



Midwives' descriptions of policies on access to maternity health services in North West Province, South Africa

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ABSTRACT

The study sought to explore and describe the various policies regarding access to Maternity health care services in the North West Province, South Africa, through the lens of midwives. Legal and ethical frameworks guide maternity healthcare services to ensure such a service's quality, safety, and standardization. A qualitative, descriptive, explorative research design was followed. Nine purposefully sampled midwives participated in a one-on-one in-depth interview. Data were analyzed using Collaizi's descriptive method based on the emerging themes and categories. One overarching theme with six categories emerged from the data. From the overarching perspective, it was evident that midwives were dissatisfied with the ambiguity of various policies guiding patients' access to Maternity healthcare services. To a certain extent, the admission policy was inconsistent with the patient's rights and constitution of the land on access to health. The ambiguity of admission position led to uncontrolled movements of self-referred patients to clinical facilities. The ambiguity of the transfer policy contributed to challenges during interfacility transfers of referred patients from lower levels of care facilities and vice versa. In addition, the policy on escorts of patients was unspecific about the healthcare personnel required to escort complicated patients in transit, which caused care interruptions. The key findings summed up in one overarching theme and six subthemes highlighted that, the existing admission, patients' transfer and down-referral, escorting high risk patients' policies. In addition some parts of the policies are in contravention of the patients rights' charter. The study findings highlight the Midwives' concerns regarding various policies of access to maternity health services, and the marked ineffectiveness of controlling patients' movement into facilities could be the reason for overcrowding, inadvertently causing a decline in the quality of maternity healthcare services. The study findings may alert policymakers to be cautious and ensure that policies are succinct and consistent with other related laws.

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Introduction

Maternity health service (MHS) refers to women's health during pregnancy, childbirth, and postnatal (WHO). Approximately 140 million births are recorded annually from women admitted to clinical facilities (The World Counts, 2023). About 287,000 women, in total, died while giving birth in 2020 (WHO, 2020). As it stands, the maternal mortality rate is 151 deaths per 100,000 live births. The current maternal mortality rate is double the expected rate according to sustainable developmental goal 3.1, which aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births (WHO, SDG). On the other hand, 2.4 million newborns died within the first month of life in 2020, with a neonatal mortality rate of 18 deaths per 1,000 live births in 2021 (WHO). The current neonatal mortality rate remains alarmingly higher than the sustainable developmental goal 3.2, which aims to end preventable deaths of newborns and to reduce neonatal mortality to at least as low as 12 per 1,000 live births by 2030 (WHO & SDG).

Sub-Saharan Africa has the highest maternal and neonatal mortality rate in the world. These higher mortality rates are related to the ailing health systems in these countries. In 2020, sub-Saharan Africa had 545 maternal deaths per 100,000 live births and a neonatal mortality rate of 27 deaths per 1000 live births. In South Africa, 1002 577 births attended by healthcare professionals were recorded (DOS, 2020). The current maternal mortality rate is 113 per 100,000, while the infant mortality rate for South Africa in 2023 is 23.573

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deaths per 1000 live births (DOS, 2022). South Africa is a Sub-Saharan African country with an upper middle-income economy, and it is classified as a developing country with a challenged health system (International Citizens Insurance, 2023). There are limitations to access to health services, including MHS. The high maternal and neonatal mortality rates herald a need for pregnancy and births to be attended by healthcare professionals. Skilled healthcare professionals can save the lives of both mothers and newborns if the resources are sparingly used for MHS (Becker et al., 2022).

The MHS in South Africa are divided into levels of care ranging from clinics, midwife-led obstetric units (MOU), District hospitals, regional hospitals, and tertiary/academic hospitals (DOH,2016). These services range from everyday problems and low-risk conditions being managed at the clinics and MOU, while high-risk conditions are managed in hospitals (DOH, 2016). For women to gain access to MHS, they will have to be admitted into the healthcare facilities either as an out or in-patient.

During pregnancy, women may seek MHS due to pregnancy-related conditions such as pregnancy-related hypertensive disorders and intrauterine growth restrictions (Ala et al., 2021). Admission is necessary during pregnancy to ensure that the woman receives specialized antenatal care services and conservative management. This ensures that the positive outcomes of pregnancy are maximized (DOH, 2016). The intrapartum events that could lead to a need to access MHS include the onset of normal labor and any medical condition that may arise during labor, such as antepartum hemorrhage (Lord et al., 2023). The woman can still access the MHS during the postnatal period so that pregnancy-related conditions are unresolved, and even emergent postnatal problems such as secondary postpartum hemorrhage and puerperal sepsis (Lord et al., 2023). Admission of a woman to MHS is a standardized procedure aligned with the maternity healthcare guidelines and admission policies (DOH, 2016; WHO, 2019? year). An admission policy as a written guideline provides structure and standards used to direct decision-making during the admission of a woman in a healthcare facility (Jooste, 2017). The major component of the admission of a woman for maternal health service includes obstetric triage (OBT), in which the woman is comprehensively assessed and prioritized according to their health needs (Tukisi,2023). Ideally, women are to be admitted to the clinics and MOU for OBT by the midwives, and their diagnosis post-triage will determine the level of care of MHS they require. The OBT takes place at every contact between a midwife and a woman, and the level of care of MHS required by the woman is determined, which helps promote access (Moudi et al.,2022).

A pregnant woman can be admitted into the health care facility for a variety of reasons, such as pregnancy-related conditions such as hypertension, where specialized antenatal care services are necessary—Intrapartum-related conditions such as the onset of normal labor or labor-related complications. A pregnant woman's admission into the healthcare facility depends on the severity and seriousness of the condition that led to them seeking maternity healthcare service (Moudi et al., 2022). Access to healthcare is a fundamental human right according to section 27 of the constitution of South Africa (1996:11). Access to MHS is based on the previous millennium developmental goals 4 and 5, which aimed to reduce child mortality and improve maternal health (SDG, 2016). The MHS remains anchored in the third sustainable developmental goal concerning maternal and child health (SDG, 2016). The human rights charter stipulates that every human has a right to health and medical care. The patient's rights charter in Section 27 of the constitution (1996:11) also stipulates that every patient can access health care and choose a healthcare service to support this human right. Basic antenatal care (BANC), which is a component of MHS, mandates that the healthcare facility should be within a five-kilometer radius for easy access to pregnant women in case of emergencies to improve positive perinatal outcomes (Sibiya et al.,2018). The standardized maternity care guidelines states that patients must be referred from lower levels of care to higher levels of care (DOH, 2016:17). This referral system depends on the seriousness of the maternal and fetal condition.

