decisions to seek antenatal care, decisions on the place of birth and their role is also shaped by culture and tradition as illustrated by studies done in Kenya (Nanjala & Wamalwa, 2012; Rotich, 2011; Tweheyo, Konde-Lule, Tumwesigye, & Sekandi, 2010). Moreover, male/partner involvement during labour evokes positive outcomes.

However, there are barriers that hinder women from making choices, including the paternalistic nature of health care services where women are informed of what to do with routine procedures being performed on them such as use of Oxytocin for augmentation of labour, forcing women to deliver in certain positions and not giving them an option to choose or decline certain

interventions. Sometimes women are reluctant to make choices and are not able to decline options of care for fear of retribution, ridicule or any other negative consequence from the midwife informing her of her choices.

Page, (2003) emphasises the need to give power to the mother and family during pregnancy and childbirth as an initial basic building block for future encounters “positive personal power” to be used during a lifetime of parenting. Lothian, (2007) and the coalition for improving maternity services, emphasise empowering women and their families. Empowerment can occur through interpersonal understanding in a relationship that fosters reciprocity, mutuality and dialogue, during which the needs of the woman and her family are elicited during communication (Widdershoven, 1999). The engagement of the women in their health decision-making ensures that their concerns and expectations are addressed, their physical, mental, psychosocial wellbeing is protected and their health outcomes before, during and after pregnancy and childbirth are secured (McLachlan *et al.,* 2012).

5.3.2.5 Privacy and confidentiality

Ensuring privacy and confidentiality assures dignified care which can be achieved through screening of examination couches, covering women during examination with minimal exposure of the area being examined and minimisation of the number of providers in a room during an examination. Minimisation of the number of providers is usually hindered by the large number of students who rotate in clinical areas in most maternity settings as identified in a study done in Nairobi, Kenya (Warren *et al.,* 2013).

Confidentiality can be maintained by avoiding sharing of woman’s information with unauthorised persons and handing over in private rooms or by the woman’s bedside and not in

the corridors (Warren *et al.,* 2013). However, the facility's layout was found to be a challenge in ensuring privacy and confidentiality due to available space, especially for women who were seeking the prevention of mother-to-child-transmission of HIV services.

5.3.2.6 Culturally sensitive care

Respect for women's culture involves having health care providers who are aware of and sensitive to cultural beliefs and practices. Women in the study cited lack of cultural sensitivity in some instances when they were asked to bring along baby clothes during labour which was considered an abomination in some cultures. Postnatal mothers in Ghana avoided seeking services and preferred to use herbs for babies and only sought services when their babies were sick as they felt that the health care providers were not sensitive to their culture (Dako-Gyeke, Aikins, Aryeetey, McCough, & Adongo, 2013). A deviation from this expectation makes women resort to seeking services from traditional birth attendants or herbalists who are aware and uphold the woman's culture.

Midwives and other health care providers are expected to understand the women's cultures and be sensitive to taboos associated with pregnancy and birth and caution women on harmful cultural practices. Understanding cultural beliefs helps to allay any fears related to seeking maternity services arising from the beliefs (Dako-Gyeke *et al.,* 2013). Cultural sensitivity also entails understanding the role of men during pregnancy and childbirth. In some cultures, men are not supposed to have contact with their women during labour and requiring women to bring their husbands along during labour may be against some cultural practices and expectations.

5.3.3 Excellence in evidence-based practice (E)

Excellence in evidence-based practices entails continuity of care, targeted responsive and effective interventions and application of evidence-based practices. Koblinsky *et al.,* (2016) argue that the millennium development goal five target of a reduction in maternal mortality by 75% was not achieved, despite the use of maternity care. They attribute the slow progress to quality of care. They further propose the introduction of certain interventions to realise the sustainable development goals, especially the goal three target of a reduction of maternal mortality to 70 deaths to 100 000 live births. The interventions include provision of quality care that is specific to context, universal health coverage to achieve equity, strengthen health systems and optimise the workforce and increase resilience, guarantee financing and accelerate progress through evidence, advocacy and accountability.

ten Hoope-Bender *et al.,* (2014) identified the increasing expectations from the users on high-quality care during pregnancy and childbirth in low- and middle- income countries. These expectations influence decisions on the choice of place of birth with women bypassing nearby facilities in preference for those with a good reputation associated with the availability of equipment and drugs, local opinion about the facility and the experience at the facility by other members of the community.

5.3.3.1 Continuity of care

According to the study, continuity of care entails having a midwife working with two other midwives to provide care to the women anytime they visit the facility. With this arrangement, there is a higher likelihood of the women meeting at least one of the three midwives anytime they sought services at the facility. Having the woman meeting the same midwife when they seek

care promotes building of relationships and understanding which the women reported to be the reason they preferred seeking care from traditional birth attendants in some parts of western Kenya (Dietsch & Mulimbalimba-Masururu, 2011). However, a shortage of midwives and high staff turnover, arising from frequent transfer was a hindrance to providing continuity of care. Sandall *et al.,* (2011) proposed reviewing how midwives work and deploying support staff to perform non-midwifery functions to free the midwives to concentrate on their roles. Increased use of administrators and midwifery support workers has been shown to increase effectiveness within the midwifery workforce.

The study proposes the provision of maternity services 24 hours a day, seven days a week and outreaches at the community to achieve continuity of care. When midwives provide services at the woman's home or in the community, they can assess the woman to include her everyday living environment and is able to provide holistic care. However, in caseload models of care, a birth talk at around 36 weeks is well established in many areas and empowers women, enabling them to achieve their potential (Kemp & Sandall, 2010).

If home visits were also re-introduced for the antenatal booking appointment in early pregnancy, as well as in the latter half of pregnancy to prepare for birth, this could really address women's concerns and help the midwife to form a partnership relationship with the woman. However, provision of care at the woman's home also has challenges when women have to wait a whole day for a midwife for a postnatal visit. This can be mitigated using a text-based technology where an administrator sends women a text giving a short time slot when the midwife is likely to attend. This could be updated if the midwife gets caught up with a birth or takes longer with previous visits due to unexpected circumstances.

Apart from the midwives visiting the community, continuity of care would be achieved through continuity in the provision of care in the community by midwives handing over the management of the mother to a community health service, such as community health workers, and linking the woman to existing support women groups.

5.3.3.2 Targeted, responsive, effective interventions

Targeted responsive interventions involve doing accurate assessments, provision of a wide range of services including comprehensive care based on protocols and the condition of the woman, observation of standard operating procedures and application of effective practices for care and management. Accurate assessment guides decisions regarding the management of the mother, foetus and baby and during labour whether the woman will birth naturally or will require interventions.

Targeted responsive care is achieved through the provision of quality care to achieve good pregnancy outcomes in the UPENDO-S model. These outcomes lead to a live mother and newborn, minimisation of perineal trauma and an overall reduction in morbidities and mortalities related to pregnancy (Sandall, Devane, Soltani, Hatem, & Gates 2010). Renfrew *et al.,* (2014) propose a system-level shift from identification and treatment of pathology for the minority, to skilled care for all which can be achieved through more engagement with midwives.

Skilled care for all should be aimed at promoting the physiological process of labour and minimisation of interventions in support of woman-centred care (Shaw *et al.,* 2016). Homer *et al.,* (2014) elaborate on the effective maternal and newborn health interventions in the essential interventions commodities and guidelines for reproductive, maternal and newborn child health that can be delivered by midwives. The interventions found effective before conception include

the use of family planning. Around the time of conception, effective interventions include folic acid supplementation, safe abortion services and post-abortion care. After conception, tetanus toxoid, IPTp, multiple micronutrient supplementation, calcium supplementation, syphilis detection and treatment. During labour and birth: clean birth practices, immediate assessment and stimulation and active management of the third stage of labour. In the postpartum period, promotion of breastfeeding, kangaroo mother care, maternal sepsis management and hospital-based care for newborn infections are all necessary interventions.

Midwives are expected to promote normal labour, minimise unnecessary interventions and promote the woman's ability to birth naturally (Homer et al., 2014: Van Lerberghe *et al.,* 2014). Physiological birth has been hindered by the increased use of interventions and lack of robust surveillance systems to ascertain the cause of maternal deaths and accurate identification of the underlying cause of death (Shaw *et al.,* 2016). Identification of the causes can be achieved through maternal death reviews and action taken on the recommendations arising from the reviews.

There are risks associated with over-utilisation of interventions such as *placenta accrete* from previous Caesarean section. Overuse of interventions that were designed to manage complications is considered poor quality care (Renfrew *et al.,* 2014). Poor quality care does not only lead to mortality but also leads to long-term effects to the mother and newborn estimated at 20 million of the total population of births annually (Renfrew *et al.,* 2014). Some countries such as the USA, rank lower than countries such as Poland and Estonia from the 2013 Maternal Index as a result of overuse of interventions that have a risk to iatrogenic harm to women and

newborns. Van Lerberghe *et al.,* (2014) suggest addressing two blind spots the provision of respectful woman-centred care and the minimisation of over-medicalisation

> *epidemic of Caesarean sections associated with ability and willingness to pay.*

5.3.3.3 Excellence in evidence-based practice

The main goal of the application of evidence-based practices is the provision of quality care and normalisation of birth. This is almost certainly because midwives' philosophy is that pregnancy and childbirth is a natural process and their conviction is to support the normal processes of labour and birth. The model proposes use of evidence-based practices and performance of research and knowledge translation. Use of evidence-based practices in Kenya is low as evidenced by a study done in Western Kenya, where its lack of use deterred women from seeking services at health facilities (Patel *et al.,* 2016).

Miller *et al.,* (2016) outline different evidence-based practices during childbirth to include provisions for pain relief using pharmacological and non-pharmacological methods, change of position during labour and birth, integration of HIV/AIDS services with maternity care, allowing food and drink during labour and birth, change of position in management of shoulder dystocia, use of technology in provision of care and active management of the third stage of labour.

