

The role of the midwife in facilitating continuous support during childbirth: a qualitative study

J Jordaan



orcid.org 0000-0001-7668-5497

Dissertation submitted in partial fulfilment of the requirements
for the degree Master of Nursing Science in Professional
Nursing at the North-West University

Promoter:

Prof CS Minnie

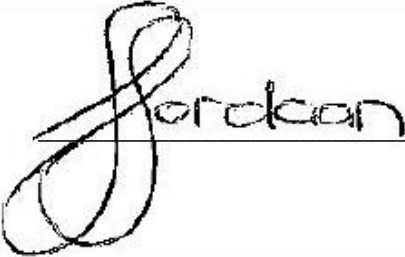
Graduation May 2018

Student number: 21619824

DECLARATION

I hereby solemnly declare that this dissertation, entitled 'The role of the midwife in facilitating continuous support during childbirth: a qualitative study', presents the work carried out by myself and to the best of my knowledge does not contain any material written by another person except where due reference is made.

I declare that all the sources used or quoted in this study are acknowledged in the bibliography, that the study has been approved by the Ethics Committees of both the North-West University and the Department of Health, North West Province and that I have complied with the standards set by both institutions.

A handwritten signature in black ink, appearing to read 'Jordaen', is written over a horizontal line. The signature is stylized with large loops.

Joha-Nita Jordaan

15/11/2017

Date

References have been done according to the revised Harvard Guidelines – NWU (North West University) 2012. NWU: Potchefstroom library.nwu.ac.za/files/files/documents/quoting-sources.pdf.

ACKNOWLEDGEMENTS

I would like to give thanks to:

- My Heavenly Father for the grace and strength to persevere;
- My mother Emmerentia and father Johan for your continued love and prayers;
- Lizé van Graan for your encouragement and numerous cups of coffee;
- My haven Anzelde for all your love and encouragement;
- My friends, Marnus, Deon and Johan, for your exceptional advisory skills;
- My role models, Willie and Gernus for your ongoing words of wisdom and support;
- Mr Chandos Nkate for being my mediator and right hand throughout the data-collection process;
- The CEO of the Thusong/Gen de la Rey Hospital complex, Mr John Seleke for granting me study leave;
- My co-coder, Mrs Kathleen Froneman, for co-coding the interviews;
- My study colleagues for your encouragement when times were tough; and
- I would also like to thank the midwives most sincerely who participated in this study, especially for their positive attitudes.
- The greatest thanks I would like to give to my supervisor Professor Karin Minnie for your support, patience and most of all for your sustained faith in me.

ABSTRACT

Background: Continuous support during childbirth is an example where best practices are known but not consistently implemented. The midwife is the ideal person to provide continuous support, but if impossible, the midwife should facilitate continuous support. This study investigated the role of the midwife, in facilitating continuous support during childbirth, as part of a larger project aiming to promote continuous support during childbirth.

Objective: The objective of this study was to explore and describe the role of the midwife, providing antenatal and intrapartum care, in facilitating continuous support during childbirth according to the perspectives of midwives working in a selected public hospital and Community Health Centre (CHC) in the North West Province of South Africa.

Design: The study followed an explorative, descriptive and contextual design using a qualitative descriptive research approach to reach the objective of the study.

Method: An all-inclusive sample of the midwives working in one selected public hospital and one CHC in North West Province was used. Face-to-face semi-structured interviews were conducted with 14 midwives, seven from the selected hospital and seven from the selected CHC. Data were analysed qualitatively and presented in a thematic chart.

Findings: Two main categories were identified, each with a number of themes and sub-themes. Facilitating continuous support during childbirth was the first category. The midwife's role in facilitating continuous support during childbirth while providing antenatal and intrapartum care were the underlying themes. The second category identified roles in facilitating continuous support during childbirth with facilitating and impeding/hindering factors related to continuous support during childbirth as themes.

Conclusion: Two main categories with a total of four themes and 20 sub-themes were identified, illustrating the complexity of the issue. A unique finding was the recommendation by participants of mobile phone communication via 'mom-connect' as a way of facilitating continuous support during childbirth. The participants were not familiar with the use of doulas. Recommendations were made for research, education, practice and policy based on the role of the midwife in facilitating continuous support during childbirth.