Evidently, the MHS is a global response to the escalating maternal and neonatal mortalities. Whilst MHS serves as an essential tool to reduce the maternal and neonatal mortalities, this paramount service remains inaccessible to patients because of the policies guiding the provisions of the service. However, overcrowding and increased patient waiting time remain a challenge in the clinical facilities thus reducing patients to MHS. The overcrowding and long patient waiting time are associated with deleterious outcomes as patients' condition tend to worsen while awaiting care (Savioli, Ceresa, , Gri, & et al,2022). The midwives are primary caregivers who render the MHS daily through application of various policies guiding access to and rendering of MHS. Midwives' involvement and contributions to the healthcare policies is a neglected topic. The purpose of the study was to explore and describe the policies on access to MHS in the North West Province, South Africa to answer the research question: "What is your description of the policies on access to maternity health services"

Literature Review

The purpose of the literature review was to provide a theoretical perspective that underpins this research overview of the research problem. The paradigmatic perspective of Theory for Health Promotion in Nursing (THPN) guided the study (University of Johannesburg, 2017).

Theoretical and Conceptual Background

THPN stresses that the persons health is dependent on their holistic interaction with the environment and the nurse/midwife.

Person

The researcher believes that a person component within the paradigmatic perspective of Theory for Health Promotion in Nursing (University of Johannesburg, 2017:9,10) in nursing represents the patients experiencing obstetric health problem such as pregnancy,

related condition, labour pains and are seeking MHS. A patient seeking MHS is a whole person and embodies dimensions of body, mind, and spirit thus functions in an integrated interactive manner with an environment Theory for Health Promotion in Nursing (University of Johannesburg, 2017). The patient seeking MHS may be experiencing psychological and emotional discomfort attached to the anticipated health outcomes post MHS. Consequently, the patient seeking the MHS need physical, emotional, and psychological support during MHS.

Health

Theory for Health Promotion in Nursing (University of Johannesburg, 2017) defines health as the interactions in the person's environment, which contribute to or interfere with health promotion. In the context of this study, it implies the hospital and MOU is a therapeutic environment where MHS are rendered to promote the total health of the patients. However, the ill prepared therapeutic environment may interfere with the total health of the patients during the MHS. According to Mahmood and Tayib (2021), the hospital environment threatens the emotional wellbeing of patients due to variety of invasive interventions performed on patients. Therefore, patients may pre-empt such interventions being instituted on them.

Nursing/Midwifery

Midwifery is an interactive process whereby a midwife uses a sensitive therapeutic professional approach and facilitates the promotion of health through the mobilization of resources (Theory for Health Promotion in Nursing University of Johannesburg, 2017). In the context of this study, the midwives are advocates of patients in need of MHS. The Midwives described the policies that guide their practices during the MHS. The MHS points out the possibilities of decline in quality of care and MHS which inadvertently threaten their main goal of health promotion for patients in their care.

Environment

The environment includes an internal environment consisting of dimensions of body, mind, and spirit, as well as the external environment consisting of physical and spiritual dimensions (Theory for Health Promotion in Nursing University of Johannesburg, 2017). The body refers to the anatomical structures and physiological processes of pregnancy, pregnancy related disorders and labour within the patients seeking MHS and these processes are duly regarded as determinants of their health status (Theory for Health Promotion in Nursing (University of Johannesburg, 2017). The mind refers to the preconceived ideas, knowledge, and myths women have regarding the quality of MHS which may include: the prolonged waiting times because of the overcrowding within the facilities. The patients may pre-empt all these challenges which could be anxiety generating and a major source of patient's dissatisfaction. The external environment in the context of the study refers to the selected hospital and MOU rendering MHS under the prescribed legal and ethical framework including the policies under study. The social interactions will refer to the interaction of patients with midwives during MHS when various policies are applied. In addition, the interaction will be between the midwives and other health team members such as doctors and emergency services personnel, during interfacility transfer and referrals

Empirical Review and Hypothesis Development

Access to healthcare is a human right according to the constitution and patient rights charter of South Africa (Gordon et al., 2020) The MHS, as an essential service, aims to eliminate maternal and neonatal morbidities and mortalities so that South Africa can realize its sustainable developmental goal (SDG) 3 (Chiu & Fong, 2023). To ensure more favorable outcomes, the quality of MHS should be standardized and consistent, which heralds the legal and ethical framework (Edmonds et al., 2020). Therefore, as a branch of an essential health service that is universally accessible to patients and families concerning the Constitution and Patients' Rights Charter (Dahab & Sakellariou, 2020)

The factors limiting access to MHS

Access to health care refers to the availability of preventative, therapeutic, and rehabilitative measures to address illnesses and disorders impacting human health(Gordon et al., 2020; Weiss et al., 2020). Access to healthcare services should be affordable for all persons (Weiss et al., 2020). Although South Africa has made healthcare services available and accessible to South African citizens, it is noteworthy that 84% of 60,994,095 South African citizens rely on public health services (Malakoane et al., 2020). Consequently, only 16% of the population can afford healthcare, which is a significant cause of overcrowding in clinical facilities, thus limiting access (Burger & Christian, 2020). To mitigate overcrowding in clinical facilities, South Africa has divided the clinical facilities into the lower, middle, and upper levels of care depending on the health services (Edoka & Stacey, 2020). The low-risk patients requiring basic MHS are managed at the primary healthcare clinics and MOUs.

Meanwhile, the high-risk patients requiring the specialized MHS are managed in the district and academic hospitals, which are higher levels of care institutions, depending on the complexity of their conditions (Belay Tolu et al., 2020). Unfortunately, there is an even higher shortage of staff, which has led to specialized professionals in the higher levels of care of clinical facilities. Consequently, specialized MHSs are inaccessible in lower-level clinical facilities, requiring patients to be referred from lower-level to higher-level clinical facilities (Belay Tolu et al., 2020). The quality of MHS needs to be maintained throughout to ensure no interruption of care.

The quality of care in MHS

Quality of care is the degree to which health services rendered to individuals will likely result in positive and desired health outcomes (Wasik, 2020). In the context of this study, the desired outcomes are reduced maternal and neonatal morbidities and mortalities. However, to avoid deleterious and undesired outcomes, the MHS must be effective, safe, people-centered, timely, equitable, integrated, and efficient (Mndebele, 2021; Vogus et al., 2021). The legal and ethical framework comprises various policies such as admission policy, inter-clinical facility transfers, down-referral policy, Escort of patients with complicated conditions, and management of overcrowding within clinical facilities policy are laid to safeguard the quality of MHS (Mndebele, 2021). However, the consistent application of various policies on access to the MHS has been challenging, which led to a gradual decline in the quality of care within the various aspects of MHS (Wasik, 2020).