Campbell *et al.* (2016) reiterate the need to provide maternity care at a facility that guarantees the seven signal basic emergency obstetric care functions (BeMONC) – namely administration of parenteral antibiotics, administration of parenteral uterotonics, administration of parenteral anticonvulsants for pre-eclampsia and eclampsia (magnesium sulphate), manual removal of the

placenta, assisted vaginal birth, removal of retained products of conception (manual vacuum aspiration), and basic neonatal resuscitation (Bailey, Lobis, Maine, & Fortney 2009). Campbell *et al.,* (2016), in their review of data from eight sub-Saharan countries, including Kenya, revealed that only 16% of health facilities had the capacity to provide BeMONC. The situation is poor as it was found that, of the eight countries, only four had the capacity to provide five basic BeMONC functions. Thus, a need to avoid the unethical practices where women give birth in places with low facility capability, no referral mechanism, with unskilled providers, or where the content of care is not evidence-based. To achieve maternal safety, Shaw *et al.,* (2016) suggest use of protocols, drills and team training in a simulation environment, to address preventable causes of mortality and morbidity, such as massive obstetric haemorrhage.

ten Hoope-Bender *et al.,* (2014) propose regular discussions and evaluation of the package of care for the provision of quality maternal and newborn health care. This includes evaluation of education to ensure a balance between theory and practice, technical capacity, inter-professional relationships, the involvement of communities and overall evaluation of organisation of care and the health system. ten Hoope-Bender *et al.,* (2014) highlight that responsive care entails development of policies that meet the needs of women by considering composition and distribution of health workforce, effective measures to identify and tackle systemic barriers to high-quality midwifery e.g., the low status of women, interprofessional rivalries, poor understanding of midwifery care and what it can do, and unregulated private sector maternal and newborn health care.

5.3.4 Networking (N)

Networking involves collaborations and partnerships, the formation of linkages and stakeholder engagement, the involvement of the community and political leadership in decisions related to maternity care.

5.3.4.1 Collaboration and partnership

The model recognises the role of partnerships to achieve quality care. Through partnerships, there have been improvements in different areas at the facility and external partners have been able to bring support in certain areas. External partners have played a key role in capacity building of health care providers and in technical support. With the rapidly changing demography, epidemiology and evolvement of economies, there is a need for a change of focus to woman-centred care with better linkages across reproductive, maternal, newborn, child and adolescent health and more, as non-communicable diseases and other maternal illnesses become apparent (Koblinsky *et al.,* 2016). It is critical to have responsive maternal health strategies which can be achieved through collaboration with different partners to improve access to efficient, high-quality respectful care, within a functional health system.

5.3.4.2 Establishment of linkages and stakeholder engagement,

The model recognises the strengthening of linkages with community health workers and traditional birth attendants. Koblinsky *et al.,* (2016) reiterate the need for involvement of different stakeholders to achieve quality maternal health care for all women and girls, and the guarantee of access to care to realise the sustainable development goals. An Increase in skilled birth attendance has been realised when community health workers are integrated into the formal public health system (Liu, Sullivan, Khan, Sachs, & Singh, 2011).

5.3.4.3 Engagement of community and political leadership

Participants also envision the involvement of the community and political leadership in decision making. Political leaders have a role in the formulation of health laws and policies. Involvement of the community in the management of the facility ensures that the needs of the general public are considered and the care provided is responsive.

Van Lerberghe *et al.,* (2014) in their study in Indonesia, Morocco, Burkina Faso and Cambodia, stated that the countries achieved improvement in maternal and newborn health through the commitment of political leadership to the expansion of the cadre of midwives. Morocco, Burkina Faso and Cambodia used universal access to promote maternal health agendas and invested in midwives to scale up access that led to a rapid increase in uptake and coverage.

5.3.5 Dedicated supported midwives (D)

This entails having midwives who are knowledgeable, skilled, updated, supported and protected to maximise their skills. The International Labour Organisation (ILO) recognises midwives as the primary professional group to provide maternity care (Renfrew *et al.,* 2014). Van Lerberghe *et al.,* (2014) identify the different maternity care providers to include midwives, family physicians, general practitioners (doctors) and obstetricians. Campbell, Sochas, Cometto, & Matthews, (2016), further elaborate that a provider's designation (midwife or obstetrician) indicates their skill level and defines the level of care they can provide, for instance, midwives can provide routine maternity care and BeMONC while obstetricians come to support the midwife when comprehensive Emoc such as Caesarean section and blood transfusion is required. Renfrew *et al.,* (2014) identified the benefits of care led by midwives who are educated, licensed, regulated, integrated into the health system and working in interdisciplinary teams. With a

combination of efforts between professionals, there is the likelihood of realising improvements in maternal health and cautions against reliance on one professional category to achieve scale-up.

Midwifery can lead to positive health outcomes, especially in settings in which midwifery services are valued and respected, community-based and integrated effectively into a functioning health system (ten Hoope-Bender *et al.,* 2014). This therefore requires midwives to be committed to provide respectful woman-centred care as much as the commitment they have towards provision of clinically expert care. However, care is hampered by the training of providers; for example some are not trained to perform manual removal of placenta and yet is a basic Emonc function (Campbell *et al.,* 2016). Provision of care is also hampered by a shortage of skilled providers where most fall below the threshold of 23 midwives, nurses and doctors per 10 000 population. Provision of maternity care is also hampered by the uneven distribution of midwives and other providers in urban settings creating disparities in coverage in rural areas.

5.3.5.1 Knowledgeable/skilled and updated midwives

Knowledgeable/skilled and updated midwives are those who have undergone a minimum level of education through a curriculum that meets the competencies required to become a midwife. The ICM provides a clear definition and necessary competencies of a midwife (International Confederation of Midwives (ICM), 2017). A midwife is expected to demonstrate expertise in the application of skills during the provision of care and the way they attend to women during routine as well as emergencies. Midwives experienced satisfaction when they utilized their knowledge and skills successfully especially during emergency and difficult situations as evidenced by the study done in England by (Lavender & Chapple, 2004). Through accurate assessment, they can provide appropriate care and apply life-saving skills to achieve better outcomes in emergencies such as retained placenta, obstetric

haemorrhage and shoulder dystocia (ten Hoope-Bender *et al.,* 2014). According to Campbell *et al.,* (2016), in addition to the psychomotor skills, midwives are expected to communicate respectfully.

For midwives to sharpen their skills, they are expected to attend continuous professional development. Continuous professional development has been found to be useful among nurses as it is used to update and expand knowledge and to improve the quality of care they provide (Thompson, Fullerton, & Sawyer, 2011). Van Lerberghe & De Brouwere, (2001) reported on experiences in four low- and middle-income countries (Burkina Faso, Cambodia, Indonesia, and Morocco) and recognised the benefits on maternal and newborn health of scaling up midwifery education to increase the number of midwives for deployment to health facilities. Egypt realised an improvement in the quality of care and saw a 68% decline in maternal mortality between 1992 and 2008 with the introduction of midwives (Campbell *et al.,* 2005).

5.3.5.2 Defined roles, teamwork and professionalism

The model recognises midwives as pivotal and that they work with other healthcare providers to form a team with different roles and responsibilities. This then requires effective interdisciplinary teamwork and integration across health facilities and community settings (Renfrew *et al.,* 2014). A midwife is expected to have clearly defined roles and responsibilities and clinical autonomy to practice. However, the midwifery profession has been restricted by a failure to apply consistent definitions in implementation of midwifery, resulting in a mixed workforce of professional and non-professional staff, many of whom provide only some components of midwifery care. In Indonesia, for example, women sought maternity services from traditional birth attendants because they perceived that midwives and traditional birth attendants played a role in the provision of maternity services whereas institutional birth was

aimed at those who experienced obstetric complications (Titaley, Hunter, Heywood, & Dibley, 2010).

Homer *et al.,* (2014) examined the contribution of midwifery interventions rather than the contributions of midwives and noted that midwives provide services across different continuums, from the community to complex clinical settings not done by a medical specialist. However, the full spectrum of care up to specialist medical care averts maternal deaths, and thus emphasis is placed on midwives to be part of a team within a functional health system, effective and efficient transport services and defined referral system. Collins, Fereday, Pincombe, Oster, & Turnbull, (2010) reiterate the importance of teamwork, camaraderie, working with like-minded midwives' and with midwives they like and respect.

The midwives philosophy of normal birth and minimisation of interventions has been evidenced in western Europe, Scandinavia and New Zealand, where midwives provide 70–80% of care during pregnancy and in low-risk births. Midwife-led models, in comparison with medical-led care, do not demonstrate any adverse effects. There are benefits related to midwifery-led models to include reductions in epidurals, episiotomies and instrument births. There is more involvement of midwives in France and Japan than in the USA. Maternity care is more physician-led in North America with midwives assisting in 12% of all vaginal births. Two out of 10 provinces in Canada have embraced midwives and enacted legislation to regulate them (Van Lerberghe *et al.,* 2014).

There are benefits associated with women receiving care from midwife-led models of care with more women likely to experience spontaneous vaginal birth and have a higher rate of maternal satisfaction, and a cost-saving effect compared to other care models according to a Cochrane

review from studies done in Australia, Canada, Ireland and United Kingdom related to midwifery continuity of care models (Sandall, Soltani, Gates, Shennan, & Devane, 2016). There has been an increase in interventions such as induction of labour, Caesarean birth and other childbirth interventions in the US as maternity services are provided by obstetricians (Shaw *et al.,* 2016). Sweden has had a history of good outcomes as they embrace midwives and have a robust midwifery regulatory body and association.

5.3.5.3 Recognised, supported, motivated midwives

A recognised motivated workforce has a sense of self-worth, self-identity and self-esteem and demonstrates commitment and dedication to their responsibilities (Prytherch *et al.,* 2012). To achieve this, it is important to have a well-designed reward and recognition system. According to the UPENDO-S model, recognition and reward come from simple acts such as "thank you", provisions for opportunities for growth, competitive remuneration and recognition and reward for outstanding performance.

Through performance appraisal systems, well-performing midwives can be recognised and rewarded. Promotion of staff is considered a motivator and boosts morale. The model proposes pegging promotions on years of experience and positive performance appraisal. Having high staff turnover is challenging and hinders continuity of care.

Other ways of recognition of staff are listening to them and considering their recommendations. When staff recommendations are taken seriously, staff feel safe and contented. In the study, midwives felt unappreciated, their contributions ignored, especially when they gave suggestions for improvement in certain areas. Penn-Kekana, Blaauw, & Schneider, (2004) recommend

dialogue with staff and promoting an environment where healthcare providers can implement systems changes.

Collins *et al.,* (2010) and ten Hoope-Bender *et al.,* (2014) emphasise the need of an enabling environment with functional equipment, effective communication and transportation for women and newborns and effective back-up and strengthening referral systems and providing midwives with the back-up of specialised care when needed. In addition, midwives are expected to have targets and check on indicators such as intrapartum stillbirths, early neonatal deaths and maternal deaths surveillance.