Key words: Antenatal care, better birth initiative, childbirth, continuous support during childbirth, intrapartum care, midwifery in South Africa

OPSOMMING

Agtergrond: Deurlopende ondersteuning tydens kindergeboorte is 'n voorbeeld waar die beste praktyk bekend is, maar nie konsekwent toegepas word nie. Die vroedvrou is die ideale persoon om deurlopende ondersteuning te verskaf tydens kindergeboorte, maar indien dit onmoontlik is, behoort die vroedvrou deurlopende ondersteuning te fasiliteer. Hierdie studie het die rol van die vroedvrou ondersoek in die fasilitering van deurlopende ondersteuning, as deel van 'n groter projek met die doel om deurlopende ondersteuning tydens kindergeboorte te bevorder.

Doelwit: Die doel van hierdie studie was om die rol van die vroedvrou, wat voorgeboorte en intrapartumsorg verskaf, in die fasilitering van deurlopende ondersteuning gedurende kindergeboorte te ondersoek en te beskryf.

Ontwerp: 'n Verkennende, beskrywende en kontekstuele navorsingsontwerp is gevolg met 'n kwalitatiewe beskrywende benadering om die doelwit van die studie te bereik.

Metode: 'n Alles-insluitende steekproef van vroedvroue werksaam in een geselekteerde publieke hospitaal en een gemeenskapsgesondheidsentrum in die Noordwes Provinsie is gebruik. Aangesig-tot-aangesig semi-gestruktureerde onderhoude is gevoer met 14 vroedvroue, sewe van die geselekteerde hospitaal en sewe van die gemeenskapsgesondheidsentrum om data in te samel. Die data is kwalitatief geanaliseer en voorgestel in 'n tematiese kaart.

Bevindinge: Twee hoofkategorieë is geïdentifiseer, elk met 'n aantal temas en sub-temas. Die eerste kategorie is geïdentifiseer as die fasilitering van deurlopende ondersteuning tydens kindergeboorte. Die vroedvrou se rol in die fasilitering van deurlopende ondersteuning terwyl voorgeboorte en intrapartumsorg voorsien word, was die onderliggende temas. Die tweede kategorie identifiseer die rolle in die fasilitering van deurlopende ondersteuning gedurende kindergeboorte. Faktore wat deurlopende ondersteuning fasiliteer en belemmer tydens kindergeboorte is geïdentifiseer as onderliggende temas.

Gevolgtrekking: Twee hoofkategorieë met 'n totaal van vier temas en 20 sub-temas is geïdentifiseer wat die kompleksiteit van die navorsing illustreer. 'n Unieke bevinding is die aanbeveling deur die deelnemers dat mobiele telefoonkommunikasie via "mom-connect" 'n manier is om deurlopende ondersteuning tydens kindergeboorte te fasiliteer. Dit is ook bevind dat die deelnemers nie bekend is met die gebruik van "doulas" nie. Aanbevelings is gemaak vir navorsing, opleiding, praktyk en beleidvorming gebaseer op die rol van die vroedvrou in die fasilitering van deurlopende ondersteuning.

Sleuteltermes: Voorgeboorte sorg, beter geboorte inisiatief, kindergeboorte, deurlopende ondersteuning gedurende kindergeboorte, intrapartum sorg, verloskunde in Suid-Afrika

ABBREVIATIONS

ANC	Antenatal care
BBI	Better Birth Initiative
CEO	Chief Executive Officer
CHC	Community Health Centres
DCST	District Clinical Specialist Team
DHT	District Health Team
DoH	Department of Health (of South Africa)
DOSA	Doula Organisation of South Africa
HREC	Human Research Ethics Committee
ICM	International Confederation of Midwives
IYCN	Infant & Young Child Nutrition
MDG	Millennium Development Goals
NDoH	National Department of Health (of South Africa)
NICE	National Institute for Health and Care Excellence
NMM DHER	Ngaka Modiri Molema District Health Expenditure Review
NWP	North West Province
NWU	North-West University
PHC	Primary Health Care
SA	South Africa
SANC	South African Nursing Council
SCC	Safe Childbirth Checklist
SDG	Sustainable Development Goal

SMS	Short Messaging Service
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Emergency Fund
WHO	World Health Organization

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CHAPTER 1: GROUNDING OF THE RESEARCH

1.1 INTRODUCTION

It is important to implement best practices to ensure a high quality of care. Continuous support during childbirth can be seen as an example where best practices are known but not consistently implemented. According to the recent Cochrane review (Bohren *et al.*, 2017:2), continuous support during childbirth has numerous advantages and no identified adverse effects. Unfortunately, continuous support during childbirth is the exception rather than the rule in public hospitals and Community Health Centres (CHC's) in the North West Province (NWP) of South Africa, as observed by the researcher.

