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Mary L. Cerulli
University of Pennsylvania

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Go Ask the Midwife: Professional Identity in Cape Town, South Africa

Abstract

The legacy of gendered professionalization, the racial hierarchy of apartheid, and profound health care policy changes in the post-apartheid era, facilitated a specific scrutiny of maternity nurses working in the public sector in independent Midwife Obstetric Units in South Africa. Within scholarship on the quality of maternity care in South Africa, the professional identity of nurses is used to explain issues of rudeness and abuse faced by patients (Jewkes, Abrahams & Mvo, 1998). However, the perspective of nurses themselves on their experience of identity and how it shapes their work is notably absent. It is the aim of this paper to connect the social forces that have shaped the nursing profession and its narratives to original data about nurses' experience of profession and identity. I will argue that three factors – the valuation of autonomy as a practitioner, a close connection to community, and intentional distancing from the private obstetric standards of care – provide an alternate narrative of how professional identity is experienced by nurses working in primary, public maternity care as a factor that promotes rather than denigrates quality care.

Disciplines

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Go Ask the Midwife:
Professional Identity in Cape Town, South Africa

By
Mary L. Cerulli

2016-2017 Penn Humanities Forum Undergraduate Research Fellow
University of Pennsylvania

A SENIOR HONORS THESIS
in Health & Societies

Submitted to
The Department of History and Sociology of Science
Thesis Advisor: Dr. Kimberly Trout, PhD, CNM

2017

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ABSTRACT

The legacy of gendered professionalization, the racial hierarchy of apartheid, and profound health care policy changes in the post-apartheid era, facilitated a specific scrutiny of maternity nurses working in the public sector in independent Midwife Obstetric Units in South Africa. Within scholarship on the quality of maternity care in South Africa, the professional identity of nurses is used to explain issues of rudeness and abuse faced by patients (Jewkes, Abrahams & Mvo, 1998). However, the perspective of nurses themselves on their experience of identity and how it shapes their work is notably absent. It is the aim of this paper to connect the social forces that have shaped the nursing profession and its narratives to original data about nurses' experience of profession and identity. I will argue that three factors – the valuation of autonomy as a practitioner, a close connection to community, and intentional distancing from the private obstetric standards of care – provide an alternate narrative of how professional identity is experienced by nurses working in primary, public maternity care as a factor that promotes rather than denigrates quality care.

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INTRODUCTION

Nursing, primary care, and pregnancy triangulate a context in South Africa that is rare around the world: government-sponsored clinical space run by women, for women, not in sickness but in health. Presiding over pregnancy and birth at the primary care level are nurse-midwives, responsible for two lives, mother and baby's. Birth can be overwhelming to witness. Labor is a process of deep intensity involving a kind of emotional physicality that comprises both herculean bodily effort and vulnerability. The first time I saw a baby's head emerging from the birth canal was in the labor ward of the Retreat Midwife Obstetric Unit in Cape Town. Once the baby finally made its way into its mother's arms – from inside the familiarity of her body, to the hands of the midwife, to the safety of the breast – I suddenly felt light-headed and nearly fainted there on the labor ward floor. I learned to never skip breakfast and had the privilege of witnessing another fifteen births in that labor ward, each one unique in its own challenges and grace.

Sister Robin Layne, the nurse manager of the Retreat Midwife Obstetric Unit described her passion for midwifery care as appreciation for the process of pregnancy and for the privilege of bringing new life into the world. She describes the midwife's role in the sanctity of birth as a process:

“Because my thing is, I always take it from nothing, like from the sperm till the egg joining, fertilizing, from nothing there this baby come, it's fascinating! And here this baby, you the first person, you the first person touching that baby, you in control of the delivery if anything, so I like that idea. You're the first person, you can speak peace over that child's life that you're birthing. Remember you're first, as I always say it like, very first, even the mother didn't hold that baby yet, you as a midwife.”

The experience of nurses working in maternity care – the stories they shared with me about their lives, the way their lives and their work intertwine, and the stories about their lives that are told for them – are the heart of this project. It is my privilege to represent their words here in this paper and I hope to do them justice by utilizing this academic space to advocate for aspects of their experience of professional identity that have been overshadowed by criticism.

Throughout the discourse of South African maternity care, from local news to international reports, runs a narrative of nurses as rude and abusive to the patients in their care. Nursing-led midwifery care in South Africa stands on a foundation of gendered professionalization and the racial hierarchy policies of apartheid,¹ which facilitated a specific stigma to be attached to nursing identity that is still relevant today. Within scholarship on the quality of maternity care in South Africa, professional identity of nurses is used to explain rudeness and abuse. However, the discussion of professional identity has been extrapolated primarily from patient experiences, third-party research, and physician observations. The perspective of nurses themselves on how they experience identity and how that experience shapes their work is notably absent.

It is the aim of this paper to connect the forces that have shaped the nursing profession and its narratives to original data about nurses' experience of profession and identity. The gender and race dynamics that influenced the professionalization of nursing in South Africa during apartheid overlaid by the post-apartheid policies for expanding access to maternity care placed nurse-midwives, charged with providing primary care for all pregnant women in need of public sector, under particular scrutiny within the health system. From this scrutiny emerged a narrative,

¹ Apartheid refers the era of South African history from 1948 to 1994 in which the Afrikaner National Party's explicit agenda of racial segregation and oppression was the official rule of the country.

represented by an omnipresent study by Jewkes, Abrahams, and Mvo published in 1998 of public maternity nurses, specifically, as rude and abusive to their patients due to feelings of insecurity in middle-class status. This narrative of professional identity as the cause of problematic nursing behavior is perpetuated throughout scholarship and has endured as a dominant feature of maternity care discourse in South Africa.

Section I of this paper analyzes the social axes of the current critical narrative that associates professional identity with issues in quality maternity care by illustrating how historical gender and racial hierarchies have contributed to the current narrative of professional identity criticism.

Section II of this paper analyzes the thematic findings of interview data of maternity nurses' experience of professional identity, which challenge the dominant narrative analyzed in Section I.

I will argue that three factors – the valuation of autonomy as a practitioner, a close connection to community, and intentional distancing from the private obstetric standards of care – provide an alternate narrative of how professional identity is experienced by nurses working in primary, public maternity care as a factor that promotes rather than denigrates quality care.

Methodology

I conducted a total of 23 semi-structured interviews at three different maternity care sites in Cape Town: Retreat Midwife Obstetric Unit (MOU), Al-Nisa Maternity Home, a semi-private MOU, and the maternity ward of the private hospital Vincent Pallotti. Fourteen of my interviews

were conducted at Retreat MOU, five at Al-Nisa Maternity Home, and four at the labour ward of Vincent Pallotti Hospital.

The interview guide included questions on the following topics: an interviewee's decision to become nurse, the different health care contexts she had worked in and what the challenges were in each as well as any preferences she had for different work environments and her reasons for those preferences, how becoming a nurse affected her self-concept and her relationship to her community, and how she viewed nursing in a societal context. I interviewed advanced midwives, professional nurses also known as Sisters, staff nurses, and nursing students. For a summary of interview participants, see the Appendix.

I was granted ethics clearance for this interview project by the University of Cape Town's Health Research Ethics Committee and worked with Dr Christopher J. Colvin of the Social and Behavioral Sciences department in the school of Public Health and Family Medicine. I recruited participants through my own personal connections and those facilitated by Dr Colvin.² The documents related to my study, including the consent form and interview guide, can be found in the Appendix.

The mean length of the interviews was 31 minutes, the median was 25 minutes, and the interviews ranged from 8 minutes to 90 minutes. I recorded and transcribed 21 of the 23 interviews, however, two interviewees consented to the interview but not the recording, in which case I took down detailed notes by hand. Each interviewee had the option to request a copy of their transcript and/or the final thesis paper and any publication that uses interview data from this project upon completion. I did not provide any opportunity to alter the interview transcript or revise quotations, nor were interviewees consulted about the thematic results of my analysis.

² The Health Research Ethics Committee reference number (HREC REF) for my thesis fieldwork is 322/2016. May 2017 final paper submitted for Penn Humanities Forum Undergraduate Research Fellowship 8
Mary L. Cerulli, College of Arts & Sciences 2017, University of Pennsylvania

I coded the interview transcriptions and notes using NVIVO software. I coded according to several broad themes that I identified after transcription including: autonomy, community, and nursing identity. I then sub-coded these themes according to care location: primary care, tertiary care, and private care. Using the analytic capacity of the software I was able to search and compare different combinations of these coding tags. For example, I used the overlap between *community x primary care* as well as the overlap between *community x nursing identity* to formulate the different claims of the “Centering Community Connection” section of this paper. Similarly, the overlap between *autonomy* and the three different settings of the health system is the basis for the “Valuing autonomy in practice” section. Not every interviewee is directly quoted in this paper but all interviews were coded and taken in to account during analysis.

In addition to my interview data, I have spent approximately 300 volunteer hours at Retreat MOU from a service internship in 2015 as well as an additional 120 hours of volunteering and fieldwork there in 2016. As a researcher, I wrote fieldwork summaries of each day that I spent in the MOU. As a volunteer I observed and assisted the nurses with a variety of tasks and learned about daily nursing practice as well as the general functioning and routine of the MOU. I observed sixteen births in the labor and delivery ward and spent approximately 190 hours in the antenatal ward. I conducted informal interviews with visiting high school students during job shadowing, HIV testing and adherence counselors, NGO volunteers, and visiting social workers. I am unable to represent these fieldwork summaries and informal interviews directly in this project, but the insight they provided me helped guide my research and deepen my understanding of Retreat MOU and maternity care in Cape Town.

ETHNOGRAPHIC ORIENTATION

Setting

Midwife Obstetric Units (MOU's) are the centerpiece of for women, by women maternity health care. They are free-standing health centers that include an antenatal clinic, a labor and delivery suite, a post-natal ward, and administrative offices. MOU's are located throughout Cape Town, specifically in the Cape Flats and township areas of the city, which during apartheid were reserved for people of color based on racial categories. The Cape Flats was designated as a Coloured zone whereas townships like Khayelitsha were designated as African, an apartheid term for black indigenous ethnicities.³ Care at MOU's is free – from prenatal check-ups through to post-natal follow-up. Care at MOU's is provided by a team of nurses of several different professional levels, and although these maternity centers are designated as primary care centers, advanced nurses are trained to deal with emergencies or unanticipated complications that can, and often do, occur during birth. When risk factors or complications arise that require physician care or hospital resources, nurses at the MOU utilize referral protocols to transfer patients to public hospitals. Ambulances are called to transfer patients from the MOU to the hospital based on the needs of the patients. At the MOU vaginal deliveries are the norm based both on both an ethos of viewing pregnancy as normal rather than pathological and a practical lack of access to any medication, like epidurals, that are deemed unnecessary.

³ The Group Areas Act of 1950 was one of the first official policies of the apartheid government and forced people, categorized by race as per The Population Registration Act of the same year, to relocate to racially defined zones radiating out from city centers of white wealth (Thompson, 2014). Although official residential segregation was abolished by the African National Congress, the party of Nelson Mandela, when elected in 1994, many of the areas that were racially-defined zones during apartheid still are dominated by one racial group and segregation persists in cities as well as rural areas.

Positionality

The majority of my interviews are based at the Retreat MOU location for both incidental and intentional reasons. The first, incidental, reason is that it is a health center with which I was already familiar before I began conducting interviews in June 2016. During the previous year, I spent two months as a volunteer at Retreat MOU after spending a month as an observer and volunteer at the adjacent Day Hospital. I shadowed nurses and midwives at the MOU and learned how to make myself useful with administrative work and assistant tasks in the antenatal clinic. I also had the opportunity to shadow the midwives working in the labor and post-partum wards. My experience at Retreat MOU as a volunteer in 2015 was the direct inspiration for my return as a researcher in 2016. My familiarity with the context of primary public maternity nursing was one of the factors that enabled me to receive support from the University of Cape Town and my previous connection to several of the nurses working at Retreat MOU worked as an advantage as I asked for staff to make time to be interviewed before they returned home after a long day.

The second, intentional, reason for basing my research at Retreat MOU is that, as a MOU it represents the section of the health system most relevant to my research in terms of nursing-only care and maternal health access. Based on its status as a site of primary maternity care situated within a low-income community, Retreat MOU provides for women, by women care in a community that relies on the free care of the public health system.

Additionally, as I moved through the research process I encountered both informal and academic assertions that Retreat MOU was a leader in high quality primary care in Cape Town. Evidence of Retreat MOU as in some way exemplary appeared in conversations with UCT researchers, anecdotes from Retreat MOU staff and volunteers, as well as a reference in an

academic report that showed quality at Retreat was higher compared to other MOU's (Abrahams & Jewkes, 1998). Although it was not necessarily my intention to base my research on a particularly high quality MOU, this provided an opportunity to witness a narrative that represents professional identity's relationship to positive care for patients in terms of nurses' connection to their community.

Although I focus on primary care in the public sector, my interviews also represent nursing experiences across the primary-tertiary and public-private continuum of maternity care. Al-Nisa Maternity Home is also designated as a MOU and thus falls within the category of primary maternity care; however, the fact that it functions as a semi-private institution, with user fees set at subsidized rates through personal funding from Al-Nisa's founder, situates it between the public and private health systems. When complications or risk factors emerge, Al-Nisa staff access the public system and refer patients to Mowbray Maternity Hospital or Groote Schuur Hospital, the major secondary and tertiary hospitals of Cape Town, for further care. Patients of course have the option of instead proceeding to a private hospital, but most Al-Nisa patients could not afford the full cost of private hospital care. The maternity ward of Vincent Pallotti Hospital provides a contrast to both Retreat and Al-Nisa because it is fully encompassed within the private system and is not restricted to primary care at all. Although the focus of my research centers on primary public care because that is where the narrative of abuse resides, the differences between Retreat MOU, Al-Nisa Maternity Home, and Vincent Pallotti Hospital offers a broader understanding of professional identity in nursing by representing the influence of context on nurses' perspective, specifically through the contrast between public to private and primary to tertiary care.

Personal Statement

I am a white woman and a current senior undergraduate student in the Health and Societies major with a concentration in Gender and Health at the University of Pennsylvania. I trained as a doula in April 2016 and have been taking prerequisite courses to prepare for applying to nursing school with the aspiration of becoming a midwife myself one day. I spent a year and a half in Cape Town, South Africa over the course of three different time periods spanning from 2012 to 2016. I volunteered in the Cape Flats at the NGO Mothers Unite in Lavender Hill and then at the Retreat Day Hospital and MOU. Although my experience in Cape Town and in the Cape Flats area of the city offers me some perspective, I do not claim to be an expert on South African nursing, identities, communities, or health policy. It is my intention in this paper to analyze existing sources on South African maternity care and nursing and to present the thematic analysis of the interviews I conducted with nurses at Retreat MOU, Al-Nisa Maternity Home, and Vincent Pallotti Hospital. I have not altered the meaning of any interview quotations or intentionally misrepresented the content of any interview quotation used.