5.3.5.5 Professional regulated

Midwives are expected to uphold professionalism, belong to a regulatory body and practice within defined professional codes of conduct and standards and uphold professional ethics. The study also recognises the need for a well-regulated midwife who is protected by law and has the autonomy to practice as a midwife and demonstrate expertise in his or her work. In the Human Scale Development axiological category of protection, a person is legally defined as a midwife because they have the right competencies to practice as a midwife, is accountable and licensed to practice. The very identity of midwives entails belonging to a professional association and being registered by a regulatory body. ten Hoope-Bender *et al.,* (2014) echo the importance of having systems to support midwives through the strengthening of health systems and making regulatory changes to enable midwives to practice to their full capacity.

5.3.6 Organisation of care (O)

The organisation of care entails maintained infrastructure and essential departments, maintained adequate clinical resources, spacious comfortable facilities, improved hospital processes and

effective systems, maintained health information systems and well-defined nature of service at the facility.

Kruk *et al.,* (2016) foresee transformation of maternal health in the next 20 years through social, political, environmental and demographic changes. With the rise of well informed and urban women, demand for information and a rise in expectations of high-quality women-centred care, it is inevitable for health systems to be responsive. With the burgeoning donor support as time goes by, there is a need for increased domestic financing. The increased costs have been a challenge to maternal health which has been mitigated by the introduction of universal health coverage (UHC) in countries like Rwanda and Ethiopia. Koblinsky *et al.,* (2016) reiterate that, with the introduction of UHC, there is a likely improvement in maternal health with the elimination of financial hardship to receiving care.

Kruk *et al.,* (2016) further emphasise the need to put in deliberate efforts to realise improvement in maternal health. Maternal health is embedded in sustainable development goal three of ensuring healthy lives and promoting wellbeing for all ages, unlike the prominence it was given in the UN-sponsored Millennium Development Goals where it was a stand-alone goal. With the growing decentralisation of Governments, in the low- and middle-income countries, there is an expectation for improvement as a result of close supervision and greater demand for better services from the public and civil societies. On the other hand, the situation may worsen as a result of the competing financial needs among the different departments in the Regional Governments. There are challenges of quality in many health facilities arising from unregulated, poorly trained providers and facilities that are not equipped to provide obstetric emergency services. In Nairobi, 70% of women interviewed delivered in health facilities with only 48%

delivering in facilities that meet the minimum standards for obstetric care (Fotso, Ezeh, & Essendi, 2009).

Finally, as these efforts yield independent and rigorous data, such results can guide national and local governments and global partners in working together to focus on what is needed to reach the SDG target for a maternal mortality ratio less than 70 by 2030, and to attain equitable and accelerated improvement in maternal (Koblinsky *et al.,* 2016).

5.3.6.1 Maintained infrastructure and essential departments

Of key importance in the organisation of care is a modern maternity unit with good infrastructure and essential clinical facilities. This requires having infrastructure that meets the minimum standards for the provision of obstetric care and for the demand of services for all women who receive antenatal care at the facility. Another important aspect of infrastructure and physical resources is ensuring that the facility is frequently renovated and maintained.

(Campbell *et al.,* 2016), in their review, identified that 66% of facilities lack basic infrastructure; for example, in Tanzania, 56% of facilities lack water and basic sanitation. An important aspect is ensuring the maintenance of hygiene and good sanitation. Good hygiene can be achieved through consistent water supply and upholding high standards of hygiene such as hand washing and proper disposal of wastes. Maintenance of hygiene can be maintained by making hand washing facilities available, cleaning toilets regularly and having a cleaning schedule. This agrees with other studies that found that maternity services were affected by lack of water Fotso, Ezeh, & Essendi, 2009).

Security is an important aspect of the model of care. This ensures protection from theft and prevention of strangers/idlers from accessing the facility. Theft of babies in some maternity units

has occurred where strangers dress in nurses' uniform and abduct babies (Jackson, Lang, Dickinson, & Fullerton, 1994). Several measures have been taken in certain maternity units to enhance security such as vigilance on visitors at the unit and restricting the entry points (Cocks, 2003).

Infrastructure includes passable roads with availability of transport to the facility, which is a challenge in some parts of sub-Saharan Africa. This then indicates the need for having defined referral systems and availability of ambulances during emergencies.

5.3.6.2 Maintained adequate clinical resources

Resources entail having a well-equipped facility for ease of early diagnosis and management. It also entails having a consistent supply of drugs and commodities, good storage arrangements and maintenance of stock. Lack of essential equipment, such as anaesthetic equipment and arm gloves, contributed to low utilisation of services among urban poor women in Nairobi, Kenya (Fotso, Ezeh, & Essendi, 2009).

Adequate resources include human resources. It is expected that deployment of staff should be aimed at supporting staff to perform maximally considering the midwife: to woman ratio that meets the recommended ICM and WHO standards of 1:1 during labour and 1:30 for antenatal and postnatal care (International Confederation of Midwives (ICM), 2017; WHO, 2010). WHO (2010) recommends one skilled attendant to 175 pregnant women. There is a need to have clear human resource policies that define procedures for recruitment, deployment, transfer of staff from one facility to another, promotion and discipline.

However, achieving a good midwife to woman ratio is hindered by a shortage of midwives, the expectation of midwives to perform multiple roles such as making book entries, receiving and passing on information by telephone, attending to relatives, as well as performing their core business of caring for women.

5.3.6.3 Spacious, comfortable facility

Kruk *et al.,* (2016) state that maternal health is influenced by the structures and resources of societies, communities and health systems. In this regard, such a facility should have basic amenities for women seeking services, with a good ambience and a waiting bay for women to sit as they wait to receive care. A baby-friendly and safe environment where mothers can place their children on the floor and not get worried that their children will get infections is desirable. In a study done in Malawi, the factors considered as important for a facility to provide reproductive health services are adequate reception waiting area, functional toilets, adequate examination, procedure and examination area, availability of equipment supplies and material and defined health records (Rawlins *et al.,* 2013).

5.3.6.4 Improved hospital processes and effective systems

Defined processes, systems and structures involve having organisational structures, policies and guidelines. Policies and guidelines should define clinic hours, referral structures and feedback mechanisms. The organisation of services also denotes the availability and location of services. This can be achieved by organisation of the services as per departments for ease of location and provides for timely access to services. It requires organising services in a distinct manner, such that those women attending antenatal clinic have their place and those seeking other services have their place.

An important component is directions at the facility, which is achieved through signage for ease of accessibility of services complemented by a customer care desk to provide information. Through clear directions and signage and well-designed flow of women, efficiency will be improved and it will aid in facilitating access to services and minimising delays, leading to a reduction in waiting time. This requires signage and clear directions,

The organisation of care also entails established good referral systems, which include good management of women before and during referral, availability of functional ambulances and effective communication and good interpersonal relationships between the staff at the referring and receiving facilities. Poor referral systems and operation times for facilities serving rural areas seemed to have affected the implementation of the free maternal health care services in Malindi District as well (Lang'at & Mwanri, 2015).

An aspect that dominated discussions among the different participants is having clean toilets and a clean environment. This can be achieved by assigning a cleaner checked regularly by the supervisor to ensure it is kept clean and reiterates the importance of an enabling environment of work. Midwives experience motivation from a pleasant work environment where there is mutual understanding, less tension and good relationships between women, midwives and health service managers. An enabling environment, apart from interactions, deals with the actual physical environment of interaction which provides for sitting places for staff during breaks and a place where staff can warm or buy food while at work (Collins *et al.,* 2010).

5.3.6.5 Maintained health information systems

Health information is a critical aspect of health care as it is used to record women's data that is used to ensure the provision of quality care and also in decision making. Graham *et al.,* (2016)

emphasise the need for strengthening vital registration to be able to monitor births, maternal and foetal deaths using technology. Through monitoring, measures to prevent the factors that cause the deaths can be instituted. Campbell *et al.,* (2016) reiterate the need to track indicators to ensure high coverage of skilled birth attendants at birth and antenatal care. The use of District Health Information System (DHIS) II has been effectively used for storage and tracking of health indicators. Health information is underutilised and yet there is an opportunity to use the Demographic and Health Surveys and health facility assessments data to identify the areas of poor performance and institute measures to address them (Campbell *et al.,* 2016).

Midwifery records could be computerised and replace handheld notes so that women can have access to their electronic data. Technology can be used for planning, organisation, implementation, documentation, record keeping, care provision, monitoring and evaluation. For technology to be effective, it requires a good electrical supply and internet connectivity to avoid disruption of the system. Proper use of technology eliminates time wastage. Midwives could access the record before each consultation to refresh their memory about what has happened previously. With the use of laptops, and particularly tablet computers, this could be an invaluable time-saving device for both women and midwives.

Homer *et al.,* (2014) reiterate the need to invest in proven systems to collect and collate data suitable to a specific context depending on the needs and available resources. This requires the development of appropriate tools aimed at building the capacity of countries to be able to generate accurate data and use the data for the provision of care and decision-making and policy direction.

5.3.7 Supportive leadership (S)

Supportive leadership entails experienced focused leadership with good governance who embrace supportive supervision and engage in proper planning and financial management.

5.3.7.1 Experienced, focused leadership with good governance

Good governance and leadership entail having leaders who are focused and engage in inclusive decision making. Such leaders understand their roles, are approachable and can make decisions. They can identify areas of improvement, liaise with different departments to initiate actions for implementation and mitigate challenges.

Experienced focused leaders are leaders who are visionary and can make decisions and support staff to ensure the provision of quality services. Leaders with the requisite management skills, clear strategic priorities and who are supportive to team members. Such leaders are appointed competitively and on merit, vetted, trained on leadership and have good values. Leaders who are appointed based on capability and can perform tasks such as planning, budgeting, organisation, delegation and supportive supervision. They update their leadership skills, are focused and have clear priorities communicated to the team members. They value staff and utilise participatory approaches in decision-making. Pillay (2010), in a study done in South Africa, identified the importance of having health care leaders with people management skills, task-related skills and self-management skills.

Having good governance entails having laid down channels of communication, providing and receiving feedback, being sensitive to employee needs and understanding and listening to their concerns. Leaders create forums to engage with their staff, create consensus and involve them in designing and implementation of policies. Such involvement could be achieved through forums

in which managers and staff discuss different issues. In the forums, the health service managers would empower and support facility managers to plan and implement decisions. Midwives envisaged a time when they would have opportunities to be supervisors and managers and be in a position to design and implement policies.

Consensus building is easily achieved when all members have moral obligations and involvement in decisions of the institution. Inclusion is considered an important aspect as it enables each member to be involved in the creation, maintenance and transformation of the institution (Cooperrider *et al.,* 2003). An all-inclusive culture provides opportunities for all to make decisions on how the institution can be transformed, which cannot be achieved by a single individual. Areas of participation include budgeting, resource allocation and utilisation, development of policies and strategic planning. Shared governance is promoted in a platform where staff can share their views or grievances with management without intimidation or victimisation. When there is inclusive decision making, the institution grows. Cooperrider *et al.,* (1987), p.100) states that the well-performing Cleveland Clinic in the US had

> *Collective authority structure encompassing decision making at the operational, tactical and strategic levels*.

