








## RESEARCH ARTICLE OPEN ACCESS

# Factors Contributing to the Underutilisation of Midwife Obstetric Units in the Tshwane District Region, South Africa

Mariatha Yazbek  | Rebecca Cadman  | Lizelle Swanepoel  | Omogolo Sejosengoe  | Kayla Heyns  | Mmabatho Ramoroka  | Khabo Thamane 

Department of Nursing, University of Pretoria, Pretoria, South Africa

**Correspondence:** Mariatha Yazbek ([mariatha.yazbek@up.ac.za](mailto:mariatha.yazbek@up.ac.za))

**Received:** 29 March 2024 | **Revised:** 31 March 2024 | **Accepted:** 29 January 2026

**Academic Editor:** Anjali Chauhan

**Keywords:** low-risk pregnancy | midwife | midwife obstetric unit | tertiary hospitals

## ABSTRACT

**Aim:** To determine why midwife obstetric units are not being utilised in the Tshwane District Region, South Africa.

**Design:** A qualitative, cross-sectional study design was used to explore and describe the factors contributing to the underutilisation of midwife obstetric units by low-risk women in the Tshwane District Region.

**Method:** Semistructured interviews provided information about individuals' perceptions, beliefs and attitudes towards midwife obstetric units in 16 diverse, low-risk postnatal women between the ages of 18 and 25 years old. Interviews were audiorecorded and transcribed, and thematic analysis was conducted to identify themes.

**Results:** We identified four major themes: (1) superior facilities and services; (2) negative experiences and perceptions; (3) staff behaviour; and (4) educational gaps.

**Conclusions:** This study provided greater insight into the factors contributing to why midwife obstetric units are being underutilised in the Tshwane District Region. Understanding these perceptions and reasons allows public health nurses, specifically those involved in midwifery to use the research, to improve the services available.

## 1 | Introduction and Background

In South Africa, the birth rate is 19.995 births per 1000 women, and the fertility rate is 2.372 births per woman, numbers well above the population replacement rate [1]. Despite the availability of midwife obstetric units (MOUs) in communities, equipped with trained midwives and designed to handle low-risk pregnancies, women often opt for tertiary hospitals for childbirth. This preference places unnecessary strain on tertiary institutions. Low-risk women, defined as those aged between 18 and 35 with no prior medical conditions before or during pregnancy and carrying a singleton healthy foetus, frequently bypass MOUs. These women exhibit no active maternal or foetal

complications that place the pregnancy at a low risk for complications.

MOUs are primary health facilities established to offer antenatal care and oversee low-risk births, along with conducting antenatal and postnatal visits and referring high-risk cases to hospitals. In South Africa, approximately 50,000 births occur in the Tshwane District each year, with 18% of these births taking place in MOUs [2]. First introduced in South Africa in 1974 under the University of Cape Town's supervision, MOUs aim to deliver quality midwifery care closer to women's residences and alleviate the strain on tertiary institutions. These units, together with clinics and hospitals, contribute to comprehensive community care. The

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World Health Organization's Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030) emphasises the significance of such maternity services in ensuring optimal clinical outcomes and preventing illness in mothers and babies.

MOUs have demonstrated efficacy and patient satisfaction in several countries. In Europe, women are satisfied with the pre- and postpartum care provided in MOUs [3]. In England, where the number of MOUs has doubled since 2010, they now account for 14% of all births [4]. A study in Amsterdam indicated a low risk for intrapartum or neonatal mortality in MOUs [5], while research in Western Australia emphasised positive birth experiences [6, 7]. In Nepal and China, MOUs were associated with more spontaneous vaginal births and fewer episiotomies, along with higher satisfaction levels [8]. Research in the United States of America highlighted that women felt more empowered in midwife-led units compared to obstetrician-led units [3]. These findings collectively suggest that MOUs are cost-effective and safe alternatives for low-risk births.

However, in South Africa, MOUs have not been successfully utilised by women with low-risk pregnancies. Despite being an essential component of the health system, many women bypass MOUs in favour of tertiary institutions. A study showed that 31.2% of low-risk women chose to give birth at hospitals instead of MOUs [9, 10]. Policies implemented in 2012 that aimed to improve MOU utilisation and reduce strain on tertiary institutions have not effectively addressed women's preferences, indicating a gap in both research and policy implementation [11, 12].