Clarification of terms

Terminology surrounding race in South Africa is unique to the history of the country, and I want to be clear about my use of terms when writing about race in this paper. I will be using the term of color to refer to a group of people who would have been classified as Coloured, Indian, and/or African during apartheid. Despite its historical use as an apartheid moniker, the term Coloured is a current term used as a self-identifying label for many people who have a mixed racial heritage. Although Coloured can signify direct mixed heritage, many Coloured people

consider themselves to be part of a distinct racial group in South Africa and identify as Coloured and not mixed race or bi-racial. Unlike in the United States, Coloured is not considered a derogatory term and represents a distinct racial identity in itself. In South Africa today, the term African, an apartheid label for indigenous ethnicities, has been mostly replaced with black. Except when specifically discussing apartheid policy, I will use the term black to refer to people who have identified themselves as belonging to one of the many ethnic groups indigenous to South Africa, including but not limited to Xhosa and Zulu.

Nursing in South Africa uses a set of professional terminology that also deserves clarification at the outset of this paper. Professional nurses are referred to as Sisters,⁴ and have completed a set of courses and clinical hours as part of a four-year diploma course. This coursework includes both midwifery and psychiatric nursing instruction in addition to general and acute care; however, before 1986 midwifery and psychiatry were considered supplementary qualifications⁵ and were not included in the standard two-year training for staff nurses (Blaauw, Ditlopo, & Rispel, 2014). This educational format was designed to train staff nurses rather than professional nurses, Sisters. Nurses who were trained in this way graduated as staff nurses and were required to take a year of either midwifery or psychiatry to become a professional nurse. Staff nurses who trained before 1986 and wanted to qualify for advanced certificates must complete a year of midwifery or psychiatry training as a prerequisite.

Nurses who refer to themselves as midwives are Sisters who work in maternity care and have either received the four-year diploma qualification or trained as staff nurses and then

⁴ Sister as a term for both nuns and nurses was brought to South Africa from British tradition and stuck

⁵ In South Africa the term “post-basic” is used to describe this level of coursework

studied for a midwifery qualification to become a Sister.⁶ Advanced midwifery, alongside courses in other specialties designated as advanced, is a qualification for Sisters that enables them to significantly expand their scope of practice to that of an obstetrician without an operating room (National Department of Health, 2015). Nursing staff also includes Enrolled Nursing Auxiliaries (ENA's), who have received a certificate through a combination of study and working hours, completed in a year, that qualifies them to assist staff and professional nurses in their work. This paper contains interview data from Sisters, Staff Nurses, ENA's, and students enrolled in the diploma course to qualify as Sisters.

⁶ To clarify, South African midwifery mirrors the United Kingdom model in which midwifery is a sub-specialty of nursing. Because midwifery requires either a professional nursing qualification or an additional year of study after becoming a staff nurse, nurses working in maternity care will often describe themselves as midwives rather than nurses or even Sisters because it describes their highest level of qualification.

SECTION I The Abusive Maternity Nurse

A. THE NARRATIVE

In a study not only widely referenced across the literature on South African maternity care, but often referenced as “seminal” to scholarship on the topic, Jewkes, Abrahams, & Mvo’s 1998 research, titled “Why do nurses abuse patients? Reflections from South African Obstetric Services,” found that maternity nurses working in the MOU of a primarily Xhosa township in Cape Town “deployed violence” against patients through humiliation and outright abuse (Jewkes et al 1998 p. 1781). As the title suggests, the study delineates an explanation for why nurses abuse patients. The explanation the study provides, one grounded in a concept of how nurses experience professional identity, has become a foundational claim in the academic understanding of South African maternity care.

The Jewkes et al study, using data from 103 minimally structured interviews and four focus groups, asserts that abusive nursing behavior originates from “a struggle to assert their [nurses’] professional and middle class identity...as a means of creating social distance and maintaining fantasies of identity and power” (Jewkes et al. 1998 p. 1781). Based on these findings, black nurses feel only a tenuous claim to a middle-class social status and the resulting fragility of self-concept causes them to lash out at patients. The authors describe how black midwives’ status as middle-class professionals is “insecure” based on the combined limitations imposed by the inequalities of apartheid, the poor working conditions in clinics, and patients’ resistance to nurses’ authority (Jewkes et al. 1998). It is these limitations that make a middle-class identity and its social power a “fantasy.” The explanation for nursing abuse thus resides in

nurses' motive to protect a middle-class identity attacked by broader social inequalities by applying an "ideology of patient inferiority" (Jewkes et al. 1998 p. 1781).

If this motive of social distance and its application of abuse is the explanation for nursing behavior, how do nurses working in MOU's conceptualize their relationship to their community outside the nursing role? Does this identity rationale apply differently to nurses working in hospital rather than community settings? How do nurses define their identity, and how do personal and professional factors co-contribute in their definition? The resounding influence of the Jewkes et al study on the discourse of South African maternity care and the questions it left unanswered prompted my own research into professional identity within maternity nursing. It is not, however, my goal to refute claims of abusive behavior by maternity nurses. In fact, the issue of punitive measures enacted by midwives against patients was something that several nurses acknowledged as an issue for some practitioners during my conversations with them. In analyzing the narrative of nurses' professional identity as the cause of abuse and therefore a threat to the quality of maternity care in South Africa, it is my goal to juxtapose the story told for nurses in Section I with nurses' own words and experiences of identity in Section II.

The aim of Section I is to illustrate the social content of nursing narratives and the theoretical frameworks that shape them in order to demonstrate the way that scholarship perpetuates historical stigma attached to nursing identity. Gender and racial biases have shaped the professionalization of nursing in South Africa and constrained positive associations with nursing identity. Local and international scholarship disregards the fraught social position that nurses occupy and perpetuates a simplistic notion of how nurses experience identity, laying blame on nurses personally for quality of care issues.

Gendered and racialized concepts of care: The stigma of domestic labor

Sr. Peters and I are sitting in the large cubicle at the far end of the clinic, the one with the sitting wooden desk and the ultrasound machine, that by unspoken rule is always used by the most senior midwife working that day. The antenatal clinic is closed, the patients have gone home, and the nurses are writing in today's statistics, calling people with test results, and preparing for tomorrow's 7am rush. I ask Sr. Peters what she thought about nursing as a profession before she decided to apply to nursing school. She tells me that, "I thought nurses was similar to doctors. Nurses was very important people, nurses is out there," but that the older people in her family a different perception of nursing. Talking about her granny's reaction, Sr. Peters describes the resistance she faced within her family when she chose nursing as a career:

"When [granny] found out that I'm going to become a nurse, she said to me 'No, why do you want to be a nurse, all nurses do is clean patients' bums and change nappies the whole day, and clean beds'... They [the older generation] didn't have a full understanding that there's more to nursing. To them, nursing was more classified similar to home-base care. She [granny] was so surprised when she heard that you can deliver babies, that you working in psychiatric hospitals, because in the older generation they thought that nurses were like cleaners."

For Sr. Peters a nursing career represented the opportunity to achieve a professional status and a knowledge base similar to that of physicians, but her grandmother perceived nursing as essentially cleaning and disapproved of her decision. The relationship between nursing and domestic work has a twofold origin in South Africa that relates to both gender and racial prejudice.

Beginning with gender as a conceptual framework for understanding nursing's social value, I will use theory outlined by Margarate Sandelowski in her book *Devices & Desires: Gender, Technology, and American Nursing*. Although the author's work focuses on American

nursing history, her conceptual hierarchy is also applicable to the gender tensions at work in nursing in South Africa. Referencing historian of technology Ruth Schwartz Cowan, Sandelowski explains that, “technology is to science as manual is to mental and female is to male, with technology, manual, and female in these metaphoric pairs in subordinate positions” (Sandelowski, 2000 p. 8). This pairing asserts that physicians are societally imbued with the scientific, mental, and male characteristics of medicine, whereas nurses are relegated to the lesser category of technological, manual, and female characteristics. However, an exception to this framework is when nature is viewed as superior to technology. Sandelowski points out that, “Only when technology is paired with nature does [the previously mentioned nursing model] occupy the superior position by reference to the ideological system in which nature is female and technology is male” (Sandelowski, 2000 p. 9). This exception is particularly pertinent to maternity care, because birth is considered a natural life-course event for a woman and associated with both femininity and nature.

Within the gender hierarchy framework posited by Sandelowski, maternity nursing is a site of power contradictions. Pregnancy is a natural event, within the realm of feminine superiority to technology, rather than a medical event; therefore, in this case nursing care rather than medical care would be considered more valuable. However, in Western biomedical culture pregnancy and childbirth have been pathologized as an adverse medical event and, therefore, belong to the scope of physician care.⁷ The medicalization of pregnancy and childbirth ensured that the hierarchy of science, mental, and male were still dominate maternity care, where

⁷ A discussion of the medicalization of childbirth is beyond the scope of this paper. For further reading about the medicalization of childbirth in Western biomedical tradition see Heather A. Cahill’s “Male appropriation and medicalization of childbirth: an historical analysis” (2000).

Nature's superiority over technology might in theory elevate the estimation of nursing care and place the pregnant female body within feminine jurisdiction.⁸

The gendering and devaluation of nursing care within a male, medical hierarchy and its association with manual rather than mental labor is one vehicle of stigma. Nursing's specific association with cleaning, in the words of Sr. Peters' granny: "cleaning patients' bums, chang[ing] nappies the whole day...and cleaning beds," is not only a result of gender hierarchy between medicine and nursing but of racial hierarchy as well. In South Africa, nursing's association with manual labor combined with an existing association of domestic labor with race. Shula Marks, a pre-eminent scholar of nursing history in South Africa, argues that gender-tension between nursing and medicine as well as the specific racial and class constraints defining society in South Africa made nursing the site of intersection between two axes of prejudice (Marks, 1994).

Gender and racial hierarchies sum together in nursing as disdain for nursing's association with domestic labor. In her definitive book on the race, gender, and class dynamics that shaped nursing in South Africa, Shula Marks explains the implications of nursing's social location as the determining factor of professionalization:

"The drive towards professionalisation, so central a characteristic of the history of nursing in Britain and the USA, had in South Africa both a class and an urgent racial agenda. If nursing was to be a respectable occupation for white women, the stigma of domestic labor had to be removed; and control over the profession had to be kept white" (Marks, 1994 p. 9)

⁸ In South Africa, the biomedical model is as relevant as it is to the British or American health systems, and is particularly relevant to South Africa's private sector. As discussed in both Sections II A and C, the private sector of maternity care is physician dominated and has rates of caesarean surgery at about 70%. This resembles Brazil's health system, divided between a free public sector and for-profit private sector, which has caesarean rates of 80-90% (WHO).

This passage asserts that unique race and class influences combined in South African nursing to create a more complicated hierarchy than in the US or UK as described by the Sandelowski framework. Unlike in the United States or the United Kingdom, domestic labor was not only characterized as feminine, but as exclusively black and feminine. Therefore, nursing is not only characterized as manual, technological, and feminine, but black and feminine. This is not to say that racism was not a factor in US or UK nursing professionalization, but rather that South Africa had “an urgent racial agenda” that was explicit in South Africa in ways it was not elsewhere.

The historical tensions that both empowered and prescribed nursing during apartheid are the prelude, literally, to Jewkes et al’s claim that true middle-class status for nurses is unattainable. The authors begin their published study with a summary of Shula Marks’ *Divided Sisterhood* with the intent of describing the historical frustrations of nurses of color. Integral to how Jewkes et al interpret professional identity is through emphasizing the way that nurses of color were denied the rights, both professionally and personally, of white nurses during apartheid. According to Marks, the narrative of nurses as abusive began in the 1950’s when black nurses became a significant professional force within black communities (Marks, 1994). This critical narrative, as yet social and not academic, was strongly associated with gender roles as well as apartheid’s racial hierarchy. According to a demographic analysis of the apartheid workforce, women of color working as nurses outnumbered men of color working in any profession at all (Crankshaw, 2002). Practically, black and Coloured nurses had a measure of power in the apartheid system through employment unavailable to many unemployed black and Coloured men. Nurses’ role as actors within the health system during apartheid, a system inextricably linked to oppression and racial disparities, combined with subverted gender employment expectations to create a narrative focus on nurses’ use and abuse of power.

In a rare defense of South African nurses that focused on holistic identity, an unpublished thesis by June Webber at the University of Natal attempts to explain why nurses were unable to make positive changes for themselves and the health system during the post-apartheid transition and refutes the abusive nursing narrative as a tool of oppression. During apartheid nurses were leaders in protesting Pass Laws, a policy that required people of color to register and carry identification when outside their racially-defined residential zone, before a ban on strikes and political activity was successfully enforced by the South African Nursing Council in 1978 (Marks, 1994). In the 1990's nurses went on strike again in an attempt to create better working conditions under a post-apartheid government but both the new governing party and public opinion strongly rebuffed their efforts as selfish and harmful to patients (Webber, 2000). Webber uses interview data collected from 1996 to 1999 from nurses working in public hospitals and applies a feminist analysis to demonstrate that the negative image of nurses' moral character is "highly inaccurate, albeit a useful tool for the reinforcement of [nurses'] subjugation" (Webber, 2000 p. 8).

The gendering of nursing and the constraints of racism are both societal constructs that disempower nurses and affect the concept of identity as it relates to profession. The extent to which discourse reflects and consequently perpetuates gender and racial stigma is seen in the way current media and scholarship treat nursing identity.

Nurses in the news

Media representations of hypercritical attitudes towards nursing transfers the stigma attached to the profession to negative views of nursing personally. In her manager's office, Sr. Layne recounts an incident that she thinks represents the media's role in public opinion:

“Nowadays, they don't seem to respect the nurses anymore. I don't know, it doesn't help that you see on tv the nurses smacking [patients] ... Some family was complaining that there on their loved-ones was marks or something, so the authorities put in a camera, my god, and then you saw nurses smacking the elderly. Now that wasn't good. I mean, you don't, that make you think twice of putting the loved one in care, you think you're putting in care. So that was aired on television, so obviously people see that so they generalize all nurses.”

Sr. Layne was not the only one to bring up negative media portrayals of nurses as a force shaping public opinion during her interview. When I asked about changes in nursing she had experienced during her career, Sr. Sameera Patel, an advanced midwife at Retreat MOU, postulated that negative representations of nurses in the media has led to a skewed view of nurses in general. She explained to me that, “They listen to the media and everything, and that’s the repetition...When they come there [clinical space] they get scolded or shouted at, and then it goes to the public, and then they say ‘Oh well that place they rude, the nurses are rude’ ...It goes to the media and then it goes along.” The “repetition” that Sr. Patel describes and the “generalization” to all nurses represents media’s role in using individual instances to amplify existing negativity towards nursing and nurses socially. Both Sr. Layne’s example of “gotcha” reality tv and Sr. Patel’s example of the media picking up particular instances of rudeness suggest the presence of broad negative stereotypes with powerful influence over the concept of what a nurse does and who a nurse is.