Midwives felt that they understood the system well and were in a position to contribute to areas of improvement based on what they have been doing best.

5.3.7.2 Facilitative supervision

This involves having leaders who provide clinical supportive supervision and, in the process, understand, care and listen to staff concerns and provide feedback. Such managers can create a good environment and build relationships with staff. They monitor the performance of staff and

identify areas of success as well as areas of improvement and challenges that staff face. This they achieve through support supervision at areas of work. Managers can visit facilities and be able to identify challenges and provide solutions to the problems. Primary health care providers in Tanzania desired to have structured and more supportive supervision by managers (Manogi, Marchant, & Bygbjerg, 2006).

Health service managers are expected to be visionary and astute in decision-making. Such leaders provide the necessary support to staff and guide them so that they are competent to make decisions and resolve any challenges that arise. They provide forums for feedback mechanisms through regular meetings between them and staff and schedule visits at service delivery points. They also use such forums to listen and implement recommendations from staff. They can understand, care and listen to staff concerns and can make decisions, identify and respond well to areas of staff needs.

5.3.7.3 Planning and budgeting

Managers are expected to plan for activities, budget, set priorities, make decisions and ensure fiscal responsibility. Planning entails organisation of the general physical systems of the facility, designing organisational structures, policies and guidelines. Maluka *et al.,* (2010), in their study in Tanzania, recommend that priority setting in budgeting should meet four conditions of accountability for reasonableness: relevance, publicity, appeals and revision and enforcement. This ensures fairness, legitimacy and sustainability of the priority-setting process. Planning also requires putting in measures for monitoring and evaluation.

5.4 Strategies for implementation of the UPENDO-S model

The study identified six strategies for implementation of the model: collective responsibility and accountability, the inclusion of women in implementation, planning and budgeting, documentation and communication, benchmarking, and monitoring and evaluation (Powell *et al.,* 2012). Like other behaviour change theories, the UPENDO-S model is more process-oriented and requires whole parts to work in harmony to achieve the desired change. Michie, West, Sheals, & Godinho, (2018) proposes the evaluation of effective strategies based on practicability, applicability, sensitivity and specificity. Forster, Newton, McLachlan, & Willis, (2011) concur that integration and implementation of new models to existing systems is quite complex and requires understanding of organisational context in addition to proposed changes in clinical encounter.

5.4.1 Collective responsibility and accountability

Successful implementation of the model requires collective responsibility and accountability through the involvement of all staff, clear allocation, definition and differentiation of roles. It was agreed to constitute a committee to lead the process. Change initiatives that consider employee participation and contributions have been shown to be successful (Cooperrider *et al.,* 2008). Through committed and supportive leadership that meets regularly with staff to share their successes, change can be achieved.

According to the study, the midwife is recognised as the driver of the wheel who works with other team members. The success of implementation requires commitment from each stakeholder, including community and political leaders in the affairs of the hospital.

5.4.2 Inclusion of women in implementation

During the implementation of the model, emphasis should be placed on value for the women, and it should empower women to seek care. This can be achieved through the development of a communication package detailing services provided and resources available at the facility. Another aspect of implementation involves inclusion of women in structured organisational forums, meetings and activities.

5.4.3 Planning and budgeting

Successful implementation of the model requires planning. It requires a clear work plan, setting clear goals, and formulating a clear organisational structure, vision, mission, goals and objectives. The activities also require adequate financing (Powell et al., 2012).

5.4.4 Documentation and communication

Documentation of progress made in the implementation of the model is considered critical. Documentation involves capture and analysis of facility data. Important in documentation is having clear reporting structures where achievements are recorded and clear recommendations made (Thoroddsen & Ehnfors, 2007). Improved data is important as it will help to initiate important interventions.

Communication between health care providers is important as it provides support to colleagues, contributing to job satisfaction and ultimately impacting on patient safety. Health care service providers communicate in different ways and their communication can be facilitated by having good communication channels such as telephone extensions, memos, reports and service charters (Schillinger, Bindman, Wang, Stewart, & Piette, 2004).

Similarly, Havens et al., (2006) identified improved communication and collaborations across disciplines and sectors and increased nurse involvement in decision-making processes as crucial to successful recruitment and retention of nurses and the delivery of high-quality care. Factors affecting work performance and negative organisational culture or sub-cultures are also reported to affect workplace efficiency, effectiveness and safety of both health care professionals and patients (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Kennerly *et al.,* 2012).

5.4.5 Benchmarking

Benchmarking with other well-performing institutions was one way that participants felt would facilitate the good implementation of the model. This will facilitate the implementation of the model, as learning best practices from other health institutions and experts is an important element of the model. Growth will also be achieved through dynamism and diversity, embracing new advances and new knowledge. It requires flexibility and adaptability to new changes to improve provision of care. This is aimed at making the facility a centre of excellence, against which other health institutions would benchmark.

5.4.6 Monitoring and evaluation

Monitoring and evaluation were considered important to assess the impact of the UPENDO-S model. This requires the design of monitoring and evaluation tools. The study proposes a monthly review of performance. In addition to the monthly review meetings, the study proposes organising quarterly meetings with managers, facility in charges and staff, and use of such forums to share positive experiences and identify areas of improvement. In addition, mutual assessment and feedback among the staff are crucial in fostering the implementation of the model. de Bernis *et al.,* (2016) propose monitoring of key performance indicators of quality

maternity care and this should be reported with the aim of eliminating substandard antepartum and intrapartum care, which is too-often present when a stillbirth occurs.

5.5 Study strengths and limitations

This section discusses the strengths and limitations of the study from the method, selection of participants, data collection and instruments, data recording, analysis and reporting.

5.5.1 Strengths

The strengths of the study arose from the framework that guided the study and procedures for data collection and analysis. The study utilised Appreciative Inquiry and Human Scale Development frameworks. The participatory nature of the two approaches created an environment for participants to articulate their views and contribute to the development and design of the model.

5.5.1.1 Appreciative Inquiry

Appreciative Inquiry provided a systematic way to design the model. As the study progressed, the five principles and four characteristics of Appreciative Inquiry emerged (Whitney & Trosten-Bloom, 2003). The Appreciative Inquiry process of involvement of different participants and harnessing their potential, led to the development of the UPENDO-S model that is practical and applicable to the context. Crawford *et al.,* (2002) recommend the involvement of users in the development and planning of health care for acceptability and use. There has been criticism of development of models without the involvement of users, which has led to the models not being applied as intended. This may be due to the introduction of concepts not deemed applicable to

the users or narrow and not representative of the views of participants but representing views of the developer (Murphy, Gaughan, Hume, & Moore, 2010).

The positive principle and the appreciative characteristic was seen when participants shared positive stories which ignited momentum for change in the organisation witnessed throughout the study period. The poetic principle was illustrated by the provocative and collaborative characteristics in the team spirit among participants. There was sharing of positive past, present and future stories, and collective "dream" and "design" of the model.

The constructionist principle was evident from the way participants deliberated on innovative ideas and initiated actions such as the constitution of a quality assurance team and designed data collection tools. This also demonstrated the applicable characteristic view of Appreciative Inquiry, whereby they referred to what seemed to have worked in the past and elsewhere. For example, they stated in the discovery phase that they achieved good outcomes with teamwork. The development of the model used the constructionist principle and emphasis was placed on the building of relationships.

The principle of simultaneity emerged as participants identified the changes they could make during the study and initiated changes within their sphere. There was the constitution of a quality improvement team at the hospital, request for the purchase of a television set and linen for women, renovation of the maternity section and measures put in place to ensure that toilets were cleaned regularly (Whitney & Trosten-Bloom, 2010).

This does not mean that all the changes were as a result of the study, but the Appreciative Inquiry propelled the initiative for continuous improvement. It brought to the fore areas where

change could be realised with minimum input. Participants gave life to the language, which led to the realisation of the required change as the study progressed, demonstrating the organic nature of the approach.

The anticipatory principle is demonstrated by the visuals participants had for the desired future. They built mental images and finally, the model that would lead to a life-giving future. Participants had an opportunity for self-reflection achieving a positive shift in perspective. According to Carter, (2009), individuals have the ability to envision and give life to an ideal future through the process of storytelling.

The study confirmed that Appreciative Inquiry provides an opportunity for searching for new ideas and generating theories as a team (Bushe, 2007). Appreciative Inquiry provided a platform for midwives, women and health service managers to draw from their extensive experiences and deep understanding of the actual practice context to contribute to a conceptualised model of care, both recognised and owned by them. It provided a platform for reflection on professional practice, identification of what works well and what is needed to perpetuate best practices through appreciation, creativity and self-awareness (Keefe & Pesut, 2004). It also provided an opportunity for the discourse on dynamics that contribute to failure through "naming the elephants", that is, talking about things that were not done well and did not work in the institution (Hammond, 2013). Midwives, who were consistently available for the focus group discussions, demonstrated an understanding of the process. They felt they were part of the research from inception to completion.

5.5.1.2 Human scale development framework

The Human Scale Development framework guided the study in understanding the requirements for satisfaction of the fundamental human needs. The framework also provided practical aspects of day-to-day activities that were considered during the development of the model. The use of the matrix created clarification on the specific existential and axiological axis.

The inputs to the existential and axiological axis demonstrated the specific desirable future within their means. This made clear what specific needs were required and how the needs would be met. For example, participation, decision-making and opportunities to make choices were important. Women wanted to be involved in decisions regarding their care. Midwives, as well as administrators, also voiced the need to be involved in planning and making decisions at the facility.

5.5.1.3 Data collection and analysis

The systematic but flexible approaches to data collection and analysis benefitted from multidisciplinary perspectives. The participatory nature of the study ignited change that was experienced from the onset of the study and solidified the importance of shared common goals and values for each member. Women, midwives and health service managers provided for different views.

The researcher carried out all interviews and transcribed and analysed all the data. Two other people were involved in addition to supervisors to listen to tapes and read the transcripts, increasing the trustworthiness of the study.

The Appreciative Inquiry approach and the Human Scale Development framework were emancipatory as they brought changes during the study period. Participants were able to identify areas of improvement and initiate necessary actions.