In South Africa, the underutilisation of MOUs is a significant concern, particularly in the Tshwane region where the gap between the availability of MOUs and their usage by low-risk women is evident. In the labour wards of tertiary institutions, there is an average of around 10-15 beds available. By placing low-risk women in these beds, we are limiting the number of high-risk women who can be admitted. The primary research question is as follows: 'Why are Midwife Obstetric Units in the Tshwane Region not utilised by low-risk pregnant women?' To unravel this, the research aims to evaluate the awareness and perceptions of low-risk pregnant women regarding MOUs, exploring factors influencing their childbirth location decisions, such as past experiences, accessibility and infrastructural adequacy of MOUs and perceived quality of health care. Ultimately, the research intends to identify opportunities for enhancing the appeal and functionality of MOUs, aligning them more closely with the preferences and needs of low-risk pregnant women, and thereby suggesting interventions to optimise the maternal healthcare system in the Tshwane region.

## 2 | Methods

Ethics approval from the University of Pretoria was obtained before beginning our study (673/2022). Participants were between the ages of 18 and 35 years, low-risk postnatal women who delivered at a tertiary institution and provided informed consent as explained in further detail below.

### 2.1 | Design

We employed a cross-sectional qualitative design to conduct our research.

### 2.2 | Study Setting and Recruitment

Between January 2023 and October 2023, we conducted semi-structured interviews with 16 low-risk postnatal women who recently gave birth in any one of three selected tertiary institutions after being booked to deliver at their local MOU. Originally, between 15 and 20 women were to be interviewed; when we reached our 16<sup>th</sup> interview, we reached data saturation. These women were flagged by viewing their antenatal cards and determining whether they attended antenatal care at an MOU, were booked at an MOU, and were low-risk. Data collection took place in the postnatal ward at three separate tertiary institutions within the Tshwane District Region before the women were discharged. Permission was obtained from each facility to address the specific patients based on the inclusion criteria. The specific inclusion criteria were women over the age of 18 who were deemed to have a low-risk pregnancy and who were booked at a MOU to deliver, but instead delivered at a tertiary institution. A purposeful sample was used; this method was chosen as it allows the researchers to identify low-risk women who were booked to deliver at an MOU but instead chose to deliver at a tertiary institution. This has been chosen as it allows for rich data to be collected from the participants. Our study collected data through interviews, to which the patients consented, allowing the women to answer probing questions with unbiased opinions.

### 2.3 | Data Collection

An interview guide with a central question and probing questions, developed by the researchers, was utilised during the face-to-face interviews, and all answers provided by the participants were recorded with an audio recorder to ensure that it could be transcribed verbatim. Each participant was asked the same questions in the same order to ensure consistency and comparability, while also reducing bias as the context and flow of questions could influence how participants respond to subsequent questions. Field notes and observations were noted throughout the interviews. No leading questions were included in the interview guide, as these questions can be manipulative; thus, our own bias and perspective were not introduced into the interview process.

### 2.4 | Data Analysis

The data from the audio recordings were transcribed verbatim. Once these data were transcribed into text, the data were analysed into specific themes and categories by the following steps described by Creswell [13]. The researchers read through the data transcribed to text and obtained a sense of the overall meaning. The data were organised into specific categories and labelled with headings. The researchers described these headings and identified the themes within them. The data were interpreted by the researchers and confirmed by the co-coder as suggested by Creswell [13]. The finding was presented in a way that adequately and meaningfully conveyed the results.

### 2.5 | Ethical Considerations

Before any data were collected, the potential participant in the postnatal ward was given all relevant information about the study as well as time to read through it to ensure that she was willing and was not being coerced or forced into participating.

**TABLE 1** | Thematic analysis results ordered by decreasing frequency.

Themes	Number of mentions
1. Superior facilities and services in hospitals	<b>20</b>
1.1. Poor infrastructure and resources at MOUs	6
1.2. Superiority of hospital facilities and services	9
1.3. Preference for hospitals due to availability of doctors	5
2. Negative experiences and perceptions	<b>15</b>
2.1. Negative experiences of MOUs	8
2.2. Negative community stories about MOUs	7
3. Staff behaviour	<b>11</b>
3.1. Negative interactions with MOU staff	11
4. Educational gaps	<b>8</b>
4.1. Lack of health education at MOUs	6
4.2. Inadequate knowledge of MOU availability	2

Note: Bold values indicate the total of number of times of mentions of each theme.

After she agreed, an informed consent document was given to them to sign voluntarily. Participants consented to the interview and its recording. All interviews were conducted in a private room by the researchers, and they were recorded and transcribed.