Safety of patient during MHS

Midwives whose primary responsibility is to maintain patients' safety during MHS experience challenges in executing this responsibility, particularly during inter-facility transfers (Mndebele, 2021). The policy on inter-transfer does not seem to grant the midwives powers to maintain the safety of patients in transit. Consequently, some patients with complicated conditions are not accompanied by skilled midwives to the hospital, which raises safety concerns (Mndebele, 2021). The pre-empted decline in the quality of care threatens the equitability of MHS based on the geographical area and socio-economic status. The patient whose safety in transit is questionable is being referred from the rural area with limited resources to the hospital in the city (Burger & Christian, 2020). In addition, the current inter-facility transfer policy contributes to poor interprofessional collaboration (IPC) between the Midwife and the emergency service personnel responsible for transferring patients from one facility to the other. (Rogers & Warwick, 2022). The IPC between the Midwife and the emergency service personnel could benefit the patient because of the variation in knowledge and skill set that can be collectively applied to enhance patient safety (Rogers & Warwick, 2022).

Patient waiting times

The critical staff shortages in clinical facilities are a long-standing problem that has contributed to severe imbalances in midwife-to-patient ratios in clinical facilities (Jean-Baptiste et al., 2023; Mattison et al., 2020). On the other hand, there is a critical overcrowding of patients in clinical facilities as the public sector caters to 84 % of the population (Mattison et al., 2020). The fewer staff members on duty and the overcrowding of patients contribute to the long waiting time, which results in serious complications. According to the literature, patients with conditions such as pre-eclampsia, antepartum, and postpartum haemorrhage (APH & PPH) require urgent attention as their conditions deteriorate with time (Daniels & Abuosi, 2020). The public health sector of South Africa has limited resources and is overburdened; therefore, the available resources must be used efficiently to maximize their benefit.

Research and Methodology

Research design

A qualitative, explorative, descriptive and contextual research design was followed to explore and describe the admission policies for access to MHS in the two selected facilities which was the MOU and the hospital in North West Province. A researcher asked a central question to all participating midwives and qualitatively captured their responses as they naturally described the admission and their experiences. The central question "What is your description of the policies on access to maternity health services" was posed to all the participants and it was followed by the probing questions based on participants responses. The probing questions were ideal to uncover in-depth understanding of the phenomenon from the midwives point of view. The setting for the study was the Rustenburg sub-district, one of five sub-districts in the Bojanala district, comprising 21 clinics, three midwife-led obstetric units (MOU), and one secondary hospital. Data was collected in the selected secondary level of care hospital and one of the three MOUs. The hospital under study is the only secondary hospital within the Bojanala district that serves as a referral hospital for maternity cases from the district hospital, MOUs, and clinics. The selected facilities are accessible to approximately 555,000 people in Rustenburg who rely on public health care services (Statistics South Africa, 2022). At the time of the study, the hospital recorded approximately 650 normal vaginal deliveries and 200 cesarean sections. There were 30 midwives, four consultants, seven medical officers, and four intern doctors. The hospital under study had one labor ward with an admission room where data were collected. The MOU at the time of the study recorded close to 300 deliveries monthly, with 13 midwives.

Population and sampling

The population of this study comprised all the midwives employed in the selected facilities providing midwifery healthcare services within the Rustenburg Sub-district North West province. The sum of the population of midwives in the selected facilities for the study was 43. A purposive sampling technique was used to select 15 midwives using the following inclusion criteria:

- i. Employment within the Bojanala district
- ii. Current placement in midwifery unit where MHS are rendered
- iii. A minimum of 3 years of midwifery experience
- iv. Current registration with the South African Nursing Council (SANC) as a midwife

Midwives and advanced midwives who did not meet the given inclusion criteria were excluded from the study using the following exclusion criteria:

- i. Non-employment by selected facilities of the Bojanala district.
- ii. Midwives and advanced midwives registered by SANC are not currently in the midwifery unit of the selected hospital.
- iii. Less than three years of midwifery experience.

The total number of participants was nine black females who were registered nurses and midwives. Six participants had a diploma in nursing and midwifery (67%), and three held a bachelor's degree in nursing science and midwifery (33%). Two participants held another qualification: Post-basic Diploma in advanced midwifery (22%). During data collection, the participants' clinical midwifery experience ranged from 5 to 18 years. The participants' information is summarized below (Table 1).

Table 1: Summary of description of the participants

Code	Age	Gender	Ethnicity	Qualifications	Experience
P1	27	Female	Black	Bachelor of nursing & Midwifery	5 Years
P2	40	Female	Black	Diploma in nursing & midwifery	16 Years
P3	42	Female	Black	Diploma in nursing & midwifery	8 Years
P4	52	Female	Black	Diploma in nursing & midwifery Post-basic Diploma in advanced midwifery	18 Years
P5	27	Female	Black	Diploma in nursing & midwifery	5 Years
P6	40	Female	Black	Diploma in nursing & midwifery Post-basic Diploma in advanced midwifery	12 Years
P7	40	Female	Black	Bachelor of nursing & Midwifery	16 Years
P8	26	Female	Black	Bachelor of nursing & Midwifery	5 Years
P9	36	Female	Black	Diploma in nursing & midwifery	7 Years

Source: Tukisi, K.P., 2019, *The experience of midwives with regard to the use of obstetric triage by midwives in Bojanala District*, Master's dissertation, University of Johannesburg, Johannesburg, viewed 03 June 2024, from <https://hdl.handle.net/10210/412370>.

Findings and Discussions

Findings

Data obtained from nine participants resulted in one overarching theme, with six categories that were descriptive of policies guiding access to MHS through the lens of midwives. The results are summarized in Table 2.

Table 2: Summary of description of theme and categories.

Themes	Categories
Lack of well-defined admission and down-referral policies	Unclear admission policy
	Admission policy contravenes patients' right's charter
	Unclear down-referral policy
	Unclear policy on transfer of women from clinics & MOU.
	Unclear policy on escort of high-risk patients
	Unclear policy are the reasons for overcrowding in facilities

Theme 1: Lack of well-defined policies that control patients' movements within clinical facilities.

A lack of well-defined policies that control the movement of patients through in-hospital admissions, down-referral, referral, and escorts of patients during emergencies forces the midwives to function with limited protection and control over patients in their care. The limited control over the patient's movement between facilities is the cause of overcrowding in the facilities, putting midwives and patients at risk of adverse perinatal outcomes.

Category 1: Unclear in-patient hospital admission policy

The hospital admission policies guide the in-patient hospital admissions of pregnant women. However, midwives experienced that the in-hospital admission policy is unclear regarding the conditions that warrant admission of pregnant women.