5.5.2 Limitations

The utilisation of the Appreciative Inquiry approach and the Human Scale Development framework by a novice researcher constituted new concepts to the researcher as well as to the participants. This required extensive reading by the researcher for a better understanding of the framework to be able to utilise the framework and provide explanations to participants. The supervisors guided the researcher during the different researcher stages from development of the proposal to the writing of the thesis.

The Appreciative Inquiry cycle of meeting participants in the four phases required the engagement of participants multiple times and required them to dedicate more time to participate in the research. This however, provided an opportunity for integrating Appreciative Inquiry into the midwives day to day work (Carter & Little, 2007). Having different teams of women from start to finish did not bring about the continuation and energy seen in the midwives. Similarly, the same change was not noted in discussions with the managers as not as much time was spent with managers as with midwives. Another limitation is the lack of involvement of obstetrician in the study and thus their views on the model of care not captured. This was hindered by the fact that the study site did not have any obstetrician or any other specialist. However, views of a medical officer available are included.

The study captured the views of women with different demographic characteristics seeking maternity services. This does not guarantee the generalisability of the findings due to the small

sample of women who participated in the study despite providing detailed descriptions of their experiences with maternity care and contributions to woman-centred care. Women who participated in the study had to be conversant with English or Swahili languages. The researcher conducted all the focus group discussions and interviews in either English or Swahili, depending on participants' language preference for standardisation.

All midwives and health service managers were aware at the start of the study of the researcher's position as a midwife lecturer and a board member of the nurses and midwives regulatory board. The women viewed the researcher as an expert clinician visiting the facility for purposes of the research study. There were occasions that the women expected to receive expert advice from the researcher and had to clarify the researcher's position and refer the women to an attending clinician. This, therefore, posed a risk on social desirability as participants may have described what they thought the researcher desired to hear based on her position, rather than a true reflection of their opinions. The researcher consistently informed the participants of the importance of expressing their views freely as the information would be treated confidentially. The tension was only palpable in the first focus group discussions but as the study progressed, participants seemed balanced in their contributions bringing out both positive and areas of improvement.

Another limitation is patriarchy, where women depend on health care providers or their spouses to make decisions on their behalf. Having them speak out during the focus group discussions required a great deal of persuasion. Midwives too assisted in recruitment of women participants. It could not be ruled out that they selected participants friendly to them. The women seemed balanced in their contributions and they highlighted both positive and negative aspects freely.

Being a doctoral student and using thematic analysis and thematic network analysis without the benefit of other co-researchers to review the data and robustness of the findings and the themes as they emerged was a limitation. The analysis process required intense concentration and back and forth reading of the transcripts. The researcher discussed assumptions with the two research supervisors which provided for an opportunity for reflection of emerging categories themes. There was no on-site supervisor. The researcher had regular Skype meetings with the supervisors and all the transcripts and audio-taped records were uploaded in Dropbox accessible to both supervisors. Member checking was also used for verification and received positive feedback from participants.

The midwives and health service managers did not understand the concept of continuity of care an important component of woman-centred care. The design of the study was to recruit the women for focus group discussions when they presented as it was the only feasible as the practice is the women visit hospitals without any appointments and there was no guarantee that the women would return to seek services at the hospital even when given next return date. Another limitation of the study is scarce literature on implementation of woman-centred midwife-led care in low and middle resource countries.

5.6 Chapter summary

The chapter discussed the findings with each component of the UPENDO-S model discussed. The section explained the application of Appreciative Inquiry approach and Human Scale Development framework in the study. The section has also provided an explanation on strategies for implementation of the model. The strengths and limitations of the study were also discussed.

6. IMPLICATIONS, RECOMMENDATIONS AND CONCLUSION

6.1 Introduction

This concluding chapter presents the implications and recommendations for further research.

6.2 Implications

The implications of UPENDO-S model are presented in relation to practice, women, midwives, health service providers, education, and research.

6.2.1 Implications of the UPENDO-S Model

Through this study, the potential to contribute to the existing body of knowledge was achieved through the design of the UPENDO-S model, using Appreciative Inquiry and the Human-Scale development framework. Its participatory nature involved women, midwives, and health service managers. The model is intended to strengthen the provision of maternal and newborn care in Uasin Gishu County hospital.

Achieving change in health care system is dependent on several factors which may require transition from one identity to a new identity (Campbell, 2008). The implementation of the model requires making adjustments in certain areas and routines at the hospital to integrate certain services into existing services, such as increasing hours for the provision of antenatal services and other maternal and newborn health services, sensitisation and encouraging women to seek antenatal care services earlier, and early identification and management of complications, to achieve a live mother and newborn. Varkey & Antonio, (2010) emphasises that for change to

occur, communication is important and there are certain steps that need to be followed mainly assessing readiness for change, establishing sense of urgency, developing a change plan and achieving a culture change anchored within the system. The Appreciative Inquiry process that was used in the study provides guidance especially in implementation of the model provided in phase IV of the Appreciative Inquiry cycle. Campbell (2010) reiterates the importance of recognising the different dynamics getting the vision right, and having to communicate to get buy-in, enable action and identify areas of short quick wins.

6.2.2 Implications for practice

The UPENDO-S model places emphasis on provision of quality care that meets women's needs and preferences. The goal is to achieve good maternal and neonatal outcomes and have a live and well mother and baby. The State of the World's Midwifery UNFPA, (2014) and ten Hoope-Bender *et al.,* 2014) state that improvement in maternal and newborn outcomes can be achieved through improvement in accessibility, availability, acceptability, quality midwifery services and an increase in universal health coverage.

Due to the emancipatory nature of Appreciative Inquiry, midwives during the design stage were able to design ways of improving their recording and assigning each midwife responsibility for the follow up of women they reviewed each day. The model also recognises the application of evidence best practices and benchmarking to share best practices and provision of up-to-date care. The model also recognised partnerships and networking as critical to providing quality care. This is an opportunity to incorporate external partners in decisions of care, especially during the development of work plans.

The model identifies a spacious facility with good ambience as important. Such an environment is expected to encourage women to seek care and be able to give birth in a clean, safe environment. Even though participants dreamt of the construction of a new facility, they were able to modify existing structures to provide for more room, with a vision of moving to a larger facility in future. Considering the current facility set up, ensuring privacy is a challenge. A process of renovation and partitioning of the facility had already commenced.

6.2.2.1 Implications for Women

The components of user-friendliness and person (woman)-focused care places emphasis on the woman as the focal point. The connection and the building of relationships are considered critical. The women in the study wanted to be recognised as women and not patients and propelling woman-centred concepts and personalized responsive care. The study identified provision of culturally-sensitive care as being critical. This requires women to disclose cultural practices that they practice and their preferences.

The UPENDO-S model considers the provision of information and consistency in the information provided as a means of empowering women to make decisions. This can be achieved through defined information packages and other structured means of providing information, such as childbirth classes. Although embedding a birth plan section in standard maternity notes has benefits, these are not always realised in practice. Having knowledgeable informed women means they can take active roles in the process of planning during pregnancy, birth and after birth. Women are expected to make choices on place of birth, position of birth and on procedures done on them (Cook & Loomis, 2012).

The provision of compassionate, culturally sensitive care is highly valued. This can be achieved through ensuring privacy and confidentiality for the woman. It is also necessary for midwives and other healthcare providers to take time and understand the woman's culture to avoid contravening cultural practices and also to be able to identify culturally harmful practices and to discourage women from such practices.

6.2.2.2 Implications for Midwives

The study identified the need to have qualified skilled updated midwives who uphold professionalism. The midwives are expected to apply evidence-based practices during the provision of care and any encounter with the women. This then requires the midwives to undergo continuous professional development and training to ensure that they are updated and have appraised of current best practices. This will be facilitated by the availability of and access to current journals and other materials for staff to update themselves on best practices.

Another implication is having a sufficient number of midwives to achieve continuity of care and the monitoring of women during labour and for antenatal and postnatal follow up. Midwives also need to be supported by other cadres of staff so that they can refer appropriately.

6.2.2.3 Implications for Health Service Managers and Policy

This study affirmed that health service managers at the facility, county and national level have different roles to play and a key role in ensuring the provision of quality maternity care. This requires managers to design ways to identify the needs of facilities and, through participatory processes, be able to devise ways to develop and achieve organisational goals. It also requires the introduction of new skills to health service managers to enable them manage people and processes and be able to make decisions.

The study identified the need for the health service managers to take the lead in organisational change and involve a wider group of stakeholders, including women, midwives, and the community, in decision-making. This way they can provide relevant and workable ideas and solutions. This requires health service managers to organise public forums between managers, staff, women and the community.

Other areas in the policy are resource allocation, staffing and the deployment of staff, infrastructure and leadership. Successful implementation of the model requires policymakers to identify and prioritise areas of action. This requires planning for staffing and the rationalisation of staff according to facility workload. Organisational change is complex and requires midwives and health service managers to engage in formal and informal negotiations for the model to be adopted and implemented. This is as a result of wide and conflicting interests among the different actors. This requires that management activates different resources and mechanisms to achieve organisational change.

Infrastructure was thought to be the main challenge and there are opportunities to modify different areas to meet the needs of women. Findings indicate that the facility cannot meet the demand for birth services. This requires policymakers to have a policy on the norms and standards for maternity care through a tiered system that clearly describes what is to be managed from primary, secondary and tertiary level of care. Development of standard referral protocols will be helpful in ensuring that prompt referrals are done without any delays.

Another area of concern is the development of human-resource policies that clearly stipulate terms of services, specifically for staffing, promotion, recognition and reward. Other important policy documents include a communication strategy and a referral strategy. The study also

proposes recognition and reward for outstanding performances through simple acts, like appreciation for a job well done, and designing yearly awards for different categories.

The model placed the emphasis on the use of health information systems to capture data. This requires midwives to create standardised collection and reporting tools and to be able to monitor and evaluate the care provided. Through a standard register, midwives can have a record and track women.

6.2.3 Implications for education

The different parts of the wheel are articulated in the UPENDO-S model. As such, it can be integrated into the midwifery curriculum for both pre-service and in-service students as the model defines the concepts that are important in the provision of person (woman)-focused care. The model provides a framework to introduce nursing and midwifery students to concepts considered important in the provision of maternity and midwifery care.

6.3 Recommendations for further research

The study developed UPENDO-S model. The next steps for research are validation of the model and adaptation for use in different maternity settings. There is need for further research on understanding of woman-centred care and the UPENDO-S model. This is because the study identified a gap in understanding of woman-centred care among women, midwives and health service managers. The study identified a lack of understanding of models for the delivery of woman-centred care and continuity of care. Further research is required to identify the practical application of the model to achieve woman-centred care and sustainability of the model.