An analysis of print newspaper portrayals of nurses and nursing conducted by Oosthuizen supports Sr. Layne and Sr. Patel’s impressions of the media as a source of negative representations of nursing and nurses and provides evidence for contradictions within public opinion that emphasize nurses’ fraught social location. The qualitative content analysis of 161 newspapers from 2005 to 2009 found that nurses were mostly portrayed as “overworked,

uncaring, lazy, ruthless, incompetent, and suffering from burnout” (Oosthuizen, 2012 p. 49). The study divides the newspaper coverage findings into four themes that demonstrate a juxtaposition of public expectations of nursing care, access to technology, and personal accountability with the constraints imposed by the health system, namely a lack of resources. Three of the four themes represented negative concepts of nursing, while the fourth limited positive coverage of nursing as a “noble profession” mostly occurring during International Nurses Week.

The first two themes of coverage were “Nursing shortage and emigration” and “Declining healthcare system and poor working conditions” and together they contrast nurses and the state’s accountability to patients. For the first theme newspapers reported on the “exodus” of South African nurses abroad and blamed them for abandoning South African patients and allowing the health system to fail. Yet the second theme focused on the “appalling conditions in public hospitals” and the daunting situational factors facing nurses at work, including grueling work schedules, a lack of safety measures to prevent HIV transmission, and outright violence, including assault and rape by patients, as well as verbal abuse from physicians (Oosthuizen, 2012 p. 57). The contrast between these two themes demonstrate that nurses are seen as guilty of not patriotically standing by the state health system in order to serve patients, even as they are cast as fully overworked and overwhelmed by that same state health system. The tension between these two seemingly contradictory storylines represented in the press is that of accountability. In the first line of thinking, nurses are blamed for prioritizing their own personal financial interests over a duty to care for South African patients, regardless of the working conditions.⁹ In the second

⁹ Several of the nurses I interviewed had worked abroad, particularly in Saudi Arabia, from anywhere from one to ten years. When I asked Sr. Ayesha what motivated her to go work so far away from her family she emphasized the economic opportunity. It was a great deal: free flights to and from South Africa, pre-paid housing and utilities, as well as a much higher salary than she could make at home. Without her time in Saudi Arabia, she told me, there was no way she could have paid off the bond on her house in Cape Town.

line of reasoning, the state is criticized for the appalling conditions in the public health facilities in which nurses are, at worst, in serious danger and, at best, overworked and under-resourced. The fact that both storylines exist simultaneously but do not inform each other is indicative of the way that nurses are granted narrative agency only in a negative context.

The third theme of print coverage best exemplifies the way that nurses are personally held responsible for quality care issues regardless of the state health system's constraints. Titled by Oosthuizen as "Death, suffering, humiliation, misconduct, and incompetence," the third theme represents the image of nurses as selfish, lacking empathy, and apathetic, attitudes that cause patient harm. The incidents that serve as focal points for these stories center on descriptions of nurses as lacking professionalism, from neglect to outright abuse (Oosthuizen, 2012). The media's assumptions of nursing as a profession capable of care regardless of environmental or system conditions are mirrored in Oosthuizen's own thematic analysis. The author concludes that "Nursing is a caring profession – but the desired image of a competent, trustworthy and caring profession was often challenged in the South African media in their reporting on poor care, neglect and misconduct" (Oosthuizen, 2012 p. 60). The media challenged the image of care but it also constructed a framework in which nurses were culpable for unsatisfactory care no matter what. Nurses were the agents of health care injustice through their personal faults. Within this analysis there is tension between a gendered conception of nursing "care" and the restrictions on supportive care by external factors such as a lack of equipment, lack of security, and physician power dynamics. The newspaper coverage represented in this study demonstrates the way that nurses are touchstones for public animosity and frustration with health care realities and that narratives demonizing nurses personally flourish in spite of the state's role in creating working environments that potentially harm nurses and patients.

A particularly poignant example of how nurses are personally implicated in health system failures can be found in a recent article published in the Cape Argus, Cape Town's primary print newspaper. Sipokazi Fokazi, a health reporter, covered the Treatment Action Campaign's (TAC) maternity care protest in August 2015. TAC protested women being "left in labor too long" and other incidents at MOU's (Fokazi, 2015). TAC, an HIV/AIDS activist group founded in 1998 that was instrumental in organizing care for the HIV/AIDS crisis, focused the protest on complaints by women who said they had been ill treated by MOU staff during labor and delivery and had experienced trauma to themselves and their children as a result. All three levels of maternity care – primary care at MOU's, secondary care at a district hospital, and tertiary care at a specialized hospital – appear in the article. One mother recounted a story of having a stressful delivery at a MOU, being referred to a district hospital, and then sent to a tertiary hospital for emergency care that could not save her baby. Another mother quoted in the article requested to be transferred from an MOU to Mowbray Maternity Hospital but was denied. Another mother's child developed disabilities after six months and a doctor explained that brain damage had occurred during a prolonged labor (Fokazi, 2015).

Though only a few paragraphs long, this article demonstrates some of the perceived conflicts within South Africa's stratified maternity care system. The fact that a public health advocacy group like TAC protested the quality of nursing care on the grounds of nursing abuse demonstrates the way that nurses are perceived as agents of inequality in the health system. The complaints listed in the article revolve around nurses' refusal or non-compliance with patients' requests for access to technology or specialized care to the point that patients felt that quality care was being withheld. Nurses are perceived as the gatekeepers of quality; and quality care, at least in this article, is defined in regards to technology, resources, and physician proximity. The

themes that Oosthuizen identified resurface in this article through the connection made between nursing behavior as part and parcel of state deficiencies. MOU's and the nurses that run them are viewed as the lowest quality option available to pregnant women who cannot afford private coverage. Based on the perspective of the protesters, adverse outcomes could have been prevented if only patients had access to hospital care. The perception of nurses and nursing-directed care as low quality by virtue of the distance from resources, technology, and physicians relates to a concept referred to in this paper and Department of Health Guidelines as "technological appropriateness."

Technological appropriateness

The concept of "technological appropriateness" returns us to the discussion of Sandelowski's *Devices & Desires* and the role of nurses as technology, specifically as a "technology of care." Sandelowski explains the blurred categorization between nurses, technology, and care: "Do nurses care like machines or like human beings? The depiction of nursing as a technology, and especially as a technology of care, trouble the distinctions among difference kinds of caring and between caring and technology" (Sandelowski, 2000 p. 9). In maternity care patients may need no technological assistance as they experience an intervention-free childbirth or they might begin hemorrhaging early in labor and need an emergency caesarean-section. In either case, whether it be normal or emergency, the nurse must assess the risk of the patient and provide the technologically appropriate response across the intervention spectrum. The term "care" in this way takes on multiple meanings and complicates the conceptual role and the scope of the technological responsibilities of a maternity care nurse.

Discussions of technological appropriateness are directly related to patient risk classifications. What technology does a patient need to be in proximity to in order to best minimize the risks of their body? In answering this question, providers themselves can be considered as technology. Chapter 2 of the Department of Health Guidelines, titled “Levels of Care,” defines clinics, MOU’s, and district hospitals based on a technology/risk status. Clinics are for low-risk care, MOU’s are meant for low to intermediate risk care, and district hospitals are equipped for high-risk care. The highest level of practitioner at a clinic is a midwife, whereas a MOU is run by advanced midwives with a visiting or in-house physician, and a district hospital includes advanced midwives but has full-time doctors on staff and visiting specialists. Tertiary hospitals, on the other hand, are specifically for specialist care and physician training (National Department of Health, 2015). In this way, the Department of Health considers providers themselves to be “technologies of care” and uses providers’ professional qualifications to determine a facility’s capability to handle a particular patient risk level. Maternity facilities are defined by what expertise is available, and the presence of a physician or specialty physician is associated with high-risk patients, whereas clinics and MOU’s, entirely run by nurses, are associated with low-risk patient care.

This situation does not exactly mirror Sandelowski’s analysis of the United States because nurses in South Africa are practicing autonomously in clinics and MOU’s, but the conflation of technology and care, and nurses as technologies of care, specifically low-tech practitioners for low-risk care, is highly applicable to the issues raised in newspaper coverage and specifically the Treatment Action Campaign’s protest. The Department of Health states that “poor management has been identified as a major weakness of health services” and advocates for increased funding, changes in funding allocation, and better coordination between different

levels of health care sites within a district in order to improve maternal health outcomes (National Department of Health, 2015 p. 16). By the Department of Health's own admission, poor outcomes are less a result of a lack of access to "technologically appropriate" care, whether low or high risk, but rather a misalignment of resources to those categories and a lack of successful transfer between them. However, as the providers of primary, low-risk, and low-tech level care, nurses working in MOU's bare the brunt of public opinion resentment for the failures of the health system.

B. THE NARRATIVE PERSISTS

Maternal Mortality

A driving impetus for maternity care research in South Africa is the unexpectedly high maternal mortality ratio (MMR), defined as the number of maternal deaths per 100,000 live births, despite high rates of utilization and access to quality maternity care. According to the United Nation's 2013 Millennium Development Goals country report on South Africa, at least 94.3% of all births were attended by a skilled birth attendant,¹⁰ 90.8% of deliveries took place in a health facility, and 100% of women have at least one antenatal care visit (Republic of South Africa, 2013). Additionally, the United Nation's 2014 "State of the World's Midwifery" estimates that 97% of the workforce time available as per workforce time needed was met on the pre-pregnancy to post-partum care continuum based on 124,000 nurses and 39,500 physicians working in maternal and newborn health (UNFPA, 2014).

¹⁰ A skilled birth attendant is defined by international regulatory bodies, such as the World Health Organization, the International Confederation of Midwives (ICM) and the Federation of Gynecologists and Obstetrics (FIGO), as an accredited professional who has been trained to manage normal pregnancy, birth, and post-partum care and can identify complications and make appropriate referrals when complications do arise.

The United Nation's Millenium Development Goal of lowering the MMR by 75% between 1990 and 2015 instigated many analyses of South Africa's maternity care and theories regarding the unusually high MMR despite health care infrastructure far more developed than other poorer countries. The various data and methodologies used to determine the MMR value itself led to a wide range of MMR values, but according to a comprehensive report done by Blaauw and Penn-Kekana in 2010, the analysis of the trends has shown that the MMR value has approximately doubled between 1990 and 2008 to approximately 400 to 600 deaths per 100,000 live births (Blaauw & Penn-Kekana, 2010). A high MMR usually corresponds to a lack of infrastructure, especially at the primary care level.¹¹ The conventional solution to lowering MMR is to increase access to midwifery care, but South Africa has robust primary care infrastructure and high rates of utilization, as the previously cited United Nations statistics show, making the rate of maternal deaths in South Africa a confusing issue and the topic of much scholarship.

In a review of the existing information about maternal mortality, South African economist Pinky Lalthapersad-Pillay analytically examines the contradiction between South Africa's legal policies promoting maternal health and the available studies discussing maternity-related deaths. From analyzing the many published studies analyzing the South African MMR in their paper "The State of South African Maternal Mortality," Lalthapersad-Pillay concludes that the MMR in South Africa in 2001 was greater than the standard of 290 for developing countries and that by 2007 it had surpassed the estimate of 640 for sub-Saharan Africa (Lalthapersad-Pillay, 2015). The overall conclusion of Lalthapersad-Pillay's analysis is that exemplary

¹¹ As an example, the MMR of Afghanistan was one of the highest in the world in 1990 at 1,200 deaths per 100,000 live births, as estimated by the WHO. Significant improvement was achieved by training women in midwifery after which they returned to their home areas, a strategy that prioritized access to skilled-birth attendants rather than medical infrastructure. The Afghanistan Mortality Survey of 2010 estimated the MMR to have been reduced to 342.

reproductive policy has not created a correspondingly exemplar improvement in maternal health outcomes in South Africa. The paper points out that many women die from childbirth-related causes despite interacting with the health system, citing the Department of Health's estimate that 30% of the maternal deaths occurring within the public health system are avoidable (Lalthapersad-Pillay, 2015). Lalthapersad-Pillay recommends collecting high quality data and examining possible faults in the health system to improve outcomes.

Like the broad argument made by Lalthapersad-Pillay's review, individual studies demonstrate a discrepancy between policies and outcomes, though there is a range of hypotheses as to the cause. Blaauw and Penn-Kekana, women's health researchers, published a report in 2010 that confirms that access to antenatal care and skilled birth attendants, often the focus of initiatives to improve maternal health in poorer countries, have not positively affected the MMR in South Africa since 1990 (Blaauw & Penn-Kekana 2010). Summarizing its findings, the report cites infection due to AIDS, a lack of access to effective emergency obstetric care, and inefficiencies in the health system as three key causes of maternal deaths (Blaauw & Penn-Kekana 2010). A case study by Moodley et al, published in collaboration between physician-researchers and public health officials in the *British Journal of Obstetrics and Gynecology*, used the *Saving Mothers' Lives* reports to create a case study for analyzing changes in maternal mortality.¹² Acknowledging the "Know-Do gap," represented by a lack of improvement between 1998 and 2007 and repetitive recommendations, as well as the unknown status of which health system factors are relevant, Moodley et al focus on clinical issues in HIV/AIDS treatment and hemorrhage as "serious emerging issues" (Moodley et al, 2014 p. 60. Although Blaauw and

¹² The *Saving Mothers' Lives* reports are annual analyses of datasets compiled using the Confidential Enquiry into Maternal Deaths reporting system put in place in 1998 to attempt to quantify and identify trends in maternal deaths in South Africa.

Penn-Kekana and Moodley et al mention health system issues as contributing factors, they are discussed broadly and in vague terms. When discussing the role of the health system in maternal mortality, Lalthapersad-Pillay claims that, “The factors responsible for high levels of maternal mortality cannot be disentangled from the inadequacies and inefficiencies that beset the health care system” (Lalthapersad-Pillay, 2015 p. 6476).

As an example of a study that attempts to do that detangling work, Mickey Chopra, a quantitative health researcher who published several papers analyzing South Africa’s relationship to the United Nation’s Millenium Development Goals, and others use analytical methods to try to “unravel this paradox” of proactive policy and high utilization rates but poor outcomes (Chopra et al. 2009 p. 835). Using the Lives Saved Tool (LiST)¹³ software model to determine health system interventions that would address the 30% of maternal deaths that contain a modifiable action by an administrator and the 58% of maternal deaths that contain a modifiable factor by a health care provider, as estimated by the Saving Mothers Reports, the authors found that “the key gap [in plans to meet the Millenium Development Goals] is leadership and effective implementation at every level of the health system” (Chopra et al. 2009 p. 835). The authors’ analysis led to the conclusion that “within each package the high-impact interventions are not being applied or are used suboptimally,” as represented by high rates of utilization of antenatal care but insufficient care during health system contact (Chopra et al 2009 p. 840). Chopra et al’s LiST analysis concurs with the conclusions of other studies that South Africa’s policies on maternal health are not translating to positive outcomes. The deduction that issues are occurring in “leadership and effective implementation” is based on the inability for

¹³ The Lives Saved Tool (LiST) is a Spectrum software product designed to analyze public health data on infant, child, and maternal health, specifically in low-income countries. For more information on LiST see their website: <http://livessavedtool.org/>

policy to drive outcomes – the missing link is quality of care. But what specifically about care delivery is going wrong?