"Our admission policy is not clear as to whom are we supposed to admit exactly" P9

"The Policy that we had talked about was that we should admit any woman 26 weeks and above with pregnancy-related condition. P4

Midwives expressed that the unclear in-hospital admission policy made controlling the patients admitted to the ward difficult. The state of pregnancy became a point of focus for the doctors. Consequently, midwives ended up nursing pregnant women without any pregnancy-related conditions.

I am going to give you an example: one day, I was working in triage, and there came a patient referred with a stabbed wound; because she was 26 weeks old, she was referred to maternity. Therefore, you concentrate on the wound instead of the pregnancy" P4.

In addition, doctors were inconsistent in in-patient hospital admissions. Consequently, the admission criteria for in-patients could not be standardized. Midwives expressed that the admission criteria depend on the admitting doctor's discretion.

There are no written policies; it depends on who is working there; sometimes, you will find that they say we are not supposed to admit women with non-viable pregnancies; they have to go to gynecology wards. Then, the next week, when a patient with a similar problem comes, they change and say [Not for admission in maternity] because no written policy can say, we are working on this!

The midwives experienced that the existing and unclear Policy needs to be adhered to. They expressed that although they worked in the referral hospitals, they still admitted self-referred patients.

Because they say our hospital is a tertiary institution and we are only supposed to take the patients from hospitals, but we are taking patients from the clinics, health care centers, and self-referrals that are not booked for antenatal care, our policies do not protect us! P7

Category 2: Admission policy contravenes patients' rights charter.

Midwives seemed to be aware that the national admission policy regulates patients' admission in their care as prescribed in the maternal guideline. Midwives expressed their willingness to follow the guidelines.

"We are guided by the maternity care guidelines of South Africa so that our management of our patients is how it is now. We assess, triage, and manage or refer" P7.

Midwives elaborated that the admission policy, according to the maternal guideline, requires them to follow the referral system to various levels of care, considering the patient's condition. On the other hand, the patient's rights charter allows them to access the clinical facility of their choice closest to them.

"Patients know their rights; they know they can access the healthcare facilities. Maternity care guidelines have prescribed that low risk should be at the MOU, and the hospital is for high-risk patients who need admission because of possible complications. So patients will follow what is convenient, and as a midwife, there is not much you can do." P5

Although midwives followed the maternity care guidelines, midwives experienced having limited control over the patients' movements. The midwives stated that their limited controls stem from the inconsistencies between the patient's rights charter and the admission policy.

"As long as the patients' rights charter is the only document simplified for the public, it is the only document they will understand. They only learn about the levels of care and referrals from us when they are already pregnant. So, it will seem like you are denying them access to care. So, you cannot enforce the guideline at that point." P3

The midwives were concerned about the patient's rights charter; they were responsible for admitting and rendering midwifery care irrespective of their low-risk conditions.

"... because it is unclear what the hospital management expects us to do; the patient's rights charter clearly shows that I cannot turn down a patient who needs service. I have no choice but to admit her even if she is a low-risk" P9.

Midwives expressed that the contradiction between guidelines further contributes to the inconsistent movement of patients, evidenced by the low-risk patients accessing hospitals and high-risk patients accessing clinics.

"So patients seem like they do not know where to go, because a high-risk patient who lives near the MOU will go straight to the MOU and the low-risk patient staying near the hospital will walk into the hospital" P6.

Category 3: Unclear down-referral Policy

Midwives at the hospital reiterated that, without an explicit admission policy, they often deal with low-risk patients who occupy spaces meant for high-risk patients. Midwives expressed that in their attempts to create spaces for high-risk patients, they often recommend that the low-risk patients be referred to MOU.

It is called level three! There are several hospitals around it; it is the only one that is supposed to receive those complicated cases, and working at that level three hospital, you receive all those patients, and there come self-referral patients. They are expecting you to give the best care. P5

However, the midwives explained that no clear down-referral policy is in place to refer a patient to the clinic. Midwives stressed that they are not the only health practitioners needing help with the unclear down-referral Policy. Upon completing the comprehensive assessment, the doctors would conclude that the woman is in the low-risk category and recommend down-referral to a lower level of care.

"So you look at her say this is ...we usually say this is not a complicated delivery, you want to down refer then there is no policy..." P4.

"We do not know what to do if there are a lot of patients, even the doctors; they have a problem of not referring the patients." P3

Midwives expressed that the management often issues verbal recommendations for low-risk women to be down-referred. Midwives perceived these verbal recommendations as management's way of shifting accountability to them, and it suggests that those who down refer the patients have limited legal protection.

They say we must down-refer the patients, but it is tough when you need the Policy covering you! P7

"They {The management team} will just say, you could have down referred, but it is all verbally... they do not want to tie themselves. The policymakers!" P4.

Midwives explained that they are unable to down-refer low-risk patients out of fear of contravening the existing admission policies, which means that the patient remains the midwife's responsibility.

You cannot down-reference. So, you keep them, and the chaos begins in the ward because you will have an influx." P4.

All patients will remain in the hospital, waiting for you to attend to them so the doctors can see them. P9.

Category 4: Unclear Policy on escort of high-risk patients

Midwives in the MOU follow a referral system and often refer high-risk and complicated patients to the hospitals. However, midwives experienced that there is no clear policy on the escort of high-risk patients by the midwives.

The maternity care guideline clearly states that we are supposed to escort high-risk patients to the hospital because they will need to be monitored while transported. However, it is not documented anywhere in our institutional policies because now, having to escort the patient has implications on my safety according to HR {Human resource} policies. P1

Midwives expressed that they are aware that emergency medical personnel are junior in terms of managing some of the obstetric conditions, such as breech presentations and eclampsia. As a result, midwives expressed that they are often faced with the dilemma of whether to escort the patients. Midwives expressed concern that they cannot ensure that patients who need an ambulance will receive continuous care while transported.

"Our EMS {Emergency medical service} personnel are trained on basic life support and need to be more skilled in obstetrics. So sometimes you are referring to a woman with breech presentation in labor; possibilities are she could deliver on her way to the hospital. I do not think our personnel can handle that type of delivery" P3.

So now, because some of our patients are referred from the health center and go with the ambulance without the midwife, nobody monitors the patient on the way. Imagine if you are referring to a patient with severe pre-eclampsia or eclamptic, you worry. P8

Category 5. Unclear Policy on access to emergency medical care relating to channels of communication.

Midwives explained that the referral policy for high-risk patients from lower to higher levels of care needs to be clarified and more accessible. Midwives often need to learn the relevant person to communicate with to arrange for transferring the patient.