The findings propose the involvement of women in decision-making. Further research is required in this area for social change to identify the extent of involvement of women in decision-making in maternity care and their lives in woman-centred care. Considering the patriarchal nature was a limitation for women in decision making. Both healthcare providers and spouses/husbands influenced decision-making among women. There is a need to identify ways of involving men in maternity care to be more informed and involved and be able to support the women.

There is also an opportunity to identify ways in which midwives and healthcare providers can support women in decision-making, as the study recognised the need for having a knowledgeable informed woman. The provision of information was considered critical, as it was noted from the study that emergencies experienced were largely late referrals from home when women arrived late at the facility. This could be mitigated through awareness and the education of the public on the importance of seeking maternity services early, and also making the care accessible to women and taking the care close to the women or in their homes.

The provision of care at the community was emphasised and there is a need to advance through research acceptable and feasible ways of the provision of care in the community.

6.4 Knowledge translation plans

The Appreciative Inquiry and Human Scale Development participatory approach contributed to changes as the research study progressed. Whitney & Trosten-Bloom, (2003) advocates collaboration between researchers and knowledge users to change practice. The involvement of participants at every stage of the study especially during data collection using Appreciative Inquiry encouraged participants to initiate and implement changes as the study progressed

(Straus, Tetroe, & Graham, 2011). The participants were now aware and were able to provide care aimed at meeting the needs of the woman. The participants collectively contributed to knowledge translation during the research process by development of clinical guidelines to improve on recording as the study progressed implementation strategies to include planning, financing, educating, restructuring and paying attention to policy requirements (Powell *et al.,* 2012).

Research findings will be disseminated the staff at the participating facility and other health staff at the County. In addition, presentations will be made at local and international conferences and at different relevant health related scientific forums. Research findings will also be shared at different forums at the participating institutions as well as to County and National health forums. Knowledge translation will further be achieved through use of printed material especially the UPENDO-S model and it's components.

6.5 Conclusions

The design of the UPENDO-S model of care has generated a novel approach to the provision of maternity care – an area that has been minimally researched in Kenya. The objectives of the study were to discover what best maternity care looks like, to envision what best maternity care would be like, to design a model of care and develop strategies for implementation of the model. It emerged that participants can work together to design a model to guide their practice. It was clear that, when positive approaches are used, these motivate participants and enable them to share their best experiences and develop ways that suit them and their context. The main goal in maternity care is a live mother and baby. The model supports a woman-centred care and identification of the woman with needs considered.

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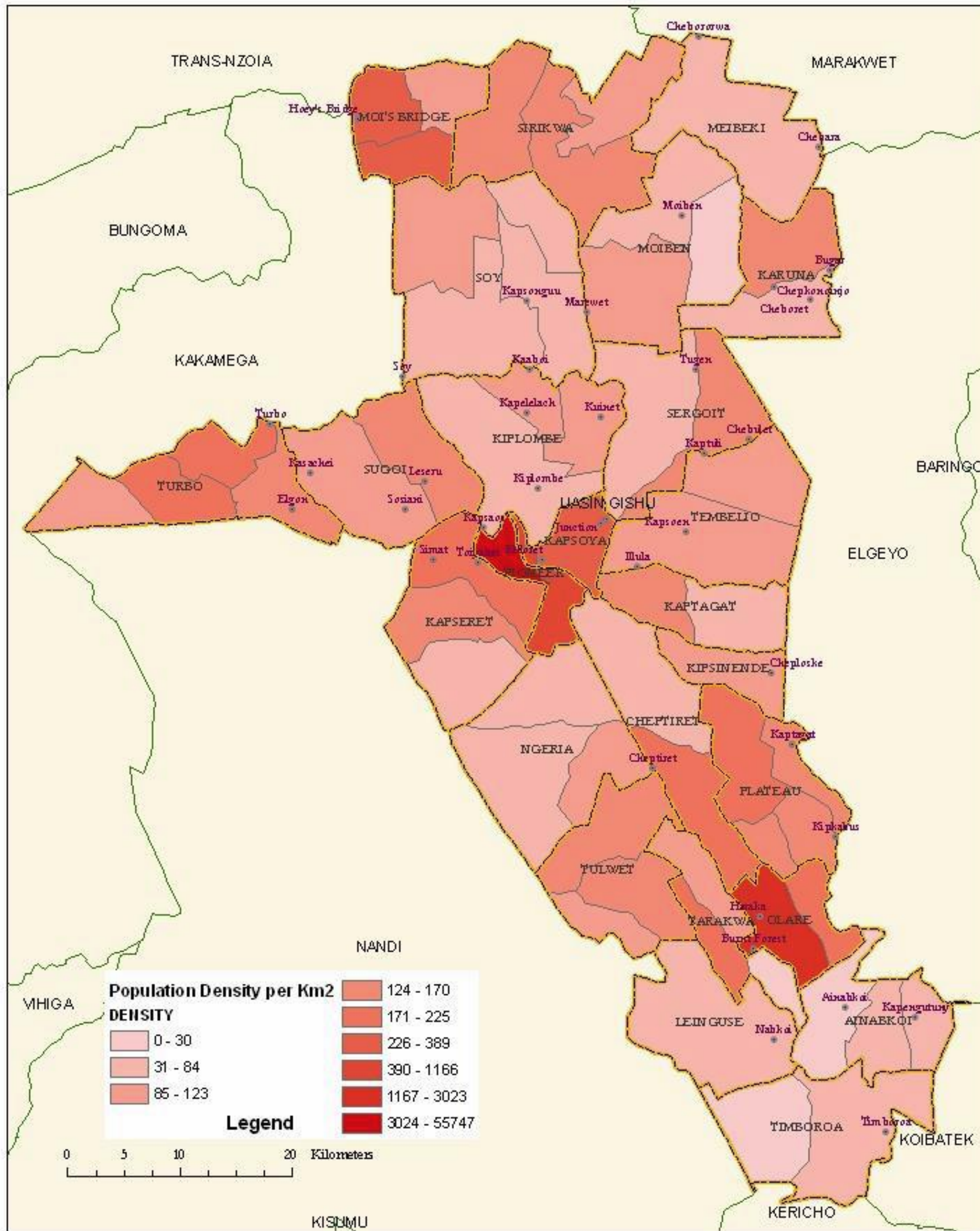
APPENDICES

APPENDIX I: Map of Uasin Gishu County



APPENDIX II: The Max-Neef Axiological and Existential needs framework

The matrices will be filled during the group discussions

Fundamental Human Needs	Being (Qualities)	Having (Things)	Doing (Actions)	Interacting (Settings)
Subsistence				
Protection				
Affection				
Understanding				
Participation				
Idleness				
Creation				
Identity				
Freedom				

APPENDIX III: University of Cape Town Ethics review Approval

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6338 • **Facsimile** [021] 406 6411
Email: shuretta.thomas@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

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17 April 2015

HREC REF: 242/2015

A/Prof M Coetzee
School of Child & Adolescent Health
2nd floor, ICH Building
Red Cross Children's Hospital

Dear A/Prof Coetzee

PROJECT TITLE: DEVELOPMENT OF A MIDWIFE-LED MODEL OF CARE THROUGH PARTICIPATORY METHODS FOR THE UASIN GISHU COUNTY REFERRAL HOSPITAL, KENYA (PhD Nursing Candidate - Ms E Rotich)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th April 2016.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please quote the HREC REF in all your correspondence.

We acknowledge that the student, Mrs Everlyne Rotich will also be involved in this study.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Yours sincerely

Signature Removed

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH

HREC 242/2015

Appendix IV: Moi University and Moi Teaching and Referral Hospital Ethical Review Approval Letter

INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE (IREC)

MOI TEACHING AND REFERRAL HOSPITAL
P.O. BOX 3
ELDORET
Tel: 33471//2/3

MOI UNIVERSITY
SCHOOL OF MEDICINE
P.O. BOX 4606
ELDORET

Reference: IREC/2014/63
Approval Number: 0001174

14th May, 2014

Ms. Everlyne Rotich,
Moi University,
School of Nursing,
P.O. Box 4606-30100,
ELDORET- KENYA.

Dear Ms. Rotich,

RE: FORMAL APPROVAL

The Institutional Research and Ethics Committee has reviewed your research proposal titled:-

"Involving Women and Midwives in the Development of a Midwife-Led Model of Care for Uasin Gishu County, Kenya".

Your proposal has been granted a Formal Approval Number: ***FAN: IREC 1174*** on 14th May, 2014. You are therefore permitted to begin your investigations.

Note that this approval is for 1 year; it will thus expire on 13th May, 2015. If it is necessary to continue with this research beyond the expiry date, a request for continuation should be made in writing to IREC Secretariat two months prior to the expiry date.

You are required to submit progress report(s) regularly as dictated by your proposal. Furthermore, you must notify the Committee of any proposal change (s) or amendment (s), serious or unexpected outcomes related to the conduct of the study, or study termination for any reason. The Committee expects to receive a final report at the end of the study.

Sincerely,

Signature Removed

PROF. E. WERE
CHAIRMAN
INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

cc	Director	-	MTRH
	Principal	-	CHS
	Dean	-	SOM
	Dean	-	SOP
	Dean	-	SON
	Dean	-	SOD

Appendix V: Moi University &MTRH continuing Approval

INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE (IREC)

MOI TEACHING AND REFERRAL HOSPITAL
P.O. BOX 3
ELDORET
Tel: 33471//2/3

MOI UNIVERSITY
SCHOOL OF MEDICINE
P.O. BOX 4606
ELDORET
Tel: 33471/2/3

Reference: IREC/2014/63
Approval Number: 0001174

14th May, 2015

Ms. Everlyne Rotich,
Moi University,
School of Nursing,
P.O. Box 4606-30100,
ELDORET-KENYA.

Dear Ms. Rotich,

RE: CONTINUING APPROVAL

The Institutional Research and Ethics Committee has reviewed your request for continuing approval to your study titled:-

"Involving Women and Midwives in the Development of a Midwife-Led Model of Care for Uasin Gishu County, Kenya".

Your proposal has been granted a Continuing Approval with effect from 14th May, 2015. You are therefore permitted to continue with your study.

Note that this approval is for 1 year; it will thus expire on 13th May, 2016. If it is necessary to continue with this research beyond the expiry date, a request for continuation should be made in writing to IREC Secretariat two months prior to the expiry date.

You are required to submit progress report(s) regularly as dictated by your proposal. Furthermore, you must notify the Committee of any proposal change (s) or amendment (s), serious or unexpected outcomes related to the conduct of the study, or study termination for any reason. The Committee expects to receive a final report at the end of the study.