## 2.6 | Rigour

Credibility was ensured by prolonged engagement, member checking and maintaining an audit trail of coding decisions and researcher reflexivity. The audio recordings were triangulated with the observations and field notes taken throughout the interview process to ensure the confirmability of the findings [14]. The findings and conclusions are supported with participant quotations, and the results agree with the interpretation of the evidence. The results are described in detail and are transferable to other contexts.

## 3 | Results

This section talks about what we found from interviews with 16 women who had just given birth in three hospitals in the Tshwane District Region. We looked at their thoughts and experiences with MOUs. The data show several themes that point out the challenges and reasons why these women made certain healthcare choices about MOUs.

We did a thematic analysis to understand why the women picked tertiary hospitals over MOUs for giving birth. From the interviews, based on questions in the interview guide, we found four main factors contributing to the underutilisation of MOUs: (1) better facilities and services at hospitals; (2) negative experiences and perceptions of an MOU; (3) how staff at MOUs behaved; and (4) gaps in knowledge about MOUs.

We looked at the women's answers and related them to why low-risk women are choosing not to use MOUs for childbirth and instead go to tertiary institutions. We present their answers, including direct quotes, to fully understand their experiences and thoughts. The following section shows the demographics of the 16 women and explores the main themes and their subthemes that came up in the interviews.

### 3.1 | Demographics of Participants

All participants were within the age bracket of 18–35 years. A majority of 11 women identified as Black African, while three identified as White, and two as coloured. Out of the total, five women were primigravida, and the remaining 11 were multi-gravida. It is noteworthy that 12 participants were of South African origin, with four being foreign nationals. The results of the participants' responses underwent thematic analysis which is discussed in the next section.

### 3.2 | Thematic Analysis

The results of the thematic analysis conducted can be seen in Table 1. Four major themes were identified as well as their subsequent subthemes. These themes are arranged by decreasing frequency of mentions, and it should be noted that some participants make mention of multiple issues. The different themes are discussed below:

#### 3.2.1 | Theme One: Superior Facilities and Services in Hospitals

This was clearly the dominant theme as illustrated in Table 1. The feedback from the interviewed women highlighted a clear preference for hospital services over MOUs. They consistently spoke about superior facilities and more comprehensive services at hospitals. One participant shared her comparison:

'I think it is much better because there's more staff here unlike at the MOU where there is only one regular nurse. The local maternity facility provides ANC and MOU. There are usually two nurses running the facility so I can't change the midwife if I don't prefer her for whatever reason'.—Participant 16

Their portrayal of MOUs was less flattering. Common complaints revolved around the inadequacies of MOU infrastructure and resources. As one woman stated:

'The lines are long; the place is not clean, and the staff is slow'.—Participant 2

A recurrent theme that emerged was the preference for hospitals due to the availability of doctors. Women felt assured with the presence of medical doctors at hand in hospitals. As one participant stated:

*'I liked that there are doctors here that nurses can confirm findings with'.*—Participant 10

The responses of the women depict the comparative perceptions between hospitals and MOUs concerning facilities, infrastructure and the presence of medical professionals. Beyond the structural and service inadequacies, women also highlighted a notable absence of rapport between patients and staff at the MOUs. The subsequent section delves deeper into these issues with service and staff behaviour.

### 3.2.2 | Theme Two: Negative Experiences and Perceptions

Another prevalent concern brought up was the negative interactions women had experienced with MOU staff. One participant remarked,

*'You can't even ask them questions because you are scared they are going to shout at you'.*—Participant 3

These negative interactions fed into broader negative perceptions of MOUs and negative community stories about MOUs. A participant shared:

*'The MOU had too many bad and scary reviews that are known by the whole community'.*—Participant 6

These negative interactions extend to poor and oftentimes prejudiced service, with one woman remarking:

*'I did not like the treatment I got there. Pregnant women are not given chairs to sit on. They are not patient'.*—Participant 9

Another said:

*'I did not like one of the nurses that helps with deliveries because she was always shouting at her staff and the pregnant women and seemed flustered all the time'.*—Participant 12

These negative interactions have led women, on occasion, to abandon their antenatal visits at an MOU due to the rudeness of the staff, as highlighted by one participant:

*'Every time I go for a visit they are rude to me. I did not even go to all the visits before my baby comes because the sisters were always fighting with me'.*—Participant 5

These negative interactions and perceptions are often intertwined with poor service and a lack of facilities and equipment, both of which commonly plague MOUs. The concerns raised by the interviewed women in this regard are discussed next.