"It is a mission to refer the patient; there is only one referral hospital, so you have to arrange for the patient to be taken to the hospital. You have to speak to the doctor in the hospital. Sometimes, the doctor in the hospital will say that we have to call our local doctor first in the clinic, which is time-consuming. P5

The Midwives explained that the time spent in the telephonic communications chain could be reduced if there was direct communication between them and the doctors in hospitals. Patients would receive the care and management they need speedily.

"Instead of having to go through the route of a resident doctor, then the hospital doctor, EMS, you see gore {Setswana word for That} you are cutting the middle man{claps hands} you want this patient to go and receive the care that they need. You know!" P6

Category 6: Unclear policies are the reasons for overcrowding in facilities.

Lastly, midwives expressed that the unclear policies left them disempowered with no control over the patients' movements. The midwives related this to policies on admission and management that contradict the laws of the land on access to healthcare.

Our policies allow every patient to go to any hospital, which is impossible to maintain. The hospital is going to be full of both low-risk and high-risk patients. There is nothing you can do about this situation. As a midwife, you are guided by written legal documents. P1

The unclear policies result in all maternity patients being admitted to the maternity ward, although they have low-risk obstetric conditions that require mild interventions in the MOU. Consequently, there is overcrowding of patients in hospitals. Midwives expressed that the midwives cannot even manage.

"If our policies are right, we will not have any problems, and we will not have patients sleeping on the floor because there is no space to accommodate all of them. We will not have many complaints if our policies are in proper condition!" P7

Midwives expressed that their limited control over the overcrowding of patients is detrimental to the quality of patient care they need to render. In the MOU, the high-risk patients need more time to receive the intense interventions they require.

"You find that the patient is a high-risk patient with more than one risk factor. The patient came straight to MOU despite being told that she would need to deliver at the hospital. We do not have enough resources to handle her condition., so the patient came to us because we are the facility closest to her. P7

The midwives explained that the situation is dire even in the hospital as the high-risk patients are further delayed because there are no beds to attend speedily to patients. Midwives explained that hospital overcrowding by low-risk clients contributes to increased waiting times and complications.

"Our admission room is four-bedded. Sometimes, it will be so full that there will be no space, even on the benches. So, it is complicated because you have to leave a patient while you are still busy to assess the one with a critical condition." P2

Even if the patient is a low risk, I still have to do everything I do with all the other patients. One assessment per patient takes thirty minutes to see one patient. P3

Discussion

The study's findings provide insights into the significant gaps in the policies that control access to the MHS as perceived by the midwives. One central theme with six categories detailing midwives' challenges with the MHS was identified. Midwives are first in line to receive patients seeking MHS in the antenatal, labor, and postnatal periods (Gaemaes et al., 2020). Midwives are, therefore, the custodians of the MHS and the related policies. The midwife's interpretation and application policies contribute to the success of MHS, which is the reduction of maternal and neonatal mortalities.

The identified overarching theme and categories suggest that the policies on access to various points of MHS could be more precise, thus limiting the midwives' control over patients' movement and management. Furthermore, the themes suggest that the unclear policies contribute to a decline in the quality of MHS, evidenced by overcrowding of patients in facilities, delayed emergency response, and an increase in waiting time. The decline in quality of MHS may contribute to adverse perinatal outcomes (Gaemaes et al., 2020).

Midwives experienced that the admission policies for patients seeking MHS in the hospital could be more transparent regarding the patients eligible for in-hospital MHS. This is a significant finding as it demonstrates midwives' knowledge of the prescribed levels of care for MHS services detailed in the maternity care guidelines (DOH, 2016). This finding suggests that patients seeking MHS should be admitted to the appropriate level of care that aligns with their obstetric condition. Primary antenatal care (BANC), which is the division of MHS, ensures that the women are screened throughout the pregnancy, and plans of care, including the specific level as the complications arise, are determined (Mthethwa et al., 2019). Classifying patients into low and high-risk is essential in ensuring that health resources are used sparingly. The use of resources sparingly is particularly significant in countries such as South Africa, which has 342 hospitals with an average of 100,000 beds for a population of 61,365,241, 83 % of which rely on public healthcare (DOH,2017). This finding demonstrates the scarcity of hospitals and heralds a need for a clear policy on in-hospital admission to ensure the appropriate use and effectiveness of in-hospital MHS to maximize the opportunities for positive perinatal outcomes (WHO,2020).

The study found an inconsistency between the patient's right to access MHS, which patients are familiar with, and the maternity care guidelines known by midwives. According to the Patient's Rights Charter (DOH,2018), the patient has a right to access the healthcare facility of their choice based on its proximity to the patient's residence and convenience. On the other hand, the maternity care guideline DOH (2016) stresses that the patients are to be transferred from the MOU to hospitals based on diagnosis of complications, resulting in a reclassification of patients as high risk. This guideline suggests that low-risk patients are not supposed to approach the hospitals for MHS but for MOUs to keep hospitals accessible for high-risk patients who require advanced obstetric interventions. This guideline supports findings in existing literature that the MOUs are safer for low-risk patients and less costly for the government (Wallace et al.,2023).

The midwives experienced that they were tasked with rendering MHS to the low-risk in the hospital setting, taking time, space, and resources meant for high-risk patients. The care of low-risk patients in the hospital contravenes the work already done to allow the processes of low-risk labor to proceed without any interference. The in-hospital MHS is costly, according to (Callander et al., 2019), as the admission of the patient is standardized for all cases irrespective of low or high-risk classification. While the MHS remains accessible to the public, when private healthcare costs for MHS are used as a baseline, the government spends approximately R16 000 to R46 000 per standard patient (South African Private Hospitals, 2016). The in-hospital admission of low-risk women is a source

of unnecessary financial burden on the already strained health system. Based on the in-hospital administration, the cost is bound to increase, which can cause low-risk patients to stay even longer in the hospital at a cost to the government. The prolonged in-hospital stay of low-risk patients is related to the patient's admission to the labor ward, which is later transferred to the postnatal ward prior to discharge by the doctor (Callander et al., 2019).

The study found that although the hospital allows walk-ins of self-referred and low-risk patients, there is a need for clear down-referral policies to deal with the increasing number of patients. Midwives expressed that this was not supposed to be the case where the hospital is of a higher level, and patients are to be screened in MOU for eligibility and referrals. Midwives explained that because of unclear policies, they are often left to deal with overcrowding of low-risk patients, making it difficult for them to deal with low-risk patients. Ideally, there should be a contingency plan to address hospital overcrowding by diverting patients to lower levels of care (Medical Brief 2019). However, this study found that there needs to be a clear down referral to support the clinical decision regarding low-risk patients following in-hospital admissions. According to Tukisi, Temane, and Nolte (2022), patients seeking MHS must be assessed using OBT for existing and potential obstetric complications and classified as a high or low risk on admission. Midwives argue that the findings of the OBT are sufficient to guide the doctor's and midwives' decision to refer the low-risk patient from the hospital down to the MOU.