Sincerely,

Signature Removed

PROF. E. WERE
CHAIRMAN
INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

cc:	Director	-	MTRH
	Dean	-	SOM
	Dean	-	SPH
	Dean	-	SOD
	Dean	-	SON

APPENDIX VI: Facility request for participation in research

University of Cape Town

Department of Health and Rehabilitation Sciences

Division of Nursing and Midwifery

20th October, 2014

Dear Sir

Request to enroll your health facility for a study

My name is Everlyne Rotich, a midwifery lecturer Moi University Kenya and a doctoral student at the University of Cape Town South Africa. I am writing to request for permission to enroll your facility for a study titled "Development of a Midwife-led model of care through participatory methods for **Uasin Gishu county, Kenya**".

Purpose of Study:

People who work in a certain place know the place best and have an upper hand in designing strategies to improve practice in their context. Learning from midwives and women will give the best answers as they understand the place best.

The purpose of this study therefore is to involve maternity health care workers and users in development of innovative ways of delivery of midwifery services.

Process:

Data collection will be carried out in a period of six months. Two focus group discussions lasting between 45 minutes to two hours will be held every month and midwives will be invited to participate in different sessions. Not all midwives will be expected to participate at the same time. Confidentiality will be maintained throughout the study. Information on the research process will be provided to you specifically how it will begin and unfold to the end. You will be expected to participate in at least 3 group discussion sessions with midwives or women lasting between 45 minutes to two hours spread over the six months. The discussions will take place at a mutually convenient place. Discussions will be audio-recorded to ensure what people say is correctly captured, and thereafter transcribed. Group discussions will be to discover the current state of care, provide participants a platform to dream about what midwifery services would be like at their best, design the desired services and finally create that desired future. Participants' demographic data will also be obtained through a demographic form.

Findings of the study will be provided to your institution. I have attached an abstract for the study proposal for your perusal.

This is therefore to kindly request for permission to carry out the study at your facility.

In case you need any clarification or any more information regarding the study, you may contact Everlyne Rotich on +254-722-358834. You can also contact research supervisors, Prof. Minette Coetzee (minette.coetzee@uct.ac.za) and Prof. Sheila Clow (sheila.clow@uct.ac.za), chair MTRH Institutional Research Ethics Committee and Professor Moi University Prof E. Were (eowere@gmail.com) and Chair University of Cape Town Human Research Ethics Committee Prof Marc Blockman (marc.blockman@uct.ac.za) through their email addresses.

Your assistance is highly appreciated.

Yours sincerely

Everlyne Rotich

APPENDIX VII: Invitation to Participate in a Research Study

University of Cape Town

Department of Health and Rehabilitation Sciences

Division of Nursing and Midwifery

Dear Sir/Madam

My name is Everlyne Rotich, a midwifery lecturer Moi University Kenya and a doctoral student at the University of Cape Town South Africa. I am inviting you to participate in a study titled "Development of a Midwife-led model of care through participatory methods for **Uasin Gishu County, Kenya**".

Purpose of Study:

People who work in a certain place know the place best and are privileged are best placed to provide strategies to improve practice in their place of work. Learning from midwives and women will give the best answers as they understand the place best. The purpose of this study therefore is to involve maternity health care workers and users in development of innovative ways of delivery of midwifery services.

Process:

If you agree to participate, information on the research process will be provided to you specifically how it will begin and unfold to the end. You will be expected to participate in at least 3 group discussion sessions with midwives or women lasting between 45 minutes to two hours spread over a period of nine months. The discussions will take place at a mutually convenient place. Discussions will be audio-recorded to ensure what people say is correctly captured, and thereafter transcribed. Group discussions will be to discover the current state of care, provide participants a platform to dream about what midwifery services would be like at their best, design the desired services and finally create that desired future. Participants' demographic data will also be obtained through a demographic form.

Confidentiality:

The results of the study will be based on group data. All data will be captured in such a way that individual identities will not be disclosed in any reports or publications resulting from this study. Fictitious names will be used in reporting of findings. No individual will be identifiable and confidentiality will be negotiated among participants at the start of each discussion.

Risks:

There are no known risks for participating in this study.

Benefits:

Participating in this study will provide you with an opportunity to be part of a group designing a midwifery model of care.

Voluntary Participation and Withdrawal:

Participation in the study is completely voluntary. Any participant can withdraw from the study at any time, without any prejudice or consequence. The hospital management has consented for the study to be carried out at this facility but this does not mean that you are obliged to participate. There is no payment for participating in this study but transport costs will be reimbursed and refreshments will be provided.

Feedback to Participants:

A summary of the results of the study will be made available to you on request.

Further Information:

In case you need any clarification or any more information regarding the study, you may contact Everlyne Rotich on +254-722-358834. You can also contact research supervisors, Prof. Minette Coetzee (minette.coetzee@uct.ac.za) and Prof. Sheila Clow (sheila.clow@uct.ac.za), chair MTRH Institutional Research Ethics Committee and Professor Moi University Prof E. Were (eowere@gmail.com) and Chair University of Cape Town Human Research Ethics Committee Prof Marc Blockman (marc.blockman@uct.ac.za) through their email addresses.

Tear-off sheet: If you are interested in participating in this research on "Development of a midwife-led model of care for Uasin Gishu County, Kenya", please tear off this part and put it in the supplied enveloped and seal the envelope. The researcher will collect the sealed envelopes from the facility. You can also call the researcher on her mobile number 0722358834.

Name:____

Phone no. ____

APPENDIX VIII: Informed consent form

University of Cape Town

Department of Health and Rehabilitation Sciences

Division of Nursing and Midwifery

I ___________________________have read the information inviting me to participate in the study and clearly understand that this study is being done by Everlyn Rotich a midwifery lecturer Moi University Eldoret, towards her doctoral studies at the University of Cape Town, South Africa. The purpose of the study is to develop a midwife-led model of care. I understand that the study involves participating in discussion groups with women and other midwives. There are no risks associated with this study. I will be expected to participate in group discussions each lasting between 45 minutes to 2 hours over a period of nine months. **The discussions will be audio recorded**. No identifying information will be included when the interviews are transcribed.

My participation in this study is entirely voluntary and I am allowed to withdraw from the study at any point in time of the study period. I am allowed not to contribute to questions that I may not be comfortable with. If I discontinue from the study, there will be no penalty. I have been informed that this research has received ethical approval from the University of Cape Town Human Research Ethics Committee and the Moi Teaching and Referral Hospital Research Ethics Committee. I have also been informed that my employer has granted permission for this study to be carried out in our facility and this does not oblige me in any way to participate in the study.

I am aware that the study results will be presented to the County health management, our facility and the University of Cape Town towards doctoral studies for Mrs. Everlyne Rotich. The findings will also be presented at scientific conferences and published in refereed journals. In case I need any clarification or any more information regarding the study, I may contact Everlyne Rotich on +254-722-358834. I can also contact research supervisors, Prof. Minette Coetzee (minette.coetzee@uct.ac.za) and Prof. Sheila Clow (sheila.clow@uct.ac.za), chair MTRH Institutional Research Ethics Committee and Professor Moi University Prof E. Were (eowere@gmail.com) and Chair University of Cape Town Human Research Ethics Committee Prof Marc Blockman (marc.blockman@uct.ac.za) through their email addresses.

The study has been explained to me in detail and I understand the purpose of the study. I agree to participate and will be given a copy of this form.

Signature of participant Date and place

Signature of witness Date and place

Signature of Researcher Date and place

APPENDIX IX: Questionnaire for obtaining demographic data from women

SECTION A: DEMOGRAPHIC INFORMATION		
	Questions	Response
1	Age	1. 18- 20 years 2. 21-25 years 3. 26-30 years 4. 31-35 years 5. 36-40 years 6. Above forty
2	Number of children	1. 1 2. 2 3. 3 4. 4 5. 5 and above
3	How many children have you had at the facility?	5 1 6 2 7 3 8 4 9 5 and above
4	Occupation	______________________

APPENDIX X: Questionnaire for obtaining demographic data from midwives/ health managers

SECTION A: DEMOGRAPHIC INFORMATION		
	Questions	Response
1	Gender	1. Female 2. Male
2	Highest Level of education completed	1. Certificate 2. Diploma 3. University Degree 4. Masters 5. Other (Specify)
3	Years of experience in midwifery	1. 1 -5 years 2. 6-10 years 3. 11-20 years 4. 21 years and above
5	Current place of practice	1. Antenatal clinic 2. Labor and delivery 3. Postnatal clinic 4. Newborn clinic 5. Family planning unit
6	Years working at current place of work	1. Below 1 year 2. 1 year 3. 2 years 4. 3 years 5. 4 years 6. 5 years 7. 6-10 years 8. 11-20 years 9. 21 years and above
7.	How many children do you have?	1. 1 2. 2 3. 3 4. 4 10 and above
8.	Did you have any of your children at the facility?	1. Yes 2. No

APPENDIX XI: Focus group/ Interview guide for the four phases discovery, dream, design and destiny

PHASE I: DISCOVERY QUESTIONS

There have likely been many times that you were happy with maternity services. Choose a time that is a personal high point-- when you felt especially alive, engaged and excited about the services.

1. What stands out as your high point when materity services were at its best?
    a. Please describe what happened and who was involved
    b. What was done differently?
    c. What made the service exceptional?
    d. What contributed most to the success of the effort?
    e. What was supportive about the situation?
2. What is it about this institution (structure, values, systems, processes, policies, staff, leaders, strategy, creates the best condition?
3. What do you consider some of the most significant trends, events, and developments shaping the future of maternity services?
4. What are the areas of improvement?

PHASE II: DREAM QUESTIONS

5. Imagine a time in the future when maternity care is at its best in our facility; assuming that all the required resources are available. People look at our hospital as an exceptional example of a thriving, attractive hospital where health care workers and women engage in the hospital's future: in this exciting future, what will be most significant?
    a. In this exciting future, what will be most significant?

b. What will be true of the maternity services?

c. What would be sustaining the exceptional services?

d. What kinds of systems and structures would be in place?

e. What would you be proud of in this future?

PHASE III: DESIGN QUESTIONS

6. What are the most important factors to achieve woman centred care to be included in the model?

PHASE IV: DESTINY

7. What next steps can be done to achieve the desired future and implement the model?

APPENDIX XII: Sample transcript

FGD 10 (12 women)

I: Imagine a time in the future when maternity care is at its best in our facility; assuming that all the required resources are available. People look at our hospital as an exceptional example of a thriving, attractive hospital where health care workers and women engage in the hospital's future: in this exciting future, what will be most significant?