Lalthapersad-Pillay’s overview of existing research on maternal mortality and the various focuses of several specific studies illustrate how the myriad factors contributing to maternal mortality are obscured by overlap and interrelated function, especially within conclusions about the health system. The cited causes of maternal deaths range from broad public health factors, such as poverty or HIV/AIDS risk, to specific tertiary care issues, to need for improvement in health system operations. The lack of consensus and specificity in recommendations for addressing the high MMR raises questions about what role nurses have in improving maternal mortality outcomes, especially considering the fact that South Africa does not conform to the expected pattern of MMR as a function of primary maternity care. Within scholarship these questions do not have direct answers but the high MMR in South Africa is continually cited as a rationale not only for maternal health research and but also for a return to the critical evaluation of nursing practice.

Post-apartheid policies

In the Bill of Rights of the 1996 Constitution of South Africa, the “Health care, food, water and social security” provision states that, “1) Everyone has the right to have access to a) health care services, including reproductive health care” and in the following provision titled “Children” it states that “Every child has the right... c) to basic nutrition, shelter, basic health care services and social services” (Constitution of the Republic of South Africa, 1996). These two provisions serve as the basis for the maternal health agenda promoted by the National

Department of Health. Few governments around the world have such explicit legal commitments to health care, let alone reproductive rights and maternal health care, as South Africa.

In the realm of maternity care, reproductive health care as a constitutional right meant expanding access to safe childbirth through expanding nursing care. In an interview in 1995, the first Minister of Health after apartheid Dr. Nkosazana Dalili-Zuma emphasized this as a priority:

“First of all, we should look at women’s health in terms of safe motherhood. I think it is shameful that so many women in South Africa die during childbirth... I believe that a normal straight-forward delivery should be done by a midwife – you don’t need a gynaecologist for that” (Zuma & Witherspoon, 1995).

The fact that a top health administrator was sanctioning the idea that normal, low-risk pregnancies should be handled by nurses rather than doctors demonstrates how the primary-care model took precedence over medicalized views of childbirth and physician autonomy in South Africa after apartheid.¹⁴ The post-apartheid government built 1300 primary care facilities in low-income areas as a concrete step to increase access (Chopra et al, 2009).

The fact that the government promoted nursing care and MOU’s, not physician care and hospitals, as a solution to health disparities in maternal deaths is indicative of how access to basic services was prioritized as the government’s strategy for treating the inherited inequality of the apartheid health system and foreshadows criticism regarding technologically appropriate care. If quality care is associated with access to technology, then the primary care approach can be viewed as a consolation prize in which high quality services are still out of reach for low-income South Africans of color. Criticism of maternity care can operate on the assumption that hospital care, and the technology it includes, is superior to what is offered at a MOU; however,

¹⁴ This promotion of midwifery by the government represents a divergence from American nursing history of maternity care, which in the United States was and is still today dominated by physician deliveries (Cahill 2000).

this critique represents a perspective in which nurses, technology, and resources can and often are viewed as one and the same. During interviews, nurses expressed an appreciation for the primary care-oriented policy as protecting the right to maternal care and justifiably promoting a basic health standard within South Africa's strictly tiered health system. Sr. Nokwela, in exasperation at the end of her interview told me, "Because if you look at our policy, you can read, it's beautiful. It's great stuff that is written there. But we need people."

Nurses as indirect research subjects

Within academic literature that makes connections between nursing attitudes and quality, the focus is on the translation of patient perceptions to provider experience. Studies aiming to understand patient experience are not obligated to explore nursing perspectives, but the way that they represent nurses and the acceptance of nursing behavior as a given factor in lowering quality is a significant characterization of the existing narrative and relies on Jewkes et al's 1998 study as the foundation for claims of abuse. A study published by Abrahams, Jewkes, and Mvo, the same authors of "Why do nurses abuse patients?", used patient interview data to examine the myriad factors contributing to a women's decision on whether or not to seek antenatal care, and concluded that perceptions of quality of care and treatment by providers was an important factor but that the extent of this reluctance to engage with nasty nurses was largely unexplored in research literature (Abrahams, Jewkes, and Mvo, 2001). Work by Chadwick, Cooper, and Harries uses patient birth stories from Cape Town MOU's to demonstrate that patients' negative experience of nurses' attitudes can adversely affect birth experiences (Chadwick, Cooper, &

Harries, 2014). Both of these papers consider nurses as subjects of patient experiences and connect their attitudes to patient outcomes. Why nurses are rude, or why patients perceive nurses to be rude, was outside the scope of the research. Instead these studies rely on previous explanations of nursing perspectives, primarily the Jewkes et al 1998 study, with professional identity claimed as the cause for issues in provider attitudes.

Within medical scholarship on maternity care quality, physician opinion pieces reiterate the Jewkes et al explanation of nursing professional identity as the cause of nursing abuse. A 2015 editorial in the South African Medical Journal, co-authored by the current director of Cape Town's secondary maternity hospital Mowbray Maternity Hospital, titled "Abuse in South African maternity settings is a disgrace: Solutions to the problem" cites the Jewkes et al study as characterizing nursing behavior at MOU's. The editorial's proposed solution alludes to a code of conduct, written in 2013 by public health staff and obstetric professionals, for maternity care staff as a means of addressing unacceptable nursing behavior (Honikman, Fawcus, & Meintjies, 2015). This code was developed in response to patient complaints and observations of fourth year medical students during their rotations in public maternity sites (Honikman et al 2015).

Another co-author of the editorial is the director of the Perinatal Mental Health Project, an organization that aims to train MOU nurses in empathy to encourage a greater respect for mothers dealing with mental illness. The training is based on an activity called the "Secret History," run by Perinatal Mental Health Project facilitators, which aims to inspire empathy by revealing a succession of underlying challenges facing both a patient and a nurse in a taxing interaction. In an article published in Health-e News, The South African Health News Service, titled "Mission Impossible: Replacing abuse with empathy," reports on the Perinatal Mental Health Project's empathic training courses that encourage nurses to identify depression among

mothers at the clinic (Cullinan, 2016). Despite acknowledging that nurses are concerned about a lack of redress for patients whom they do identify as dealing with depression and finding the time to take on social working tasks in addition to their existing workload, as well as acknowledging that MOU nurses themselves often live in the same community as their patients and are dealing with community stressors themselves, the Perinatal Mental Health Project still advocates for empathic training as an important tool for improving quality care (Cullinan, 2016).

The Health-e News article also cites a Harvard School of Public Health report, sponsored by USAID, that included data from eighteen countries and claimed that “In South Africa, women report being beaten, threatened with beating, and slapped during childbirth at midwifery units, clinics, and hospitals” (Bowser & Hill 2010, p. 9). When examining the Harvard report itself, the basis for reports of abuse rely entirely on Jewkes et al’s 1998 study ‘Why do nurses abuse patients?’ demonstrating how even current scholarly work is steeped in Jewkes et al’s foundational claims about the role of nursing identity in abuse of patients (Bowser & Hill, 2010).

A study that summarizes fourth year medical students’ community rotation reports, referenced as an inspiration for Honikman et al’s editorial, is titled “Out of the mouths of babes – innocent reporting of harmful labour ward practices.” The title itself sets the tone of the article, which portrays multiple dichotomies: between physicians and nurses, hospitals and community clinics, and innocence and guilt. This report, published in the South African Medical Journal Forum, includes criticism of clinical practices of nurses, but also lists attitudinal behaviors of nurses as quality-of-care issues, including physical abuse, neglect, and disregard for patient privacy (Farrell & Pattinson, 2004). In its conclusion, the article references Jewkes et al as evidence that rudeness and abuse within maternity nursing have been well-documented but insufficiently addressed for the previous decade (Farrell and Pattinson 2004). Farrell and

Pattinson's concern centers on the medical students and the fear that they will learn harmful practices from unsupervised nurses operating outside the sphere of the academic hospital. Although the report utilizes Jewkes et al's findings from 1998 as a foundational claim for the existence of maternity abuse, the focus is physician-centric and espouses an attitude in which nurses' behavior is a liability in need of managing.

Despite Jewkes et al's analysis dominating maternity abuse references in scholarship, there are alternative scholarly narratives as to why nurses might exhibit abusive behavior towards patients. Kruger and Schoombee used an anthropological analysis of a hospital maternity ward to illustrate the way that power dynamics shape both nursing and patient identities (Kruger & Schoombee, 2010). Titled "The other side of caring: abuse in a South African maternity ward," Kruger and Schoombee's study, which included interviews from 93 patients and 8 nurses, found that, "The abuse reported by both patients and nurses seemed to be clearly related to issues of power and control, hierarchy and order" (Kruger & Schoombee, 2010 p. 88). Because of the limitations inherent to the South African hospital setting, Kruger and Schoombee argue that the medical surveillance of birth that patients expect and nurses are responsible for maintaining is disjointed, leading to frustration for both patients and nurses. Although this study confirms problematic care practices, it provides a different explanation for abusive behavior aside from a superiority complex of professional identity. Kruger and Schoombee focus on the influence of the hospital setting and its power structures as well as medicalized expectations of birth as the cause of tension in the nurse-patient relationship.

Another paper that takes into account context as a constraint on supportive nursing care is Penn-Kekana, Blaauw, and Schneider's study "It makes me want to run away to Saudi-Arabia: management and implementation challenges for public financing reforms from a public

maternity ward perspective” (Penn-Kekana, Blaauw, & Schneider, 2004). Like the Kruger and Schoombee study, the rationale of this research differs from previous research that focused on outcomes, patient experience, or third party reports, because it aimed to understand how context affected nurses’ experience of maternity care. Penn-Kekana et al found that the Public Financing Management Act set expectations that limited nurses’ ability to give quality care and that managers’ obligations to adhere to the reform act reset care priorities (Penn-Kekana et al. 2004) Both Kruger and Schoombee and Penn-Kekana et al’s conclusions underscore the need for a greater understanding of how practitioners negotiate the set priorities of the health system context in which they work. The conclusions of both studies call for increasing dialogue between nurses and policy makers and empowering nurses within the medical hierarchy.

Except for Kruger and Schoombee’s hospital analysis and Penn-Kekana et al’s work on the unintended effects of finance policy on quality maternity care, the theme of scholarly narratives of public maternity providers is that nurses’ personal behavior, regardless of the constraints of their working environment, is impeding quality care for patients. Though these works document patients’ negative experiences with providers, they do not question provider behavior beyond a characterization of an individual lack of accountability to compassionate quality care. Resounding throughout the literature is Jewkes et al’s explanation of professional identity as the cause of abuse. The recommendations and solutions of medical scholarship offer suggestions that revolve around training nurses in professionalism and increased physician surveillance. What is notably absent from research regarding the challenges of maternity care are the voices of nurses themselves.

International Inquiries

The narrative of nursing abuse and the disproportionately high maternal mortality ratio in South Africa has elicited an international response from health and human rights organizations as well. In a colorful inset in the United Nation's 2014 State of the World's Midwifery report titled "Respectful care in maternity services," South Africa is singled out for having providers "so rude" that women avoided antenatal care and "sought attention only in labor" (UNFPA, 2014 p. 22). The citation for the inset claim is Jewkes et al 1998. The country profile in this same UNSOWM calculates South Africa has having 97% of the maternal health needs met by the existing medical staff and health system. This contrast between approval of health system infrastructure, including both primary and tertiary centers of care, but disapproval of individual nursing behavior personally reflects the local South African narrative.

Amnesty International and Human Rights Watch both published reports of South African maternity services as affronts to human rights standards. Amnesty International's report focused on barriers to antenatal care and found that three factors inhibited South African women's maternal health rights: a lack of privacy, confidentiality, and consent, a lack of health and rights education conveyed by health workers to patients, and financial and transportation barriers to accessing facilities (Amnesty International, 2011). Human Rights Watch created a sixty-six page report based in the Eastern Cape, South Africa's poorest and most rural region, whose title "Stop Making Excuses: Accountability for Maternal Health Care in South Africa" sets the tone of the findings (Human Rights Watch, 2011). Despite citing exemplary statistics of care coverage, including statistics of 92% antenatal care coverage and 87% of deliveries occurring in medical facilities, as well as acknowledging that "South Africa is one of the few countries in Africa [and the world] where maternity care is free, abortion is legal, and there is a system of confidential inquiries to assess levels, causes of, and contributors to maternal deaths," the report notes poor

quality of care and a lack of provider and supervisor accountability as the primary issues (Human Rights Watch 2011 p. 3). Whereas Amnesty International rebukes antenatal care barriers, the emphasis of Human Rights Watch is that pregnant women are utilizing South Africa's health system but that the care they receive is inhumane. The language of accountability, standard for human rights discourse, targets the South African state but also implicates providers on an individual level and mirrors academic scholarship that calls for increased accountability and professionalism training for nurses.

The non-medical considerations for nursing care as it exists in public maternity settings are acknowledged: government agendas reference social determinants of health and literature exists regarding the historical and social forces that have shaped nursing and nursing conditions in the public sphere. However, the experience of nurses negotiating the historical legacy of apartheid, the constraints of the health system, and their societal position is belittled from all sides. The narrative of the abusive nurse, present in both medical literature and in popular discourse, represents a bi-directional derision for these women and their profession. From the perspective of academia, medical research, and international aid organizations, nurses are unprofessional in the way that they express "uncaring" attitudes. From the perspective of the communities served by public health care, nurses are professional to a fault, using their expertise and medical role to advance their own social agenda. The narrative of Jewkes et al is that the nursing profession and its "insecure" claim to middle-class status is in fact the cause of unprofessional, or uncaring, care. MOU nurses in particular are criticized both for not providing *enough care* in the category of technology – not enough equipment, not enough resources, not enough specialists – and for not *caring enough* in the category of femininity and nature.

SECTION II Professional Identity Findings

The article “Why do nurses abuse patients?” by Jewkes, Abrahams, and Mvo, which Section I discussed as representative of an influential narrative of criticism in maternal care quality discourse, is preceded by two technical reports which include interviews from Khayelitsha and Retreat MOU’s. The first report, based on women’s experiences in a Khayelitsha MOU, referred to as Kwazola township in the published article, is the primary source for the argument of “Why do nurses abuse patients?”, namely that midwives’ relationship to professional identity leads to abusive behavior (Jewkes et al 1998). However, based on the technical report that features findings from Retreat MOU, there are positive aspects to the narrative of nursing care at the MOU level that are not discussed in the published article that has gained so much traction within scholarship (Abrahams & Jewkes, 1998). The focus of Jewkes et al in “Why do nurses abuse patients?” was to posit the cause of abuse, and, therefore, a lack of patient complaints was no cause for emphasis. However, the findings at Retreat MOU represent the potential for a divergent narrative of professional identity within primary public maternity care and it is this narrative that I wish to pursue in analyzing my interview findings.