Emergency medical care is another component of MHS, which ensures that the patients seeking MHS are transported safely from their respective homes to the clinical facility or from one clinical facility to the other (Ashokcoomar & Bhagwan, 2022). The study found that the policy on the transfer of patients' needs to be more specific concerning the turnaround time for the ambulance to pick up a patient during inter-facility transfer. However, midwives experienced prolonged turnaround time. This finding corroborates the findings of a study on emergency response in Kwa Zulu Natal, where the turnaround time for emergency response was between four and five hours (Ashokcoomar & Bhagwan, 2022). Regrettably, this finding suggests that although the turnaround time directly affects patients' access to MHS, the emergency service cannot be evaluated for efficiency due to the unstipulated turnaround time for inter-facility transfers. This suggests that the patients could complicate their lives while waiting to be transferred from the MOU to the hospital.

Another concerning finding is the need for more clarity on the personnel who are supposed to escort the high-risk patient from MOU to the hospital. The National Health Act, 2003 (Act No. 61 Of 2003) stipulates the various categories of emergency personnel (basic life support, intermediate and advanced life support). However, midwives in this study expressed that they are often obliged to accompany the high-risk patients out of concern that the emergency personnel dispatched to transfer patients from MOU to the hospital are junior and can manage some obstetric complications. The midwife's concern is valid as the perinatal problem identification (PIPI) inquiries on causes revealed that some adverse perinatal outcomes could have been avoided if the personnel were adequately skilled to deal with the patient's condition (Vallely et al., 2021). Furthermore, this finding suggests that the patients' access to MHS is inhibited because staff members need the proper skill set and knowledge to attend to the patient (Vallely et al., 2021).

The study revealed that the midwives are concerned about the decline in the quality of MHS. The marked decline in the quality of care could stem from the need for more well-defined and aligned policies on access to MHS. Consequently, it is difficult for midwives to manage the admission of women to MHS. This finding demonstrates the midwives' awareness of the importance of quality of care in delivering the MHS. According to the (WHO,2022), quality of care is a measure to ensure safe, timeous, effective, and efficient care, which could aid in the reduction of maternal and neonatal morbidities and mortalities. The midwives limited abilities to control the patients movements in and out of the clinical facilities affected the external environment which is the hospital according to the paradigmatic perspective of Theory for Health Promotion in Nursing (University of Johannesburg, 2017:9,10). The midwives limitations on the control of the external environment may have limited opportunities to promote health of pregnant women and their neonates.

Conclusions

Midwives are the custodians and primary caregivers in MHS and are guided by the various policies on access to MHS. This study concludes that the policies on access to MHS are not specific, which limits midwives' control over women accessing the MHS. In addition, the MHS policies are not consistent with the patient's rights charter and the constitution, which makes it challenging for midwives to control the movements of women across the levels of care. The study further concludes that the midwives experienced challenges with the existing policies on access to MHS that are detrimental to the quality of care. The detrimental effects of the decline in the quality of MHS on pregnancy outcomes herald a need for revision of policies of access to MHS. It is recommended that the policymakers be cognizant of the disparities between the MHS policies and the laws of the land to ensure the contextual accuracy and relevance of the policy. In addition, it is recommended that the MHS policies be detailed, concise, and straightforward to ensure that all implementers understand and interpret them easily. The presence of well-defined and relevant policies could aid in standardizing the quality of MHS, potentially improving the perinatal outcomes. The study opens opportunities for further studies on access to policies on access to maternal health services using a multivariate population comprising of midwives, obstetricians and emergency medical care personnel. In addition, the inter-facility transfers from lower levels of care to higher levels of care and vice versa is another study opportunity to be explored according to the findings of this study.

Implications

The study has implications for the policymakers to look for the inconsistencies and gaps within the policies, acts and regulations to serve as a guide for the amendments processes. The alignments of all the relevant framework guiding access to maternity healthcare services will enable midwives' control to manage the patient's movements in and out of the facilities and direct the patients to relevant level of care. Consequently, improving midwives' responses to the patients needs ultimately resulting in positive implications for the nursing and midwifery practice. The study has implications for the nursing and midwifery education, as the curriculums must incorporate the legal and ethical framework to conscientize the prospective midwives of the application of such legal framework in clinical practice.

Potential shortcomings and limitations

The study's sample was limited to midwives and doctors, and emergency medical services personnel were excluded from the study. The doctors and emergency personnel work collaboratively with the midwives to render MHS and apply the various policies for access to MHS. Doctors and emergency personnel would have been able to provide insightful information on the phenomena. The exclusion of doctors and emergency service personnel limited the opportunity for maximum variation sampling, which would have allowed the researcher to describe the policies of access to MHS comprehensively. The study was conducted in a single district of one province out of nine in South Africa, and only nine midwives participated. Consequently, the results cannot be generalized because of the small sample size and geographical area.

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References

- Abalos, E.E., Rivera, R.Y., Locsin, R.C., & Schoenhofer, S.O. (2016). Husserlian phenomenology and Colaizzi's Method of data analysis: Exemplar in qualitative nursing. *Nursing Inquiry using nursing as caring theory*. *International Journal for Human Caring*, 20(1):19-23.
- Ala, S.H., Husain, Samia and Husain, Saba (2021) 'Reasons for presenting to antenatal care clinics in a sample of Pakistani women and their knowledge of WHO antenatal care package', *European journal of midwifery*, 5, p. 43. <https://doi.org/10.18332/ejm/140794>.
- Ashokcoomar, P. and Bhagwan, R. (2022). The neonatal transfer process through the lens of neonatologists at public hospitals in South Africa', *Health SA = SA Gesondheid*, 27, p. 1617. <https://doi.org/10.4102/hsag.v27i0.1617>.
- Babalola, T.K., Ojungele, H.O., Shahwan, M. & Moodley, I.(2022). Analysis of factors influencing technical efficiency of public district hospitals in KwaZulu-Natal province, South Africa', *Human Resources for Health*, 20(1).
- Busse, R., Klazinga, N., Panteli, D. & Quentin, W (2019) 'Improving healthcare quality in Europe: Characteristics, effectiveness and implementation of different strategies'. *live&scope=site* (Accessed: 30 May 2023).
- Becker, J, Becker, C, Oprescu, F, Wu, C-J, Moir, J, Shimwela, M, Gray, M & Wu, C-JJ (2022). Silent voices of the midwives: factors that influence midwives' achievement of successful neonatal resuscitation in sub-Saharan Africa: a narrative inquiry', *BMC Pregnancy & Childbirth*, 22(1), pp. 1–13. <https://doi.org/10.1186/s12884-021-04339-7>.
- Belay Tolu, L., Yigezu, E., Urgie, T., & Feyissa, G. T. (2020). Maternal and perinatal outcome of preeclampsia without severe feature among pregnant women managed at a tertiary referral hospital in urban Ethiopia. *PloS one*, 15(4), e0230638.
- Burger, R., & Christian, C. (2020). Access to health care in post-apartheid South Africa: availability, affordability, acceptability. *Health Economics, Policy and Law*, 15(1), 43-55.
- Callander, E. J., Fenwick, J., Donnellan-Fernandez, R., Toohill, J., Creedy, D. K., Gamble, J., Fox, H., & Ellwood, D. (2019). Cost of maternity care to public hospitals: a first 1000-days perspective from Queensland', *Australian Health Review*, 43(5), pp. 556–564. <https://doi.org/10.1071/AH18209>.
- Chiu, W.-K., & Fong, B. Y. F. (2023). Sustainable Development Goal 3 in Healthcare. In *Environmental, social and governance and sustainable development in healthcare* (pp. 33-45). Springer.
- Dahab, R., & Sakellariou, D. (2020). Barriers to accessing maternal care in low income countries in Africa: a systematic review. *International journal of environmental research and public health*, 17(12), 4292.
- Daniels, A. A., & Abuosi, A. (2020). Improving emergency obstetric referral systems in low and middle income countries: a qualitative study in a tertiary health facility in Ghana. *BMC health services research*, 20, 1-10.