### 3.2.3 | Theme Three: Staff Behaviour

After conducting interviews, we discovered that another common factor present in women's experiences resulting in them not making use of their local MOUs is the staff behaviour at MOUs. A majority of women do not make use of their local MOUs as a result of the staff members' behaviour. When looking specifically at the foreign national population in South Africa, these women felt like they were being treated with disrespect, and they felt very unwelcome at the clinics. In one of our interviews, a woman stated:

*'You see I heard from other people or women that also don't have the South African passport that if you give birth at the clinic, they can be very rude. They will shout at you, they will be very rude'.*—Participant 3

Another woman mentioned in her interview that:

*'You can't even ask them questions because you are scared they are going to shout at you'.*—Participant 11

We found that this abusive behaviour of midwives towards women is one of the main contributing factors resulting in them not making use of the local MOUs.

Nurse bias can lead to negative interactions and adversely shape perceptions of patients, particularly when the patient is a foreign national. One foreign woman noted:

*'You see I was not born here in South Africa and I had my other baby not in South Africa so when they see I do not have the South African passport they were very rude to me. When I did not understand the question at first they would start screaming'.*—Participant 4

### 3.2.4 | Theme Four: Educational Gaps

A significant gap identified in MOUs was the perceived lack of health education. Women felt uninformed and not adequately prepared for their pregnancies. Multiple women mention issues around a lack of guidance and education, which highlighted this theme, with one woman stating:

*'Their nurses just make notes without teaching you on your pregnancy or even answering questions'.*—Participant 12

This lack of proactive engagement and communication by the MOUs was evident in many of the participants' responses, emphasising the need for a more holistic approach to antenatal care. Adding to this, several women pointed out that there was no proper communication or structured antenatal care lessons provided. Some were even unclear about the basic role and function of an MOU, highlighting an information void. Furthermore, there were reports of a lack of clear explanations or reasons behind certain decisions made by the MOUs. For instance, some women mentioned being told they could not deliver at the clinic, but they were not given a clear reason why. This absence of clarity further strained their trust and confidence in the MOU system.

## 4 | Discussion

The overarching theme identified is that of theme one, which describes that women feel as if hospital facilities and service levels are high above the level of those at MOUs. In South Africa, MOUs and tertiary institutions are independent of each other which can lead to a lapse in communication and therefore poorer service, as described by some of the participants.

In countries like England, the midwife-led units work alongside hospitals, in case of emergency or where specialised care is needed [4]. By working together as opposed to two separate entities, safe, low-risk pregnancies can be managed better. The women interviewed felt assured by the presence of medical doctors at hand in hospitals [15]. However, there was an implicit frustration with MOUs where even small requests were met with reluctance. In certain instances, women were not even given chairs to sit on while waiting to be seen. Perhaps it is time for South Africa to not see MOUs as entities on their own, but to start linking with hospitals in communities to give pregnant women a better sense of assurance. Specialised doctors can still come to these midwife-led units and assist midwives by reviewing women and reassuring them that they can safely labour in these units and do not need to make use of tertiary facilities.

A study conducted in England proved that this is an efficient way to manage the relationship between MOU facilities and hospitals, as midwifery-led units have doubled in number since 2010%, and 14% of England's births are now represented in these units [4]. When comparing these statistics to births in South Africa, Horner et al. showed that 45% of women still give birth in hospitals compared to 41% giving birth in midwife-led units [9]. Johantgen et al. [10] further went to show that 31.2% of these women were low-risk and could have given birth in an MOU but opted to go to a hospital. These numbers are alarmingly high for a country that has adequately trained midwives working in MOU facilities.

Themes two and three highlight similar issues surrounding the experiences patients have at the MOUs and how these experiences feed into the broader negative perceptions of MOUs and the negative community views of MOUs. These negative interactions extend to poor and oftentimes prejudiced service. These negative interactions have led women, on occasion, to abandon their antenatal visits at an MOU due to the rudeness of the staff. Nurses' bias can lead to negative interactions and adversely shape perceptions of patients, particularly when the patient is a foreign national [16].