This narrative of positive nursing care, a non-narrative within current scholarship, is the context for how professional identity can contribute to quality. **In Section II I aim to demonstrate that three factors – autonomy, a close connection to the community served by the MOU, and intentional distinctions from the private obstetric model of care – shape professional identity as a positive framework in the MOU context.**

Abrahams and Jewkes’ technical report featuring Retreat MOU, titled “Women’s Use and Perception of Retreat Midwife Obstetric Unit and TC Newman (Paarl) Hospital,” summarizes

the interview findings across the maternity care continuum as generally positive. For antenatal care, “Most women at Retreat were fairly satisfied with their antenatal care but highlighted the importance of good communication in the clinics in their assessments of quality of care” (Abrahams & Jewkes 1998). In fact, women expressed a preference for more time with midwives during antenatal consultations based on a desire to ask more questions and receive more information on health education and their pregnancy. In regards to care during labor, “most of the women at Retreat were very satisfied with the care they received... Overall they perceived the staff to be ‘nice’ and ‘very helpful’” (Abrahams and Jewkes 1998). There were instances of scolding during antenatal care and labor care, but these encounters with staff did not detract from women’s overall satisfaction with their care at Retreat MOU.

Understanding how Retreat MOU diverges from the dominant narrative of nursing abuse, as characterized by Jewkes et al and repeated throughout scholarship, creates an opportunity to consider the limitations of the existing criticism leveled at maternity nurses and embrace the complexity of professional identity. In “Why do nurses abuse patients” Jewkes et al posit that patient expectations are so low that scolding and abusive behavior are excused by the patient once she is able to adapt her behavior to be acceptable to the nurse, at which point the nurse’s behavior softens and a patient will forgive any rudeness (Jewkes et al 1998). Both nurses and patients use an explanation of “rotten apples in the barrel” to explain abusive behavior, which Jewkes et al refuted with their analysis of professional identity as the unifying cause of nurses’ behavior. The dominant framework for understanding nurses’ experiences have focused on the negative, i.e. ‘how does nurses’ experience of identity lead to low quality care for patients?’ Using a positive framework changes the question to ‘how do nurses’ experience of identity enable them to provide quality care in spite of the challenges posed by deficiencies in the health

system?’ This section outlines three thematic conclusions for how nurses experience professional identity in ways that facilitate a positive framework for quality care.

A. VALUATION OF AUTONOMY IN PRACTICE

As previously discussed, MOU’s represent a fraction of the health system in which nurses are in charge and patients are mostly healthy pregnant women. The previous section also reviewed how the role of practitioners at each facility determined where along the technology/risk continuum of the health system a facility fits, from clinics for basic nursing care to tertiary hospitals equipped with physician specialists. The concept of providers’ qualifications as signifying technologically defined care levels works in tandem with patient risk assignments, as patients are shifted to the technologically appropriate level according to their risk factors through the strict protocols that govern public sector health system functioning. In addition to characterizing divisions within the health system itself, technology/risk categories create sub-categories of nursing based on the varying influence of the medical hierarchy. **I will argue that a preference for working in a particular technology/risk category represents an axis of distinction within the concept of professional identity.** My findings demonstrate that nurses working at Retreat MOU value the autonomy afforded by the nursing-only environment and consider it as positively influencing their concept of the nursing role; however, nurses working at Al-Nisa Maternity Home viewed that level of autonomy as an undesirable burden of responsibility.

Independence in the MOU

In the MOU setting, autonomy in decision-making is not only unconstrained compared to the hospital context, but is necessary for effective care at the primary level. Nurses working at Retreat MOU described a lack of physician oversight as a defining feature of the primary, public care context and expressed a high valuation of personal autonomy as practitioners.

Sisters Caitlin Valentine and Sarah Nokwela, both of whom are in their first few years of nursing, described the MOU environment as defined by physician absence, enabling nursing independence. They characterized primary care as “aloneness:”

“With primary care, it’s like here at the MOU level, the nurses and the Sisters are basically alone. There’s not really, especially at the MOU, there’s not really a doctor available. Our doctor here at the MOU comes in once a week.”

Physicians are not entirely absent from the MOU; at Retreat every Monday a visiting obstetrician/gynecologist hosts a “Doctor’s Clinic” in the far cubicle with the sitting desk in order to provide a consultation for the patients whom nurses had detected a risk factor that protocol required to be checked by a physician. This outreach clinic though is still nursing-directed in the sense that the doctor sees patients based on nursing recommendation. By describing the nurses at the MOU as “alone” Sr. Valentine means that within their nursing role they are solely responsible for patients without any physician presence, and even when the physician is physically there in the MOU the physician sees only patients referred by the midwives.

Sr. Valentine goes on to describe how this independence from physicians affects the nursing mentality for making care decisions. At the MOU, independent nursing decisions define quality care for Sr. Valentine:

“If we see something needs to be done, we take the initiative and we just do it. Because that, like I said it’s not just one person we are dealing with here in the clinic, we deal with mom and baby. So if we see something is not right, we take the initiative, we do something about it, and that initiative that we take has the possibility of saving both mom and baby’s life.”

As she describes, working as a midwife in the antenatal clinic doing regular check-ups for healthy pregnant women means asserting her nursing knowledge, independent of physician input, to detect and respond to anything that may present complications to mom or baby. The stakes at the MOU are high and nursing initiative is the standard of care that protects the lives of patients.

Sr. Nokwela expresses similar sentiments about the relationship between physician distance and nursing initiative. Even when MOU nurses are working to refer a patient and interacting with physicians at secondary or tertiary institutions, they are doing so over the phone. The MOU is a space in which nurses are responsible for initiating any and all patient care. The nurse decides to call the doctor. The doctor is not there. This absence means that patients rely entirely on the knowledge and actions of the midwife:

“You, as a midwife, you are independent. You make your own decisions...you make a plan. And then if you see that there is a complication, and then you can call the doctor at the other hospital and tell the doctor what is happening and then they can say 'ok you can bring the patient in.' But what I like is that you on your own. You're always thinking on your feet. You must think fast because you know you don't have a doctor next to you where you know 'ok if this happens, the doctor is here.' So there's no doctor, you have to be sharp and be quick.”

Not only does Sr. Nokwela describe the necessity of nursing initiative, but she also explicitly states that she prefers practicing independently rather than working in a physician-accessible

environment. She likes the fact that the autonomy of a MOU requires quick thinking and taking responsibility.

Like Sr. Nokwela, Sr. Valentine describes a working environment in which the stakes are high and nursing initiative is the foundation for patient care. Sr. Valentine also brings up the fact that the practitioners at the MOU are the first health care professionals that a patient interacts with in their pregnancy. Referencing the same need for quick thinking in the MOU that Sr. Nokwela described, Sr. Valentine says, “You kind of need to (snaps fingers several times), you need to notice things very quickly, because, like I say, mainly because there’s no doctors available most of the time with us.” She echoes Sr. Nokwela’s emphasis on the absence of doctors as necessitating speed and confidence in one’s own nursing knowledge and the fact that patients and their babies are dependent on nursing initiative at the primary level. In the context of technology/risk categorization, the sense of urgency conveyed by Sr. Valentine’s snapping fingers references the role of the primary health system as the site of decision, specifically nursing decision, responsible for detection and management of risk factors.

Sr. Cheryl Washington, an advanced midwife with more than thirty years of midwifery experience and ten years at Retreat MOU, summarizes the MOU mentality in just a few words: “I’m happy, there’s no doctors, you do your own risk assessment, decide what, how to handle the patient, if you want to refer the patient, if you can manage the patient yourself.” Sr. Washington puts bluntly what both Sr. Nokwela and Sr. Valentine have described. Her professional satisfaction, “I’m happy,” comes from that fact that she is an independent practitioner, free from physician supervision, and is responsible for initiating patient care plans.

Taryn Jacobs, a student in her third year of professional nursing coursework, expresses almost the same sentiment as Sr. Washington even though she is thirty years shy of Sr.

Washington's midwifery experience:

“Here it's only the midwife, the midwife is in charge here. But there, like in the tertiary hospitals it is the doctors you see... You can't deal with a delivery by yourself. But like here, you do the delivery yourself... It's nice for me here, because you're on your own, you can make your own decisions here.”

Autonomy of practice – being alone, on your own, in charge – is a defining feature of MOU standards of care and of the nurses who enjoy practicing there, from students to advanced midwives. In the absence of a medical hierarchy dominated by physicians, nurses take ownership of care decisions and patients' holistic health. Nurse Monique Klaasen, a staff nurse with fifteen years of experience at Retreat MOU summarizes her professional satisfaction by saying, “I'm working here, and I'm like my own boss. I work, nobody pressurizes me, nobody tells me anything, I know my work and I do it.”

In contrast to hospital midwifery

This attitude of embracing responsibility as independent practitioners is not uniform across health care contexts though and is not simply a function of necessity based on technology/risk level. At Al-Nisa MOU, a semi-private but still primary care facility, midwives presented a different view in their interviews. Upon reflecting on her five years working at Mitchell's Plain MOU, another MOU in the Cape Flats, Sr. Amina Jones describes the challenges of working without doctors:

“At the MOU you had to function like on your own. Although we've got our referral hospitals, with problem cases you liaise with your referral hospital, but on the other hand you have to function,

decide, make decisions on your own... At the beginning it was a problem because of my very little experience in maternity at that time, it was a problem for me. But as the years went on I learned. Lucky for us, there's a doctor that came around on the Thursday morning and whatever difficult patients that we got, like diabetic patients, gran mal seizures, whatever other problems we've got we keep those patients for the doctor to the assess."

Though essentially describing the same set of working conditions as the nurses at Retreat, her tone is very different. She speaks of the limitations of the referral system and the relief that a visiting doctor brings. When asked if she preferred to work in a private setting, she confirmed this view by saying, "Definitely. Because you always covered with the doctor. Yeah but here, you have to make your own decisions." Sr. Jones' thoughts demonstrate that the nursing autonomy of a MOU can be seen not as responsibility but as liability. Rather than emphasizing the need for quick thinking as a positive feature of the environment or the first interaction with a patient as an opportunity, Sr. Jones speaks of "having" to make decisions without physician back-up. Though the reality of the risk of working "alone" at the MOU is reiterated, these sentiments espouse the opposite attitude of Sr. Valentine, Sr. Nokwela, Sr. Washington, and student Sr. Taryn Jacobs.

The liability perspective of working in a MOU is seconded by Sr. Ayesha Veeran, a 72-year old midwife who started her nursing training at seventeen and has worked in primary, tertiary and private care:

"Because at Groote Schuur you get doctors, like pediatricians and gynies. So you are quite safe there. But there in the MOU, you, if you get some problem...[you need to send them in to the hospital]. So best to work at the big hospitals because everybody is around you know... So I mean, the big hospital is the best you know. Because the MOU you get the high risk also. Then you had to send the patient."

Although she prefers the public tertiary hospital environment to private care, Sr. Ayesha also supports the view of Sr. Anthony that the possibility of high-risk presentation at the MOU level is a negative attribute of the working environment. Working in the hospital environment is “safer,” not necessarily for the patient, but for the nurse. When she says “because everyone is around” she means physicians. Although she describes high-risk situations for the patient, the point Sr. Ayesha makes is that the MOU is a riskier environment in which to be a midwife because of its technology/risk designation as a primary care facility. Despite being confident in her five decades of midwifery experience, Sr. Ayesha simply does not enjoy the level of responsibility a MOU demands the way that the Retreat nurses do and autonomy of practice is less important to her concept of her nursing identity.

Considering autonomy of practice and whether nurses view the independence of primary care as a liability or an integral factor in their nursing role adds a level of nuance to understanding the experience of professional identity. In addition to a distinction in the value judgment of autonomy, there is significant evidence from the interviews that shows that nursing autonomy is limited in a hospital context, especially in a private hospital context. Nursing autonomy, whether liberated by physician absence or circumscribed within the medical hierarchy, contributes to the experience of being a nurse and nursing professional identity.

Many interviewees considered hospital nursing to be an entirely different kind of nursing. Sr. Nokwela discusses how nursing care in a hospital is always secondary to physician care:

“If doctor comes with a plan and say 'ok, this is what is happening, this is how I would like this patient to be managed' then you take that plan. Yes, as a nurse you also make your plan, because you get the doctor's plan and then you get a nursing plan. But then still, you have to go according to what the doctor said...I'm not in charge of what is happening. The doctors are in charge.”

For Sr. Nokwela, being “in charge” is important and is the crux of her role as a midwife at the MOU. The direct hierarchy of physician plans as the framework under which nursing plans are allowed combined with the hierarchy of physicians being in charge of the clinical space is an entirely different power structure than the MOU environment and redefines the nursing role as subordinate. Sr. Nokwela makes the point that both her professional power and her practical work are secondary to physicians’ role in the hospital, whereas at the MOU they are first.

Sr. Nokwela, referencing her clinical rotations as a student, also makes a direct comparison between MOU and hospital midwifery in regards to the value of nursing thinking and skills:

“So then in the hospital, for me, I wouldn't like to work in the hospital. Because I know if I work in the hospital I don't have to think much, the doctor is there, I can just always say ok if I want to put up an IV-line, the doctor is there is going to put up the IV-line. So I don't get to do much. So your skills sort of, fade away, because you don't do the stuff. The doctor does it for you, they put up the line for you, they do most deliveries, they do nurse.”

The physicians “do nurse.” The fact that she views physicians as providing nursing care in that setting is a direct contrast to the view of nurses taking on physician responsibilities as independent practitioners in the MOU context. These different descriptions show that Sr. Nokwela’s experience of professional identity includes a valuation of autonomy in a way that Sr. Jones and Sr. Ayesha’s concept of professional identity does not. For nurses working in primary care and nurses who prefer to work in primary care, autonomy is a key factor in how they envision their role and purpose as maternity nurses. Sr. Jones and Sr. Ayesha both expressed a preference for working with physicians, demonstrating that their preferred “type of midwifery” involves less initiative and less overall responsibility as practitioners.

Sr. Nieuwoudt, a white midwife who worked at Mowbray Maternity Hospital for ten years and then transitioned into a career as an independent midwife for another ten years before beginning to work part-time at Al-Nisa, acknowledges that different health care contexts mandate different types of midwifery care, but makes a clear disclaimer statement defending hospital midwives:

“I’m not for a moment saying that the midwives in the secondary hospitals are in any way inferior, it’s just a very different way of midwifery, you know... Whereas the midwives in the secondary hospitals in secondary and tertiary in our government sector are strong, hard-working, thinking, and are because they also have the flow of the young medical officers coming through, they guide, they teach, they know their stuff so well from so many years and so many times of being exposed to the same scenario and also appearing and coming across and *are* very confident because they’ve done it for so long, so they come across and are really strong.”

This passage from Sr. Nieuwoudt’s interview articulates the strengths of midwives working in public hospitals, their expertise with complications and risk factor scenarios, their broad knowledge, their teaching skills, and their confidence in the hospital environment. Even as they work in a physician-run environment, Sr. Nieuwoudt articulates that the “type of midwifery” in public hospitals still involves thinking and specialized knowledge that contributes to the strength and importance of hospital midwives. The difference in autonomy between the primary and hospital technology/risk levels does not negate the value of midwifery within the medical hierarchy; however, it is an axis on which professional identity is experienced differently that alters the conception of the nursing role.