- Edmonds, J. K., Ivanof, J., & Kafulafula, U. (2020). Midwife led units: transforming maternity care globally. *Annals of global health*, 86(1).
- Edoka, I. P., & Stacey, N. K. (2020). Estimating a cost-effectiveness threshold for health care decision-making in South Africa. *Health Policy and Planning*, 35(5), 546-555.
- Fuzy, E., Clow, S.E. and Fouché, N. (2020) ‘Please treat me like a person’—respectful care during adolescent childbirth’, *British Journal of Midwifery*, 28(6), pp. 360–369. <https://doi.org/10.12968/bjom.2020.28.6.360>.
- Goemaes, R., Beeckman, D, Verhaeghe, S & Van Hecke, A. (2020). Sustaining the quality of midwifery practice in Belgium: Challenges and opportunities for advanced midwife practitioners’, *Midwifery*, 89, p. N.PAG. <https://doi.org/10.1016/j.midw.2020.102792>.
- Gordon, T., Booysen, F., & Mbonigaba, J. (2020). Socio-economic inequalities in the multiple dimensions of access to healthcare: the case of South Africa. *BMC Public Health*, 20, 1-13.
- Gray, J.R. & Grove, S.K. (2019). *Burns & Grove’s: The Practice of Nursing Research: Appraisal, Synthesis and Generation of Evidence*. 9th edition. Missouri: Elsevier ‘Hospital overcrowding: 192 instead of 51 in maternity ward’ (2019) *Medical Brief*, 2019(0259).
- International Citizens Insurance. (2023). Understanding South Africa’s Healthcare System Available at: <https://www.internationalinsurance.com/health/systems/south-africa.php> (Accessed 19 April 2023)
- Ireland, B. (2018, March 20). 5 things you need to know to prepare for your government hospital birth Accreditation. Available at: <https://www.news24.com/life/archive/5-things-you-need-to-know-to-prepare-for-your-government-hospital-birth-20180320> (Accessed: 27 April 2023).
- Jean-Baptiste, M. C., Millien, C., Sainterant, O., Dameus, K. J. R., Julmisse, M., Julmiste, T. M., Fanfan, J. G., & Raymonville, M. (2023). Quality improvement initiative reduces overcrowding on labour and delivery unit in a university hospital in Haiti. *BMJ Open Quality*, 12(1), e001879.
- Jooste, K. (2017). *Leadership in health services management*. 3RD Edition. Lansdowne, Cape Town: Juta,
- Lavin, T. and Pattinson, R. (2018). Does antenatal care timing influence stillbirth risk in the third trimester? A secondary analysis of perinatal death audit data in South Africa. *BJOG: An International Journal of Obstetrics and Gynaecology*, 125(2), pp. 140–147.
- Lord, M. G., Calderon, J. A., Ahmadzia, H. K., & Pacheco, L. D. (2023). Emerging technology for early detection and management of postpartum hemorrhage to prevent morbidity’, *American journal of obstetrics & gynecology MFM*, 5(2S), p. 100742. <https://doi.org/10.1016/j.ajogmf.2022.100742>.
- Mahmood, F. J., & Tayib, A. Y. (2021). Healing environment correlated with patients’ psychological comfort: Post-occupancy evaluation of general hospitals. *Indoor and Built Environment*, 30(2), 180-194.
- Malakoane, B., Heunis, J., Chikobvu, P., Kigozi, N., & Kruger, W. (2020). Public health system challenges in the Free State, South Africa: A situation appraisal to inform health system strengthening. *BMC health services research*, 20, 1-14.
- Mattison, C. A., Lavis, J. N., Wilson, M. G., Hutton, E. K., & Dion, M. L. (2020). A critical interpretive synthesis of the roles of midwives in health systems. *Health Research Policy and Systems*, 18, 1-16.
- Mndebele, S. (2021). Nurse Escorts’ Perceptions of Their Ability to Manage Patient Clinical Deterioration During Nurse-Led Inter-Hospital Ambulance Transfer in the Wheatbelt Region of Western Australia: A Mixed Methods Study.
- Moeti, T., Mokhele, T., Weir-Smith, G., Dlamini, S., & Tesfamicheal, S. (2023). Factors Affecting Access to Public Healthcare Facilities in the City of Tshwane, South Africa. *International journal of environmental research and public health*, 20(4), 3651. <https://doi.org/10.3390/ijerph20043651>
- Moudi, A., Irvani, M., Najafian, M., Zareiyani, A., Forouzan, A., & Mirghafourvand, M. (2022). The development and validation of an obstetric triage acuity index: a mixed-method study’, *Journal of Maternal-Fetal & Neonatal Medicine*, 35(9), pp. 1719–1729. <https://doi.org/10.1080/14767058.2020.1768239>.
- Mthethwa E, Peu MD, de Waal M, Yazbek M. (2019). Recommendations to Improve Antenatal Care Uptake through Community Participation and Local Accountability’, *Africa Journal of Nursing & Midwifery*, 21(2), pp. 1–13. <https://doi.org/10.25159/2520-5293/6214>.
- Nkosi, V., Haman, T., Naicker, N. & Mathee, A. (2019). Overcrowding and health in two impoverished suburbs of Johannesburg, South Africa’, *BMC public health*, 19(1), p. 1358. <https://doi.org/10.1186/s12889-019-7665-5>.
- Oladapo, O.T., Tunçalp, Ö., Bonet, M., Lawrie, T.A., Portela, A., Downe, S. & Gülmezoglu, A.M. (2018). WHO model of intrapartum care for a positive childbirth experience: transforming care of women and babies for improved health and wellbeing’, *BJOG: An International Journal of Obstetrics & Gynaecology*, 125(8), pp. 918–922. <https://doi.org/10.1111/1471-0528.15237>.
- Penwell, V. (2022). The Role of the Midwife in the First 1000 Days’, *Midwifery Today*, (141), pp. 46–49.
- Ravitch, Sharon, M. and Nicole Mittenfelner Carl. *Qualitative Research: Bridging the Conceptual, Theoretical, and Methodological*. Available from: VitalSource Bookshelf, (2nd Edition). SAGE Publications, Inc. (US), 2019
- Rogers, J. M., & Warwick, K. A. (2022). Stronger together: Interprofessional collaboration and sustainability of maternity services in a small northern Ontario hospital. *Canadian Journal of Rural Medicine*, 27(3), 99-103.