I In this exciting future, what will be most significant?

R: W 1 I think by that time there will be a better a bigger like bay or a waiting area

I: bigger bay?

R: W 1 yes a bigger waiting bay than present one

I: eee

R: W 1 and may be a place for mothers and babies to be a bit separate not as it is now you know now it is a bit congested. I was saying mothers and babies are going the other side then pregnant mothers going the other side then children the other side have a baby like colorful area you know such like thing it will be a better place

I: What are the other ideas that people have? Let's dream (laughter)

R: W2 yes and maybe we say like this district hospital, this one, I would rather change more mothers labor wards for mothers to deliver than causing congestion at MTRH, if possible be working 24/7 basis like other labor wards and be at least sufficient enough to hold mothers at least say 25 at a time if it's possible

I: mmm what else? (Silence)

R: W 6 another we will be having a baby mother friendly facility

R: W 3 you know something apart from the usual, it's even good to know that something different can be done apart from you going through labor or only two options like in Kenya its only the option of going through c/s or normal labor that would have been more advanced a bit

I: yes, I want to hear this side please talk,

I: what is it that you'll want to see in that future in this hospital if all resources are available?

Q 2: What will be true of the maternity services?

R: W7 we will be having separate laboratories for maternity unit at least be put somewhere even constructing one

Silence

I: what else? Please let's talk I have not heard voices of mothers from this side

I: mmm

R W 7: and then I was asking if there is a way of reducing waiting time mothers take long time from lab to here I don't know if it's lack of staff or what? At times you come here you find one nurse may be and students so if possible to increase some staff for provision of quality care

I: mmm

R: W 8 actually it will be better if midwives would be coming let's say they set a day may be say such and such a day we are coming to such and such an area then they cover may be they weigh since the amount of work is minimal. They say today we are going to kapsoya,   mothers in kapsoya wait then weigh your children in the house, it will give you better time even if is they say at a certain centre or I don't know it will give you easier time and reduce congestion for many because weighing has no much work

I: mmm

R: W 8 I am being treated as well because I have a right as a human being...

I: and as an identity as human being how do they identify you that's what I want us to do…you are identified her as who? A patient, mother or who what do you feel your identity is here?

R W 3: they refer to us as patients but we are not sick. I will like them to refer me as a mother because pregnancy is not sickness

R W 10. Midwives should inform us on anything they do to us. They need to tell us what drugs they are giving us like during immunization, they should tell us the injection the baby has been given. I don't know you know it depends on somebody's curiosity like me am very curious, I have to ask what is it for? That injection is for this and this and the other one is for that not just injected.
I: mhh…

R: W 10 maybe if we were being told like this days children are given two injections, you are told this injection is for this and the other one is for that, not just injected actually we don't even know this injection is for what. Later you hear I heard it's for I don't know if pneumonia and the other one for immunization you see it's not good to get information from the third party even others you don't know

I yes tell us more about the issue

R W 3: we have exhausted that one.

I ok let's move to the next question

Q 3 What would be sustaining the exceptional services?

R W 8: they will have a modern maternity unit that is spacious

R W6: another thing is that we shall work together as one to ensure that mothers get what they need to get

R W 9: you see like when you come here, you wait for long before being see. In that future, there will be more staff and more consultation rooms

R W 3: free maternity care

R W 2: involvement of men and community members in decisions of the hospital

R W3,: also the choice of a place to deliver is not just for the mothers haa our husbands should

be involved.

R W6: enough finances

Q 4 What kinds of systems and structures would be in place?

R: W 5 what I can say is you see this scanning machine at least be put somewhere like here because when you want to be scanned you have to go to this hospital what is it called this hospital up there

I: mmm

R: W 5 that private hospital where they hold the baby without even knowing direction he's facing, they just hold as long as they've located the head they don't know but will reach delivery period. Will be a problem because you were not informed where child is facing, so you will be shocked be told to go for c/s because it was not scanned to know if a child is having which

problem. Even that scanning Even if it is a must to pay, you know you'll pay around 2,000 even if it is placed here, it's a government facility so it will be cheaper than that private hospital

I: mmm…

R: W 6 I would like that bed for mothers to deliver be two or three because I see it's one and no need to queue while doctors are not few really

R: W2 create more labour wards for mothers to deliver sufficient enough to hold mothers at least

say twenty-five (25) at a time.

I: ohh… okay.

R: W 8 and if is in another thing also we see they don't perform there should be suggestion boxes so that we can write our complains

Q 5 What would you be proud of in this future?

R M 5-Investigations.

I-What about investigations?

R W 5-May be like urine you can..

R W 5-Investigations like urinalysis for a mother in labour should be done at the right time.

R W 11-They're usually done in ANC but sometimes they come when investigations were not done before so I will ensure that they're done in maternity during labour..

R W 12-But you know ANC also is part of this they're all here so we shall say that proper care be done in ANC

R: W 11 when we come to the clinic, we take time to relax here. Actually it's the only place we get time to relax. As a mother we run up and down to be honest, we move a lot from one place to another being a working mother you are expected to deliver at work, baby is here when you arrive at the hospital you realize that I need to sit and relax and then you realized that there's congestion, then may be the place is not even conducive. So a bigger room, a bigger waiting bay and clean surfaces that we can even put down the baby a clean and neat place as they wait for their turns even if you leave baby down you have no doubt of any problem

I: any other contribution?

R: W 12 I think here protection so far so good is better because at least people even other people consider a pregnant woman. You will find a person saying let me stand up for this lady. We can't complain protection is quite good, we get a seat.

R: W 11 mothers protect each other. They will continue to care about each other. Giving someone a seat and space. Considering someone in need

I: mmm

R: W3 if you feel yours is not so needy give first priority like those with young babies of less than a month who are there give them a space first

R: W 10 when you don't understand something, when you ask nurse or doctor they will answer you well till they make sure that you understand

R: W 10 I think you we should be allowed to deliver in a place of your choice depending on your capability. Also when delivering, you should be allowed to deliver in position of your choice unless it's inappropriate like that of squatting its allowed but is not that easy the other one like the method I was telling you I read somewhere I think it's called either water birth or something or hehehe

I: water birth?

R: W 10 yes water birth you're allowed to have it so that you don't have to go through labor but you'll get that it's not there but the only way like to hold and push the hard way

I: another suggestion? You were saying something I want to hear your point in creativity…

R: W 4 mostly I would say to expand and upgrade maternity to district hospital to be better very good place to be upgraded in every way possible

Q 6 What part would you play in this future?

R W 4 Nutrition is very important and I will be eating good food because I will know what kinds of food eat. They will teach us on what food to eat

R W 8: I will use family planning.

R W 6: I will talk to other women to come to hospital

R W 3: I will not miss any clinic appointments. I will cooperate with the midwives. I will be happy with the services

R W5: Another thing you see the birth plan we make we don't follow. It will be good to be serious with the birth plan

APPENDIX XIII: Example of the coding process

TRANSCRIPT 12 MIDWIVES	BASIC CODES
I: what shall we do…the 1st group to say one point, the next group another point, the next group another point until the last point. R: mmm… Q 1 I: okay group one In this exciting future, what will be most significant? R M 1: Good reception… I: mmm..There'll be good reception.. Talk loudly please be audible R: M 2 so we will write good attitude which is the same as haaa good reception R: M 1creating good client/provider relationship… I: Good client/provider relationship I: yes… what else will be happening? R M 3: presence of well qualified, knowledgeable midwives, skills with current update I: knowledgeable updated midwives… R M 4: skilled midwives (discussion) I: next one say R: mmm R M 4 : male involvement and birth companion R: M 4 should be male (husband) we should give priority to husbands (laughter) R M 5: we will be encouraging birth companion even if it's another female, can even be mother in law	Good reception…(M1, FGD7) good attitude (M2, FGD7) good client/provider relationship…(M1, FGD7) presence of well qualified, knowledgeable midwives, skills with current update(M3, FGD7) skilled midwives (M4, FGD7) male involvement (M4, FGD7) birth companion(M4, FGD7) male (husband) (M4, FGD7) priority to husbands (laughter) (M4, FGD7) encouraging birth companion (M5, FGD7) another female, (M5, FGD7) even mother in law(M5, FGD7)

I: next, what will be happening? R M 6: ok we will have a good well equipped maternity unit I: well-equipped maternity… R M 5: with functioning, maintenance unit. Something like that … R: so we are still in question1? I: yes have you exhausted all the points? R: ours is over others can say theirs I: what will be happening? R: M 7 good midwife/client ratio be 1:2 for close monitoring R: M 7 as in 2clients and 1 provider for close monitoring and proper nursing care I: Anything else? R. M 9: we said that us mmm to allow mothers to deliver in their own styles RM9: allow mothers to adapt to position of their	good well equipped maternity unit(M6, FGD7) functioning, maintenance unit(M5, FGD7) good midwife/client ratio be 1:2 for close monitoring(M7, FGD7) 2clients and 1 provider (M7, FGD7) close monitoring and proper nursing care(M7, FGD7) allow mothers to deliver in their own styles(M9, FGD7) allow mothers to adapt to position of their choice at birth (M9, FGD7)

APPENDIX XIV: Sample coding structure/framework

Increased demand for maternity services a challenge

Increase in number of clients (A2, FGD 6)

Not able to meet demand for services (A3, FGD 6), (A1, FGD 6)

Few women delivering at facility (A2, FGD 6)

Encounters and Experiences of women with midwives and other health care providers

Poor treatment of women (A3, FGD 6)

Treated well (W2, FGD 4) Talk to us nicely (W5, FGD 5)

Good approach/ treat people well (W2, FGD 5)

Welcome in good way (W1, FGD 2) , (W 8, FGD 2) Welcoming providers (W6, FGD 2) Good approach, appreciated, (W1, FGD 2)

Directed where to start (W1, FGD 2) Directed on sequence of events (W9, FGD 2)

Sequence of events start here t window..(W1, FGD 2)

Received well at facility / Approach to people, good care (W2, FGD 4), Warm reception (W3, FGD 4) Polite nurses (W4, FGD 4)

Governance issues

Inexperienced managers (A3, FGD 6)

Lack of clear priorities for health sector at the county (A3, FGD 6)

Managers not concerned with improving facility (A3, FGD 6)

Need to allow facility managers to make decisions of issues affecting facility (A3, FGD 6)

Midwives supported by hospital administrators (A2, FGD 6) Midwives require support (A2, FGD 6), Administrators support midwives (A2, FGD 6)

Need for involvement of staff in governance of facility (A1, FGD 6) (A3, FGD 6)

Decisions made and staff asked to implement (A3, FGD 6)