Even though she respects the work of hospital midwives and knows the value of their work, Sr. Nieuwoudt personally agrees with the Retreat nurses on the value of autonomy:

“I feel working in a secondary or tertiary institution is easier. And perhaps for me, Petra, nothing to do with, I mean this is anonymous, but for me it would be the more cowardice thing to do. I would feel I'm giving up on my power, and I'm giving up on my, my sense of, sort of knowledge, and you know, I would become more of a pawn. But not taking away from the wonderful work that the midwives do. I know them, I've worked there, I know how amazing they are.”

The fact that she considers hospital midwifery to be a cowardly decision for her, a sacrifice of power, an abandonment of her knowledge, is central to the distinction of valuing autonomy that I have attempted to illustrate thus far in this section. The independence afforded by the MOU environment within the public sector is integral to the experience of professional identity for nurses who prioritize autonomy in nursing. To work in the hospital is to be a “pawn,” despite the strength and knowledge involved in hospital midwifery. Based on the descriptions of Sr. Nokwela, Sr. Valentine, Sr. Washington, Student Taryn, Nurse Monique, and Sr. Nieuwoudt, how they relate to autonomy plays a crucial role in how they personally define themselves as nurses.

Private hospital midwives as obstetric nurses

A second comparison that further elucidates the importance of autonomy to professional identity in the MOU context is that of midwifery in the private sector of the South African health system. In the midst of her defense of public hospital midwives, Sr. Nieuwoudt compares their role to that of midwives working in private hospitals: “And I will never equate what the midwives in the secondary government institution does, I will never equate it to the midwives in the private sector. The midwives in the private sector as far as I'm concerned are reduced to

obstetric nurses.” The fact that midwives working in private hospitals are “reduced” to obstetric nurses signifies that they work within a “type of midwifery” wholly limited by physician control.

Sr. Nieuwoudt tells the story of her brief private employment as a midwife to illustrate the way that context affects maternity nursing identity. After she qualified as a Sister through the public sector four-year course she tried working as a midwife in a private hospital:

“And then instead of just continuing straight away at Mowbray Maternity, I thought 'Ok I'm now qualified, let me go and work at a private hospital.' And I lasted two months. The first month I realized that, how little I knew first of all, and I also realized that I will never develop as a midwife in the private sector. Because you really are not given the advantage of growing. You really just become an obstetric nurse in our private facilities, so I gave notice and I had to work out another month. And I went straight back and applied at Mowbray.”

Sr. Nieuwoudt has already made clear that she personally values autonomy as a midwife and believes that hospital midwifery, though important, is easier. However, in the private sector, physicians are so much in control that nurses do not even have the opportunity to gain the skills and expertise of hospital midwifery.

Sr. Jones, who also worked in a private hospital as a midwife, reiterates the reality of nursing care there: “But when it comes to the private, as I again said, there's a doctor behind you all the time. The doctor decide what you must do, and we must just carry out his orders. Observing the patient in labor, and once the patient is fully dilated the doctor comes and delivers.” What Sr. Nieuwoudt and Sr. Jones describe as nursing care does not, in fact, involve delivering babies. Despite their qualifications and the experience they may bring from training or working in the public sector, a midwife’s role in a private hospital is minimized to assisting the physician.

Melissa Doherty, a white woman who moved from the United Kingdom and trained in the public sector diploma course like Sr. Nieuwoudt but chose to work in a private hospital, describes how the power structure in the private hospital affects a midwife's role:

“This is my observation, that the midwife in a private environment would obviously have less control over the situation right. So she basically is very much a handmaiden to the gynie obstetrician. And too afraid to almost make any calls on her own. Or even rock the boat by maybe questioning something.”

In this case Nurse Sr. Doherty defines the midwife as a “handmaiden” to the physician. The experience of midwifery in the private hospital is one of caution and fear, not for the patient but for disrupting the social hierarchy within the hospital. Sr. Doherty also contrasts the timidity of midwives in the private sector with her experience of the “hands on” approach in the public sector “where midwives “are actually practicing midwives.” The midwifery mentality that Sr. Nieuwoudt, Sr. Jones, and Sr. Sr. Doherty describe as the norm in the private environment – one of cautious assistants, handmaidens, and an overall reduction of the nursing role – is the opposite of the initiative and responsibility that the Retreat nurses explained as integral to their view of nursing in the MOU context.

The contrast between the appreciation of autonomy espoused by Retreat MOU nurses, the preference for physician supervision recounted by Sisters at Al-Nisa, and the clear opinion that physician care in both public and private hospitals sets limitations on midwives' decision-making role necessitates an examination of autonomy as a factor in professional identity. Midwives' roles are determined by the health care context they are working in, but midwives' themselves relate to these roles depending on how central autonomy is to their concept of professional identity. For nurses working at Retreat MOU, autonomy making patient care decisions is paramount to how they view their identity as nurses.

B. CENTERING COMMUNITY CONNECTION

In all honesty, our community is (pause) rough. There's no beating around the bush for that one. It is a little bit rough, but then again the other thing is that it all depends on your attitude toward your patients. – Sr. Valentine

In this section I will focus on the connection between a nurse's relationship to her community and how that relationship affects the experience of professional identity. The current explanation for rudeness and abuse by maternity nurses, as represented by the repeated references to Jewkes et al, revolves around an idea that nurses attempt to create social distance between themselves as professional women of the middle class and the community women whom they treat at the MOU (Jewkes et al 1998). This may be true for some nurses, but **I will argue that my interview data demonstrates that professional identity for nurses working at Retreat MOU is shaped by a sense of closeness, rather than distance, with the surrounding community.** This sense of community connection comes from the practical ways that poverty affects nursing care considerations, the fact that many nurses working at Retreat MOU live in the same community that the clinic serves, and the way that nurses take on a liaison role between their community and the health system.

Poverty's role in nursing care

Jade Sevenster, an ENA who has worked at Retreat for five years and gave birth to her second child there, describes the needs of some of the women who come to deliver: "And then most of the women come from poor backgrounds. They must get the pack, the mother pack and then the baby pack. Some of the women really appreciate that, because they don't have anything.

They don't have clothing for the baby, they have nothing.” Mom and baby packs are donations from a NGO called the Zoe Project that leadership at Retreat MOU has worked to integrate into nursing care practices. The lack of material preparedness of some patients is a function of the poverty prevalent through the surrounding community and something that the provision of mom and baby packs attempts to mitigate, at least while the new mother is at the MOU. **Poverty and the conditions it creates for patients shapes the challenges of nursing care in the antenatal clinic, the post-partum ward, and the activities of the MOU as a whole, leading nurses to take on aspects of care that address community needs informally without the support of the health system.**

At Retreat MOU partnership with the Zoe Project is not standard practice for a MOU and is entirely the result of individual initiatives in the clinic and the NGO itself. The Zoe Project has been in operation at Retreat MOU for fourteen years and they deliver forty mom and baby packs every month, as well as provide volunteer doulas, social worker visits, group therapy sessions, and antenatal education.¹⁵ Out of these projects, the mom and baby packs are a consistent feature in daily nursing care practices at Retreat MOU. Sr. Layne describes what a mom and baby pack can provide a mother who has little to no financial support for her post-partum needs:

“Some patients come in with absolutely nothing, you remember the homeless fall pregnant, they come in they've got nothing to wash with. There's usually a two-liter ice cream container she will put in a face cloth, soap, toothpaste, toothbrush, pad, and a panty – the mom pack. Sometimes a packet of biscuit or a sweet in there something like that. That's a mom pack. Or you get your baby pack, with baby clothes, your blankets in there, nappies¹⁶ in there, that kind of thing.”

¹⁵ The provision of mom and baby packs is unique to Retreat and its partnership with the Zoe Project, a collaboration that came from the initiative of individual local people and not through any Retreat MOU policy or governmental connection.

¹⁶ The term nappies in South Africa refers to what would be called diapers in the United States.

However, Nurse Jade, a labor ward ENA, discusses how patient expectations of care include poverty-related resources that are not actually part of clinical care and the way that this can lead to a resentment of nurses individually:

“They come here and they don't have anything, and sometimes we don't have like pads, sometimes we don't have panties, sometimes we don't have. And then they will look at you and ask, 'don't you have a panty for me?' And then we will say, 'we running out of panties, can somebody bring you one?' And then they will not like that. 'Can't one of your family members bring you one?' Then they will become so offensive that they give you a lot of things that you don't even want to mention here.”

In the exchange that Jade describes, the patient perceives a lack of material resources as a failure in nursing care despite the fact that the nurse has no control over the stock of pads and panties because they are donations. The patient's frustration at a lack of resources is articulated as anger at the nurse for failing to provide her with the level of quality she expects. In these instances quality of nursing care is conflated with the quality of resources, to which the staff at the MOU are aware of the need, but have limited control over their availability.

Anger and frustration directed at nurses for issues beyond their control is a frequent occurrence in the antenatal ward as well as the labor ward. Sr. Peters discusses how patients can be rude to nurses to the point that it is difficult to provide care:

“Sometimes you can get lots of rude patients...And the patients have the tendency of, like, not assaulting, but insulting the Sisters. Swearing at you, giving you attitude, that type of things we get here in the community. So you must know how to work with patients like that. Or if you tell them 'sorry we don't have medication,' they get upset because they want the medication now.”

Sr. Peters alludes to the fact that the prevalence of rudeness from patients is connected to the MOU as being a community-based site of care. She implies that community care sites are viewed

as having lower standards of respect for staff than would a hospital, where patients would not assert the same behavior. As a matter of fact, Sr. Peters states that rudeness and aggression is just another factor to be managed. The fact that patients are not understanding of the constraints of the MOU and consider nurses an appropriate target for frustrations about resources is represented again by Sr. Peters' description of patients blaming the nurses for a shortage of medication. The patient's frustration of course is understandable, but this represents another situation, like a lack of donated panties, in which nurses are personally blamed for a perceived failure of quality beyond their control and must manage a patient's emotional response in order to continue providing care.

Another community-related factor influencing patient behavior is the prevalence of the drug 'tik,' which is a form of Jade methamphetamine. Sr. Layne describes her concern for how the drug interferes with nursing care in the clinic:

“And the other thing that impacts the staff is the abuse of that drug tik. Yes, the increased use of that. Remember now, the patients will come in that's on that drug, and if they high, they're abusive, they're very active up and down, you can't control them. And the referral hospital won't take them because there isn't a [medical] problem. And you can't sedate that patient, because you'd be giving an extra drug on top of that.”

The fact that patients come to the clinic high and simply must be managed illustrates how the MOU is integrated into the challenges of the community in ways that hospitals are not. Medically, there is nothing to be done for the patient; the best nursing care for her revolves around socially conscious health education and management by nurses who can productively work with someone who is a tik user or currently high. The examples that Sr. Valentine, Jade, Sr. Peters, and Sr. Layne gave demonstrate how proximity to the community necessitates a specific type of care competency in nurses. A lack of resources for a particularly needy population, the

frustration that patients direct towards nurses, and complications from drug use lead to MOU nursing care necessitating nurses' being able to work with the community's "roughness," as Sr. Valentine calls it.

Hunger and poor nutrition are also recurring themes in nursing considerations at the primary level. Sr. Layne spoke at length about how poverty and hunger in the community can negatively impact pregnancy and how the staff at the MOU responds to this reality. She describes how MOU's are in the community precisely so they can be accessible for pregnant women, "where [patients] are close to their family, their family can bring them food, but if there's no food at home, then not." Food for laboring and post-natal patients is not part of the MOU's budget outside of an order for coffee, tea, sugar, and milk, which is insufficient in quantity to offer every patient and insufficient in energy for a patient who is or has gone through the exhausting process of labor. To offset patients' hunger, staff members often purchase food themselves from their own finances.

Sr. Layne illustrates the dilemma of nurses seeking to balance their own needs with their desire to provide for patients living in poverty:

"So the staff is also bringing [food] from home. I mean you can't have a patient sitting here two days [in labor] and not eating. But now as you know everybody also struggling in the financial, so that's another challenge. We don't have things readily, even to give the patient to eat man... And you get really tired of buying out of your pocket, but I mean I feel strongly, somebody laboured now for hours at least give her a decent cup of tea. But now you've got the tea but there's no milk to put in. So now, I know I bring milk with from home."

Sr. Layne also told a story about coming across a tin in the antenatal storage area, which belonged to a Sister who regularly gave food to her patients during antenatal check-ups.

Addressing patient hunger is outside the professional scope of the MOU nurses, but many take

on the responsibility anyway and independently make plans to provide food for patients. Despite being an informal, non-standardized aspect of care, many nurses consider the social realities of the patient community as a nursing responsibility and adapt their care plans and their personal finances. Sr. Layne summarizes this feature of MOU nursing at Retreat by saying:

“But they [the staff] identify the need. There's genuinely a need. And especially because if you want that baby healthy, mother needs to be eating. And if there's no food then maybe she's going to feed the other children that's at home, she's not going to feed herself, that means that the baby is also going to struggle.

Hunger is a reality for many patients utilizing the MOU for maternity care, and as maternity nurses the staff at the MOU take it upon themselves to adjust their nursing care to include providing food, even though it is not formally or financially supported by the health system.

Sr. Patel expands on Sr. Layne's focus on providing food for needy patients to include other items. She says that, “Patient don't have this, I'll make sure she gets it. We'll go the extra mile too, for the patient. If we know, or if you saw a patient ok she didn't have nice clothes or shoes, we'll bring in some and bring it to her. Which we do. Yeah, so, that's an extra mile we go. We'll give her taxi fare.” Sr. Patel describes how staff members will pitch in together, each offering a contribution, in order to purchase something for a patient. That “extra-mile” of personally addressing social nursing needs of patients is a cornerstone of Retreat MOU's care philosophy and grounds nursing care in community understanding, but exists outside any formal health system policy or finances.

Nurses as community members

Nurses themselves are also community members and are affected by the community environment on both a personal and professional level. The clearest example of this close

relationship is demonstrated through the issue of safety. Student Sr. Taryn Jacobs observed the effect of the “gangsterism”¹⁷ on the MOU:

“Some patients they are living in fear here. It's like some of the staff also here, because they don't know what to expect today when you come here, because every day is a new day. There's different things that's happening and they have to take it day by day.”

The fact that patients are living in fear is relevant to nursing care and especially relevant to maternity care concerns, as stressful environments are good for neither mother nor baby.

However, Student Jacobs’ point about the way MOU staff are also dealing with the uncertainty and danger within the community illustrates the overlap between patient and staff concerns.

Sr. Peters describes how Retreat, though not as dangerous as other areas in the Cape Flats, is home to regular gunfire and gang conflicts:

“And because you in the community, and in Retreat we are in really, I won't say very, because you get areas like Hanover Park, Manenberg that's worse, but there's lots of crime in this area, like we're forever hearing gunshots. There was a big shootout here last month where the patient ran into the Day Hospital, and he had a gun on him. So you always hearing shooting around you, you don't always feel that safe. The gangsters can just run past the security sometimes, I don't know how they make their way in.”