- Savioli, G., Ceresa, I. F., Gri, N., Bavestrello Piccini, G., Longhitano, Y., Zanza, C., ... & Bressan, M. A. (2022). Emergency department overcrowding: understanding the factors to find corresponding solutions. *Journal of personalized medicine*, 12(2), 279.
- Sibiya, M. N., Ngxongo, T. S. P., Reddy, P., Ghuman, S., Borg, D., Connor, L.O., Haffejee, F., & Govender, N. (2018). Timing of first antenatal care attendance and associated factors among pregnant women in an obstetric health facility in eThekweni district, KwaZulu-Natal Province, South Africa', *African Journal for Physical, Health Education, Recreation and Dance*, 24(2), pp. 181–192.
- Senekal, A.C.G., 2021. Experiences of Gauteng-Based Emergency Care Providers Involved in Critical-Care Transfers. Master's dissertation, University of Johannesburg, Johannesburg (South Africa). Viewed at <https://hdl.handle.net/10210/476126>
- South Africa. Department of Statistics South Africa.(2022). Rustenburg Local Municipality.
- South Africa. Department of Health. (2016). Guidelines for maternity care in South Africa. Pretoria: Department Of Health. Available at: <https://knowledgehub.health.gov.za/elibrary/guidelines-maternity-care-south-africa-2016> (Accessed: 27 April 2024).
- South Africa(2018).National Department of Health: Patients' rights charter. Available at: <https://www.idealhealthfacility.org.za/App/Document/Download/150> (Accessed: 27 April 2024).
- South Africa.(2021)National Health Act: Regulations: Standards for emergency medical services. Regulation no 94 Of 2021. Pretoria . Available from: https://www.gov.za/sites/default/files/gcis_document/202102/44161gon94.pdf (Accessed 13 April 2024).
- South Africa. (1996). Constitution of the Republic Of South Africa1996. Available at: <https://www.gov.za/documents/constitution-republic-south-africa-1996> (Accessed: 27 April 2024).
- The World Counts (2023). World Population. Available at: <https://www.theworldcounts.com/populations/world/births> (accessed 19 April 2024)
- South Africa. Department Of Health(2018). Ideal Health Facility. Available at: <https://www.idealhealthfacility.org.za/App/Document/Download/150> (Accessed 16/10/2024)
- South African Private Hospitals. (2016).Childbirth Delivery Costs in South Africa. Available from <https://www.saprivatehospitals.com/hospital-care/childbirth-delivery-costs-in-south-africa/> Accessed 16 October 2024
- South Africa.Department of Health South Africa.(2003) The National Health Act, 2003 (Act No. 61 Of 2003). Regulations Relating Standards For Emergency Medical Services. Available from; https://www.gov.za/sites/default/files/gcis_document/202102/44161gon94.pdf Accessed 16 October 2024
- Sustainable Developmental Goals (SDG).2016.Transforming our World: The 2030 Agenda for Sustainable Development. Available at 21252030 Agenda for Sustainable Development web.pdf
- Tukisi, K.P., Temane, A. & Nolte, A., 2022, 'The midwives' experiences of the use of obstetric triage and obstetric triage tool during labour in Bojanala district', *Health SA Gesondheid* 27(0), a1758. <https://doi.org/10.4102/hsag.v27i0.1758>
- Valley, L.M., Smith, R., Bolnga, J.W., Babona, D., Riddell, M.A., Mengi, A., Au, L., Polomon, C., Vogel, J.P., Pomat, W.S., Valley, A.J. & Homer, C.S.E. (2021). Perinatal death audit and classification of stillbirths in two provinces in Papua New Guinea: A retrospective analysis', *International Journal of Gynecology and Obstetrics*. 153(1), pp. 160–168. Available at: <https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=eoh&AN=55492502&site=ehost-live&scope=site> (Accessed: 27 April 2024).
- Wallace, J., Hoehn-Velasco, L., Tilden, E., Dowd, B. E., Calvin, S., Jolles, D. R., Wright, J., & Stapleton, S. (2023). An alternative model of maternity care for low-risk birth: Maternal and neonatal outcomes utilizing the midwifery-based birth center model. *Health services research [Preprint]*. <https://doi.org/10.1111/1475-6773.14222>.
- Vogus, T. J., McClelland, L. E., Lee, Y. S., McFadden, K. L., & Hu, X. (2021). Creating a compassion system to achieve efficiency and quality in health care delivery. *Journal of Service Management*, 32(4), 560-580.
- Wasik, M. A. (2020). The role of the nurse in improving the quality of healthcare. *Journal of Education, Health and Sport*, 10(4), 68-74.
- Weiss, D., Nelson, A., Vargas-Ruiz, C., Gligorić, K., Bavadekar, S., Gabrilovich, E., Bertozzi- Villa, A., Rozier, J., Gibson, H., & Shekel, T. (2020). Global maps of travel time to healthcare facilities. *Nature medicine*, 26(12), 1835-1838.
- WHO Recommendations. (2016).Antenatal Care for a Positive Pregnancy Experience: Summary Highlights and Key Messages from the World Health Organization's 2016 Global Recommendations for Routine Antenatal Care. Available at: <https://apps.who.int/iris/bitstream/handle/10665/259947/WHO-RHR-18.02-eng.pdf> (Accessed: 27 April 2024).
- WHO recommendations Intrapartum care for a positive childbirth experience Transforming care of women and babies for improved health and well-being <https://apps.who.int/iris/bitstream/handle/10665/272447/WHO-RHR-18.12-eng.pdf>

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