A study conducted by Malatji and Madiba [17] found that many South African women came forward and reported instances of abuse at the MOU facilities that they used in Gauteng Province. They saw inadequate communication between nurses and patients. Communication mostly revolved around screaming and shouting [17]. Four years later, we are conducting a similar study in the same province and not much has changed. From our conducted interviews, most of the women are still reporting this type of behaviour in MOUs. A common factor present in women's experiences resulting in them not making use of their local MOUs is the staff behaviour. Women have now even become reluctant to attend all their antenatal visits in an attempt to avoid the nurses and their rude behaviour. In this same study, they found that foreign nationals were met with different behaviour when compared to South African nationals. Staff

behaviour towards foreign nationals has not changed. These women still feel as if they receive unfair treatment. Nurses are communicating more harshly with these women and have little patience if there is a language barrier present. Once again, within the 4 years that Malatji and Madiba's [17] study was conducted, no efforts were made to address the language barriers found in local MOUs.

In a study conducted in Western Australia, women reported that midwife-led units allowed for rapport to be established between midwife and patient, which in return resulted in a positive birthing experience [7, 18]. Beyond the structural and service inadequacies, women also highlighted a notable absence of guidance and education during their visits to MOUs. There is no effort being put forth for midwives in South African MOUs to develop a good rapport between them and the women they care for. Our midwives are showing a clear lack of interest, which is contributing to women having negative birth experiences in our MOUs. This enlisted a fear within these women, resulting in them being too scared to ask nurses questions about their pregnancy, which in turn led to them not receiving adequate health education during their antenatal period. Continuous research conducted by Rayment et al. [3] in the United States looked at the care provided by midwives in midwife-led units compared to obstetrician-led care. Their results showed that women felt more supported to make their own decisions when being cared for by a midwife. These women also reported that they felt empowered to make their own decisions on how they would like their birth to occur, as they received adequate and important health education during their antenatal period with midwives. Our midwives are no longer taking the initiative and providing women with adequate health education during their antenatal period. This, combined with the fear instilled in women about nurses' rude behaviour, contributes to them having negative birth experiences in our MOUs.

Theme four shows that there is a lack of proactive engagement and communication by the MOUs, which is evident in many of the participants' responses, emphasising the need for a more holistic approach to antenatal care. Adding to this, several women pointed out that there was no proper communication or structured antenatal care lessons provided. Some were even unclear about the basic role and function of an MOU as indicated by two of our participants, highlighting an information void. Adding to this, two participants had never heard of an MOU and had no understanding as to what they were, even though they were booked at one for their delivery. This break in communication and education is clearly adding to the underutilisation of these units.

## 5 | Limitations

The study was conducted in hospitals that were all situated within the Tshwane District, thus excluding the perspectives and experiences of women outside the district. The study's qualitative design and smaller sample size restrict the capacity to draw wider conclusions about the experiences of women giving birth at MOUs in the Tshwane District. Another limitation of the study is that data on the availability or scarcity of resources at MOUs and the midwife-to-patient ratio were not collected, thus being unable to support the claims made by the women about poor service delivery and the quality of care delivered. The midwives were not

interviewed, and thus, their views and experiences are not included in the study, limiting the ability of the results to yield a more definitive picture of the care given at MOUs.

## 6 | Conclusion

In examining the decisions of pregnant women in Tshwane, we have gained crucial insights that highlight areas for potential enhancement in MOUs. The main concerns raised by these women relate to interactions at and perceptions of MOUs, the superiority of the facilities and services offered by hospitals, and the lack of education at and about MOUs. By addressing these significant issues, there is a potential to increase the use and efficiency of MOUs. This could help reduce the current pressures faced by tertiary institutions and ensure that women receive high-quality birthing experiences within their communities. In the next section, we will discuss these findings in depth and suggest reasons why MOUs are not being utilised within the Tshwane region.

MOUs are an important pillar in South African health, and all these low-risk women rather than going and delivering in our tertiary institutions are placing strain on the healthcare system. Gauteng has no lack of MOU facilities; yet, all these low-risk women interviewed still chose to opt out of making use of these facilities. When looking at the results of our research, we can conclude that the big problem with MOU facilities in Gauteng is not necessarily the infrastructure provided to healthcare users, but the environment within these facilities. There is a big problem with how our midwives conduct themselves in these facilities. It is clear to us that there might be a lack of cultural competency among our midwives, which leads women to believe that they will not receive the same standard of care at an MOU compared to a hospital.

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### Author Contributions

All authors contributed to the study conception and design, material preparation, data collection and data analysis. Mariatha Yazbek finalised the first draft of the manuscript.

### Funding

No funding was received for this manuscript.

### Ethics Statement

This study was approved by the University of Pretoria Ethics Review Board (673/2022).

### Conflicts of Interest

The authors declare no conflicts of interest.

### Data Availability Statement

The data are available upon request.

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