Sr. Peters references the lack of an effective border between the MOU and the crime in the community. The ineffectuality of security against gangsters coming into the clinic space impacts her feeling of safety at work, and highlights Student Jacobs’ point that safety is not only a patient concern. Even though Sr. Peters and Student Jacobs both commute by car to the MOU from different neighborhoods, at work the community environment is not clearly demarcated from the

¹⁷ The terms gangsterism and gangster are used differently in South Africa than in the US. In South Africa the term is literally used to refer to the activities of gangs or to a gang member and is not used as a pop-culture term to describe a certain attitude or presentation

clinical environment and leaves them feeling vulnerable to the same safety concerns faced by people living in the surrounding community.

Sr. Washington, who lives nearby the MOU and walks to work, referenced the same “shootout” when describing the challenges of working in the Retreat community:

“For example, this gangs that was running in here by the Day Hospital one night, and we were on duty. And they, it seems they don't have respect for doctors and nurses. So he ran in there, and the doctor was very afraid, because she was a tiny little doctor, and then they ran out again with their guns because the one was looking for the other gang. It was crazy that night.”

The point that Sr. Washington emphasizes is that the danger comes from a lack of respect for staff and the broader issue of gang violence. Unlike Sr. Peters and Student Jacobs, Sr. Washington lives in the Retreat community. When talking about the shootout and the danger, she references how it affects the doctor and the motivation of the gangster himself, but implied in her description is the fact that the MOU is susceptible to community safety concerns. Directly after this incident the Day Hospital closed and sent all patients via ambulance to Somerset Hospital, but when I asked Sr. Washington if the MOU closed she laughed and said no they were open all night, just two midwives and a female security guard.

Sr. Layne used her managerial point of view to highlight two issues that particularly affect her staff as they negotiate the community environment, specifically the staff members that live in the Retreat area. Firstly, she mentioned the way that crime affects staff commuting to work from nearby:

“In the area also with the unrest here, going on in the shootings in the area, remember, because most of the staff stay in the community. They need to come and work, it's winter time now, it's dark. So they need to leave home early, so it's dangerous on the road. Some of them walk, and those skollies [gangsters] rob them along the way.”

She continued to talk about how she had requested van transportation for her staff, at least during the winter season when the road to and from the clinic would be dark, but that it was not accepted as a necessary expense by the district administration. The fact that most of the staff live in the community means that as a manager she views the community's problems as her staff's problems. Her solution, requesting transportation from the district office, also represents the way that community and clinical care issues blur together. Because crime in the community poses a threat to her staff, she sought health system support.

The fact that most of the MOU staff live in the Retreat community came up again when Sr. Layne described how drug abuse, previously discussed as a challenge to antenatal care in the clinic, had increased in the community over the course of her time as manager:

“Besides that remember as I said my staff is in the community, you might have an odd one who's got a child that's on [tik]. So that's come with it's own problems. So you're expected to be at work, but at home you've a got a child that's abusive, that is stealing everything. So it's a lot of that kind of, that has increased I've noticed in the last couple of years. The abuse of drugs, and specifically that drug tik. And I've got a few staff members whose kids are, unfortunately, on it. And it affects the work, because remember they need to be in. Sometimes the one can't have uniforms, he sold all the uniforms for drugs. So she couldn't come to work, she had no uniform. Sho it was a problem.”

Sr. Layne reiterates that the clinic staff are community members themselves and thus personally affected by the community's challenges and overall environment. The holistic identity of her staff, beyond their professional lives, is part of what dictates the work environment of the clinic. Aside from the emotional toll of dealing with a child who is addicted to methamphetamine, there are practical repercussions, like a lack of uniforms.

Safety and drug abuse are two issues that demonstrate the reality of the overlap between the community environment and the work environment of the MOU. In the context of professional identity, nurses' community identities are often bound to the same neighborhoods of the patient population they serve.

Nurses as community liaisons

Reflecting on her nursing career and approaching retirement, Nurse Nadia Mohamed nods her head and says almost to herself, "I must just be a nurse and do the best I can for the patients, for the community at least." Through this statement, Nurse Mohamed equates her nursing work with community work, her nursing role as a service role not just for patients but also for the community to which the MOU belongs. Mary Bergman, a visiting midwifery student who has worked as a staff nurse at Groote Schuur Hospital for more than ten years, stated that nurses don't really work in the community; nurses go to their institution to work and then come home to their personal communities. However, the nurses of Retreat MOU illustrate a different experience; their on-duty and off-duty hours include a community liaison role. At work they maintain and even cultivate community connections, and at home in their families and neighborhoods they make themselves available for nursing care as their communities seek their help regularly. Professional identity extends beyond the profession and blurs the distinction between professional and personal care, just as the MOU in a health care context is a combination of community and clinical care.

In contrast to Nurse Bergman's assertion that nurses do not work in the community, Sr. Peters describes how the community setting of the MOU is responsible for creating physical accessibility as well as shaping the nursing role: "You begin to develop a relationship where, the

patient is so much in and out again, they can just walk to the MOU if they need something, if they need help; you build this relationship with them.” Sr. Peters makes the point that the location of the MOU makes nurses available to patients, multiple times in one day, in a way that nurses commuting to “institutions” are not available to their communities. The MOU is a fixture of the community, and nurses become fixtures of the community as well, even if they are not at the MOU.

In fact, for nurses with a strong presence in their communities, the MOU can be utilized as a community space rather than an institutional space where people seek them out for care at work. For example, Nurse Monique Klaasen, a gregarious presence in any room and an unsurprisingly well-known person in her neighborhood, told me:

“I’m actually very famous in my community... On a daily basis you’ll see them looking for Sister Monique, they call me Sister. In my community, when something happens in the community, they call me... So everybody knows. They come to me if they want help, or what can I do, can I do this. Or they’ll even phone the hospital. Even in front [at reception] they know if there’s a TOP,¹⁸ if there’s a problem they’ll call me and say can you deal with this. So I’m well-known in the community. Quite well-known.”

She also brings her nursing work to the community as well. She told me that, “Currently now I’ve got five people whose HIV meds I fetch and I bring to them. They will phone me day and night.” Monique’s identity as a nurse and a community member changes both the clinical space itself and her role for the people around her. She makes herself accessible at work based on the mentality that addressing community health needs is part of MOU nursing care. By tending to the needs of her community members, she is not neglecting her nursing duties. Rather, she is

¹⁸ TOP stands for “termination of pregnancy” and refers to South Africa’s free and legal access to abortion available at Retreat MOU.

making the MOU accessible to the community and providing nursing care within the MOU as an extended community context. Additionally, the fact that she is “famous” as a nurse allows her to bring her nursing care home, as in the example of the HIV medication deliveries, to make sure that people who feel unable to traverse between the community and clinic and back again can still receive care. The fact that people feel comfortable calling her “day and night” and calling the front desk of the MOU in order to reach her personally is a sign of how available she makes herself and the lack of social boundaries she enforces around her nursing role.

Many other nurses also bring their work home, usually starting with their families. Sr. Valentine said, “So I told my mother one day that for me that is working in a MOU, even family, whether you come to the clinic for a check-up or whether I see you at home, so in a social setting, I still feel that because you are pregnant you are still kind of my responsibility.” Sr. Valentine demonstrates how nursing has become a personal role at home for her, not only a professional role at work. The mentality that pregnancy, even in a social setting feels like her “responsibility,” showcases the way she extends her professional identity as a nurse to her personal identity by bringing nursing care outside the clinical space and into her community.

Sr. Nokwela explicitly references the way that the professional identity of nursing can change personal identity within a family, and elaborates on this process by focusing on the role that others, in this case family, play in defining professional identity personally:

“If you're a nurse, your family will start treating you as a nurse now. They won't treat you as a sister, as a sibling. No, you a nurse at home, you a nurse at work. Whoever has got a problem, we African people, we've got huge families. So you find that one of your family members back there in the Eastern Cape will phone you, trying to find out 'what do I do if I've got a headache?' I mean, a headache. You can't be now phoning me to find out what do you do when you've got a headache! So your family first will start treating you like nurse. Of which it's a good thing, because at least

they have someone who has got more knowledge of it when it comes to the household. If you're there, they need advice, you can help them. So, it starts from there.”

Despite some incredulity and maybe annoyance at the lengths to which family members would go for the smallest complaints, Sr. Nokwela acknowledges that it is a good thing for her family to have someone with medical knowledge with whom they can consult. Both Sr. Valentine and Sr. Nokwela consider themselves to be nurses at home, not only at work, based on a sense of responsibility to their families and the sense of fluidity between their nursing role in the within the clinic and their personal lives outside the walls of the MOU.

Bringing nursing care home does not only apply to family or friends though. Sr. Washington gave an example of bringing nursing care to the “youngsters” in her area:

“And there was one boy and I talk about family planning, protection of sex for the youngsters. The other day I saw a group of them on the field, they were very rude before, and then when I came to them I said 'can I have a talk with them' and they said yes. And they call me Sister Bev, and I talk to them about different family planning, and condoms, and STI and HIV. And they were listening, and the people were so proud of me there because they still scholars but they very, you know, the gangster in them. I don't know why. Smoking dagga,¹⁹ and I explained to them what is the effect of dagga and that. And the other one the other day he came, he got a headache and earache and I gave advice to him, home remedy, what he can use. So they great, they look up when they see me.”

Sr. Washington mentions that people in her neighborhood, even the youth, call her Sister Cher, a nickname that includes the formality of her professional title but shortens her first name as a sign of familiarity. She took the initiative to provide sex and drug health education, and even though the group of young people she approached were rude initially they actually listened, which made

¹⁹ Dagga is a South Africa term for cannabis.

people in her neighborhood proud of her. Sr. Washington said that, “The people look up to me, there in my area, look up there in my neighborhood. They come for help or ask any questions at my place.” Sr. Washington’s dual identity as a nurse and a community member makes possible a level of community care beyond the clinical encounters of the MOU. Her house, her phone number, her stroll through the neighborhood become possible sites of community care, and her community is proud of her for reaching people otherwise outside the scope of the MOU or the broader health system.

Other nurses also mentioned that their off-duty hours are not free of nursing responsibility. Nurse Mohamed says, “I mean they know they can rely on me also at home. So, they feel I mean they can come to me or they can phone me, ‘can you help with this or help with that?’ So it does feel good, to be a nurse, I just love it.” Alexine Thompson, an ENA and breast-feeding consultant, spoke more generally saying, “Yes, in the community [nurses] do have a role, because there’s a lot of people in the community that look up to a nurse. So you’re able to say, or tell the parent or tell whoever, ‘take your medication, go to the doctor’ and they would listen to you.” Alexine’s comment points to a dynamic in which nurses can advocate for interacting with the health system to people who are not their patients but should be somebody’s patient. In addition to being reliable as a source of nursing knowledge at home as Nurse Mohamed described, Alexine’s comment shows that nurses can use their professional identity to advocate for engagement with the health system.

Sr. Nokwela extends this concept to make the claim that community members use nurses as a substitute for interacting with the health system. She said, “In the community, especially in a black community, if you a nurse they will start now using you as a hospital. They would avoid going to the hospital – they would come to your house.” This substitution dynamic has already

surfaced in Nurse Monique's discussion of supplying HIV medication to five people in her community so that they could avoid coming into the clinic themselves. Sr. Nokwela described how people would come to her asking for medical supplies, like bandages and medications, not only advice. This substitution attitude goes as far as to assume that a nurse's house can physically replace the hospital. Sr. Nokwela refers to the risk in this dynamic, because oftentimes people do need to access the health system and need care beyond what a nurse could give at home. Sr. Nokwela's advice is, "Don't tell them, 'ok I think this is this and this and this, go do that' because they won't go [to the clinic], they will do what you told them." Her attitude is that it is safer, and better overall for the person seeking help, for her to take on a liaison role and try to advocate for interacting with the health system.

Even with the risk involved of considering nurses as a substitute for the health system, community attitudes reveal the role that nurses have as liaisons, not only to the health system but even to other institutional sectors. Sr. Nokwela commented ruefully that, "And they expect you to know everything, you have to know everything. You can't say 'I don't know.'" With a tone of pride and mounting incredulity, Sr. Peters picked up speed as she rushed through an explanation of what a community expects from a nurse:

"And with regard to the community, the community feels very at ease even if they just have a nurse who lives in the road. For them that is the house that they can go to for advice, if they need something. They will even come and ask you what is the number for the ambulance, or this patient, they will come and say, 'My sister can't breathe, or my sister this' or any problems that they have, they always go to the nurse. 'Do you have Panados for me, do you have this do you have that?' They look at this person, not only as a nurse, they take you with regard to you a policeman, you everything because you a nurse. You should know everything. That's what people in the community think. They think just because you a nurse, you the dictionary."

A policeman, the dictionary – nurses are not only nurses when they leave the MOU. Their nursing identity signifies a much broader knowledge base to community members and they are viewed as touchstones to a variety of institutional and professional information or access. This quotation shows the many roles that nurses take on outside the clinical space based on the needs and expectations of the community. Nurses can be sought out as sources of advice, contact information, emergency help, medication, law enforcement, and general knowledge.

The experiences of the Retreat MOU nurses that involve both their role as a nurse and a community member demonstrate how professional identity at the primary public level is infused with a sense of connection and obligation to community care outside as well as inside the clinical space of the MOU. The nurse-community relationship represented in this section indicates a type of quality care that is absent from any medical metrics. The close connection to the community of the MOU and the expanded sense of their nursing role that the Retreat nurses apply to their social circumstances is evidence that personal identity is integrated into professional identity in a way that promotes quality community care. The fact that the Retreat nurses understand the needs of MOU patients so acutely and consider their own finances and off-duty time as viable sites for their nursing role suggests that an understanding of the societal status of community members is motivation to provide accessible health care and “go the extra mile.”

C. DISTANCING FROM AN OBSTETRIC MODEL OF CARE

I won't change it for anything. People think it's better at the private, but it's not.
- Sr. Layne

An unanticipated finding from my interview data was a thematic return to the points of contrast between public and private maternity services in the context of holistic care. Many nurses expressed disapproval of high cesarean-section rates and financial incentives guiding obstetric practices in the private sector. In South Africa, cesarean rates in public sector facilities is around 24% while cesarean surgeries comprise more than 70% of births for women with health insurance utilizing the private sector, according to a report done by the Council of Medical Schemes (Monticelli 2012, Child 2014). Several nurses interviewed at Al-Nisa and Retreat had experience working in the private sector, and they voiced opposition to perceived patient abuse at the hands of private physicians. There was a pattern of criticism of the standards of care in the private sector being driven by financial gain and physician convenience. **Because the private hospital is dominated by physician care to the point that midwives are forced to take on an obstetric nursing role, nurses considered the high rates of intervention and surgery to be indicative of physicians' enacting a form of abuse on private patients.**

Sr. Nieuwoudt's perspective comes from her ten years of experience as an independent midwife. The story of her two months as a private hospital midwife has already been told, but she returned to the private setting for patients who contracted her directly as an independent midwife but wanted to give birth with a private obstetrician as back-up. She describes obstetric care in the private hospital as manipulative:

“Because there [in the private hospital] if you just have a normal, difficult – first-time mothers birth with difficulty. It takes a long time to dilate, you know, and there, (snaps fingers), excuses are just cooked up and people have cesars. It really, unfortunately, is the truth for most of the private practitioners... Yeah, they summa say 'oh there's fetal distress.' I've seen it. I've seen it. And then you stand there, as patient advocate, and you try to say – it's really, it's twisted.”

Sr. Nieuwoudt describes a set of norms that position physicians as “cooking up excuses,” specifically fetal distress, to intervene in a natural birth process, especially if the labor is progressing slowly. Research clearly shows that obstetric interventions to speed labor, especially if based on an exaggerated sense of fetal distress, often lead to a cycle of intervention to compensate for the hormonal interference in the labor process, which often leads to cesarean surgery (Buckley, 2015).²⁰ Sr. Nieuwoudt’s assessment that the prerogative of physicians is “twisted” in the private hospital is grounded in her experience of midwifery care and her knowledge of normal, healthy labor progression. She does not shy away from shaming physicians for using fetal distress as an excuse to guilt patients into receiving unnecessary interventions that lead to surgical delivery.

Several nurses referenced a normalized set of interventions in the private hospital context that contradict their understanding of what is best for patients. Sr. Jones from Al-Nisa mentioned that during her time at Mitchell’s Plain Malomet private hospital “they induce the mummies there,” whereas Al-Nisa patients come in only when they are already in labor. Sr. Jones explains, “That is why most of the patients that are induced at Malomet ended up having cesars, because their cervix is not ripe, ripe enough.” Generally, Sr. Jones concedes that at “the private hospital, you end up having a cesar where you could’ve delivered normally, because there it is just for money, yeah they’re doing it for money.” These two quotations bring together how standards of care, like inductions, which often lead to cesarean surgeries, satisfy physicians’ financial motives

²⁰ For more information on research that shows that high intervention rates during labor are not beneficial or even harmful to patients, see Cochrane Pregnancy and Childbirth Reviews. Cochrane Reviews compile and analyze existing research and are a definitive resource on medical intervention effectiveness. For more information on the “cascade of intervention” that some women experience in a highly medicalized environment such as private labor wards in South Africa and many hospitals in the United States, see <http://www.childbirthconnection.org/maternity-care/cascade-of-intervention/>

by utilizing the highest level of technology. Although Sr. Jones' tone is not as harsh as Sr. Nieuwoudt's and she seemed to have a more matter of fact attitude towards physician behavior, she still asserted a causal relationship between routine induction and cesarean surgery, as well as intervention and financial gain.

Sr. Doherty, who compared her public sector training to the five years she worked at a private hospital Constantiaberg, one of Cape Town's wealthiest suburbs, confirmed that "It's very rare to have a natural delivery that hasn't been interfered with in some way, so either up in lithotomy poles because of induction or slowed labor." She goes on to make the same connection as Sr. Jones between the cascade of intervention leading to surgery and financial gain:

"When you present at a private environment, it sort of becomes about time efficiency and yes I really do believe a lot of it is financially driven. So that was very obvious. And I find it kind of interesting how women are so quick to relinquish control to the gynie, and ask no questions, just go with it. 'So now we're going to do an invasive induction, and then we're going to do an invasive epidural because now you're in pain, and now we're going to do invasive delivery because oh my goodness you can't move and the baby can't progress with their labor.'"

In her description of the intervention progression, Sr. Doherty posits the directives of the obstetrician as directly oppositional to a woman's "power" in labor. In this power dynamic, women must resist the assertions and recommendations of the physician in order to avoid a cycle of intervention. Sr. Doherty parodies the sense of surprise of the obstetrician, "oh my goodness you can't move and the baby can't progress with the labor," as they justify an invasive delivery. Her mocking tone indicates her skepticism of the honesty of the physician's honest surprise as interventions typically lead to more invasive procedures, often ultimately a cesarean, and aligns with goals of time efficiency and maximum financial gain.

This progression of intervention at the hands of physicians is not presented to patients in the same way in the public sector. In fact, Sr. Washington, ever direct in her commentary, contrasts the practice patterns of the public and private sectors:

“The patient for here [Retreat], the patient can stay for a half an hour fully dilated. Then you give the patient synto and manage the patient like that, then she can deliver normal. But there, they just say ok four hours in labor, go for cesarean sections. So they so quick with the cesarean section because of the money-wise.”

Sr. Washington is making a comparison between Retreat and the private Rondebosch Medical Center, where she worked for a year. Speaking about that year she said, “I didn’t like the work session there because they abuse the money of the patient.” Even at Al-Nisa, which is only a semi-private institution and has much lower fees than a private hospital, Sr. Brigid Johnson said that she didn’t know what the patients at Al-Nisa were paying for and mentioned that without the strict protocols of the public sector sometimes interventions were done unnecessarily, using the example of overprescribed phototherapy. For Sr. Johnson, the financial incentives of care, even at the low fee rates of Al-Nisa, interfere with proper nursing. She said that in a for-profit setting, even in a setting like Al-Nisa with subsidized costs, she felt unable to practice her profession as it was meant to be practiced.

However, it is not only financial incentives that lower the standard of care in private hospitals according to nurses with public sector experience. Sr. Washington gave an example of apathy in physicians due to the structure of specialization in private hospitals:

“The obstetrician, that makes me crazy, the obstetrician is finished and she don't care about the baby, the outcome of the baby, because there's another doctor coming for the baby. And I was so sad one day, when I told this obstetrician 'you know that baby, 4 kilo baby, that baby died in another hospital,' she didn't even know, she didn't even follow up on that patient. So it's only the

delivery that they do, and they don't – for me it seems just a money-making thing.”

Sr. Washington refers to the detachment of the physician as a result of disjointed care due to specialization during private hospital births, returning to the role of financial gain as a factor in setting physician standards. Despite the high-tech care and specially qualified physician access, she felt that “the way the doctors is working is not up to my standards.” The way the physicians are working is too influenced by financial incentives and the standards Sr. Washington subscribes to are defined by midwifery care principles, including a respect for the natural labor process.

The criticism from these nurses is that physician care is not caring enough. Based on their experiences in the private sector, nurses view private physicians as prioritizing the most financial gain from a birth, to the point of manipulating patients away from a natural delivery. The narrative these nurses tell is a reverse of the script of public and academic opinion, which describe nursing behavior as abusive due to social motivation. Public nurses themselves put forth a narrative critical of physician abuse of patients through financial motivations and a dispassionate attitude towards laboring women, their bodies, and their babies.

CONCLUSION

The contrast between the existing narrative focus of nurses' professional identity as the cause of abusive behavior and the findings that intellectual autonomy and community connection are central concepts to professional identity at the MOU level is indicative of how gender and racial stigma continues to shape the discourse of nursing quality in South African maternity care. Claims for empowering nurses and increasing dialogue between nurses and policy-makers so far have been isolated instances of resistance that have done little to shift the accepted view of nurses as bitter, low-quality care providers.

The data and analysis represented in this thesis are evidence for professional identity as a factor in promoting community-conscious, woman-centered quality care. A framework for understanding professional identity in a way that acknowledges the evidence supporting its role in abuse *and* its capacity for creating quality care, especially in the primary care setting where nurses function independently from physicians or high-tech accessibility, deserves representation in academic literature.

The findings of this project highlight factors that add nuance to how professional identity is experienced across different health care settings, including primary and tertiary care and public and private sectors of the health system. In different contexts autonomy of practice and commitment to providing care relevant to the social experience of patients is not necessarily valued equally. Different health care contexts shape nursing roles, but nurses and midwives relate to their roles in different ways based on how they value autonomy and how connected they are to the patient community.

As a site of public primary maternity care, Retreat MOU fosters a sense of professional identity that espouses the values of intellectual autonomy in their practice, sensitivity to

community challenges, and a holistic view of pregnancy and birth. Not only are these values underrepresented in academic literature, but they are undervalued by society at large. The gendered medical hierarchy and the racial social hierarchy have historically devalued the work of women of color, and nursing has yet to entirely shake its association with domestic labor. Medical models of care emphasize pathology over social determinants of health, and the obstetric medical model in particular, operates around a pathological, specialized understanding of pregnancy and birth. The fact that the dominant narrative in discourse related to quality in public maternity services focuses on the identity of nurses demonstrates a dismissal of the success midwives have achieved in creating quality care through resisting the gender and racial devaluation of their work and embracing positive factors of professional identity for themselves.

The experience and perspectives of nurses deserves a central role in quality care discourse. Maternal mortality and abuse in maternity care in South Africa are real issues, but a discussion of positive nursing care models that succeed despite the challenges posed by issues in the health system would be an asset not a distraction from maternal health scholarship aimed at improving the outcomes of patients. The narrative of professional identity as the cause of abuse should be accompanied by the narrative of how professional identity catalyzes quality community-conscious care. Framing solutions to challenges in maternity care only in the context of mitigating nurses' identity issues rather than in the context of empowering nurses to provide their best care is a disservice to both nurses and patients.

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APPENDIX

Consent Form

Title: Toward an Understanding of Nurses' Experience as Providers in Public Maternity Service in Cape Town, South Africa

Researchers: Christopher J Colvin and Mary L. Cerulli

Email: cj.colvin@uct.ac.za **Phone:** +27-21-406-6706

Contact Information: Human Research Ethics Committee (HREC) at the Faculty of Health Sciences at the University of Cape Town (021 406 6338)

Purpose of Research: We are inviting you to participate in a study that aims to research the experience of nurses working in public maternity care and what factors contribute to nurses' perspectives of quality and identity in that setting. We are interviewing nurses who work in public maternity settings, including junior and senior midwives, other nursing staff, and nursing students.

What is involved in participation? You are under absolutely no obligation to participate; however, if you choose to participate, we will interview you about your experience working in public maternity care and how being a nurse/midwife is connected to community identity. The interview will likely take about 30 minutes, but may go longer if you choose to speak in detail.

The interview should not pose any risks to you. If you do not feel comfortable at any point in the interview, you can stop the interview without any explanation or further questioning. You may also refuse to answer certain questions or move on to the next question if you feel discomfort at any point in the interview. If you have questions at any time, please ask me to pause the interview so that we can answer them. Following the interview, you are free to withdraw your results at any time.

This is a non-paid study. However, your opinion and personal experience are greatly valued, and will help increase understanding about how nurses experience working in public maternity care. We will also make every effort to share with you the results of this research if you would like us to do this.

Confidentiality and disclosure of information: Any information obtained in this study will only be disclosed with your permission. Direct quotes from you may be used, and/or your words may be paraphrased, but the information will be presented in a way that ensures that you cannot be identified. We will not share your comments to me with any other person without your expressed permission. The only circumstance where we would not keep confidentiality is if we have a legal obligation to share information.

If you are comfortable with this conversation being recorded, we will tape the interview and personally transcribe and analyze the content of this interview. The transcription will refer to you with a pseudonym (false name), and will be saved on a password-protected computer. After each interview is transcribed using a pseudonym, the recording will be deleted. In

publications of this research, we will rely on a pseudonym to discuss your comments. We will only use your real name if you voluntarily request that we do so.

Consent:

Do you consent to the interview?

Yes No

Do you grant the researcher permission to tape-record the interview with the understanding that you may stop the recording at any time if you so wish?

Yes No

(Signature of Research Participant)

(Please print name clearly)

(Signature of Researcher)

(Date)

.....
Follow-Up Contact Information

Would you like to be sent your transcript (typed record of the interview) before we use it for analysis?

Yes No

If we are able to publish or present on this research, would you like a copy of the final product, and/or like to be invited to a presentation?

Yes No

If you answered yes to any of the above, please specify how we may contact you

Phone:

Email:

Mailing address:

Interview Guide

1. Introductory comments about the study
2. Please tell me a bit about yourself – your name, where you are from, where you live now, how old you are, where you work and what your job title is
3. Why did you decide to become a nurse and/or midwife?
4. Have you worked in different health care contexts (eg. public v private; clinic v hospital)? Which did you prefer? Why?
5. What are the challenges of working in public maternity care? How do you encounter these issues in your day-to-day work? What strategies do you use to deal with them?
6. Since you have been a midwife, have these challenges changed? Which difficulties are new and what do you think caused them?
7. Have you interacted with health policy or protocol changes (eg. PMTCT, kangaroo care, breast-feeding, evaluation/monitoring, administrative) in your career? Which policies or protocols have you interacted with and at what level (facility, district, national) did these policies operate? Did these changes influence your daily practice? In what way?
8. How do you think of yourself in relation to the area/community you grew up in? To the area/community you live in now?
9. Do you think your profession as a nurse and/or as a midwife affects how people in your area/community think of you? In what way?
10. What role, if any, do you think gender, race, and class have in shaping how people (researchers, reporters, every day citizens) think about nurses who work in public maternity care?
11. Is there anything you would like to add? Do you have any questions for me?

INTERVIEW DATA SUMMARY SHEET

Name	Professional Level	Race	Interview Site	Interview Length	Interview Date
Nuraan Peters	Sister	Coloured	Retreat MOU	22 min	28-Jun-16
Monique Klaasen	Staff Nurse	Coloured	Retreat MOU	56 min	29-Jun-16
Caitlin Valentine	Sister	Coloured	Retreat MOU	24 min	04-Jul-16
Nadia Mohamed	ENA	Coloured	Retreat MOU	24 min	05-Jul-16
Christine Kruger	ENA	Coloured	Al-Nisa Maternity Home	25 min	11-Jul-16
Ayesha Veeran	Sister	Coloured	Al-Nisa Maternity Home	33 min	11-Jul-16
Brigid Johnson	Sister	Coloured	Al-Nisa Maternity Home	90 min	11-Jul-16
Sameera Patel	Advanced Midwife	Coloured	Retreat MOU	11 min	12-Jul-16
Cheryl Washington	Advanced Midwife	Coloured	Retreat MOU	18 min	13-Jul-16
Amina Jones	Sister	Coloured	Al-Nisa Maternity Home	35 min	14-Jul-16
Anthea Yaro	Sister	Black	Vincent Pallotti Hospital	13 min	17-Jul-16
Evelyn Bishop	Sister	White	Vincent Pallotti Hospital	12 min	17-Jul-16
Liezel Visser	ENA	Coloured	Vincent Pallotti Hospital	11 min	17-Jul-16
Ruth Dessington	Staff Nurse	White	Vincent Pallotti Hospital	18 min	17-Jul-16
Petra Nieuwoudt	Sister	White	Al-Nisa Maternity Home	47 min	21-Jul-16
Mary Bergman	Staff Nurse	Coloured	Retreat MOU	45 min	27-Jul-16
Sarah Nokwela	Sister	Black	Retreat MOU	37 min	27-Jul-16
Jade Sevenster	ENA	Coloured	Retreat MOU	50 min	28-Jul-16
Robin Layne	Sister-in-Charge	Coloured	Retreat MOU	33 min	01-Aug-16
Sharlene Truter	Student Sister	Coloured	Retreat MOU	20 min	11-Aug-16
Melissa Doherty	Sister	White	Retreat MOU	17 min	17-Aug-16
Taryn Jacobs	Student Sister	Coloured	Retreat MOU	12 min	17-Aug-16
Alexine Tompson	ENA	Coloured	Retreat MOU	8 min	18-Aug-16