For the purpose of this study, continuous support during childbirth is defined as one-to-one support throughout the childbirth process, starting early in labour, by a support person of choice. A midwife (meaning 'with woman') is the ideal person to provide continuous support (Aune *et al.*, 2014:90). However, if this is impossible, then the midwife should facilitate continuous support provided by another suitable person. This study investigated the role of the midwife in facilitating continuous support during childbirth. This could lead to the promotion of continuous support during childbirth, enhancing maternal and neonatal outcomes.

This chapter presents the background, rationale and problem statement. This is followed by the aim and objectives, the research design and methods and finally the strategies to enhance the rigour of the study, as well as the ethical considerations that were addressed during the course of the current study.

1.2 BACKGROUND

A complete discussion on continuous support during childbirth will follow in chapter 2. Continuous support during childbirth is an undisputed best practice. A recent Cochrane review (Bohren *et al.*, 2017:1-98), expanded on a previous review by Hodnett *et al.* (2006), which had been updated during 2013 (Hodnett *et al.*, 2013). This review by Bohren *et al.* (2017:95-96) reported that women, who received continuous support during childbirth, were significantly more likely to have a spontaneous vaginal birth, less likely to need intrapartum analgesia, or to report dissatisfaction with their intrapartum care, than women who did not receive continuous support. Their intrapartum stages were shorter, and they were less likely to have caesarean sections or instrumental vaginal births, or babies with low APGAR scores five minutes after birth. Other advantages included that continuous childbirth companionship enhanced the woman's memory of the birthing experience, improved the mother's management and coping strategies during the

active stages of childbirth, improved mother-baby bonding, and improved breastfeeding (Albers, 2007:208; Zhang *et al.*, 1996:739).

Even if a midwife cannot provide optimal support herself, because she might have to provide clinical care to several women simultaneously, she could encourage other people to provide continuous support. One such a person could be a doula, specifically trained to focus on support during childbirth who could be part of the hospital staff or be in private practice and specifically contracted to support a woman during the intrapartum period (Green *et al.*, 2007:27). Another solution could be a relative, such as a mother, mother-in-law or sister, as female companionship during childbirth. Although the infant's father might be present, he might not be the ideal support person as he might experience emotional, psychological and physical support needs himself, rendering him unable to focus on the new mother's needs (Iliadou, 2012:386).

The focus must be on the needs of the woman during childbirth. The Cochrane review, that included 27 trials involving 15858 women (Bohren *et al.*, 2017:2), concluded that "... continuous support from a person who is present solely to provide support, is not a member of the woman's social network, is experienced in providing labour support, and has at least a modest amount of training, appears to be most beneficial". Bohren *et al.* (2017:15) further found that the birth outcomes were better when the support person was female and not part of the hospital staff.

1.3 PROBLEMSTATEMENT

Despite research evidence about the benefits of continuous support during childbirth, women might have to go through the process of giving birth without continuous support. Continuous support during childbirth is the exception rather than the rule (Bohren *et al.*, 2017:2; Brown *et al.*, 2007:7), both in South Africa and worldwide. Spencer (2013:4) observed that continuous support during the intrapartum period is uncommon in public hospitals in the NWP.

Ideally, a woman's midwife should provide care and support throughout the entire maternity episode (pregnancy, childbirth and the postpartum period) free of organisational constraints, and with sufficient time to provide all the elements of supportive care (Rala, 2013:152). However, the limited number of midwives and South Africa's health system, pose extreme difficulties to render this kind of midwifery care. One-to-one support, during established labour by a midwife, is seldom possible in the public health care sector in South Africa.

If the midwife cannot provide continuous support in these circumstances, then the midwife should facilitate continuous support by other competent persons. Such facilitation occurs when midwives, providing care during the antenatal and/or intrapartum period, fulfil their roles as educators and advocates in addition to those of clinicians. Limited research has been done on

the role of midwives in facilitating continuous support during childbirth. This study could contribute to addressing the knowledge gap and to promote continuous support during childbirth.

The background information lead to the following research question:

What is the role of the midwife, providing antenatal and intrapartum care, in facilitating continuous support during childbirth according to the views of midwives working in one selected public hospital and one community health centre (CHC) in the NWP?

1.4 AIM AND OBJECTIVES

The aim of this study (with others in a larger project) was to promote continuous support during childbirth in public hospitals in the NWP.

The objective of Spencer *et al.*, (2018:1025), one of the other studies in the larger project, was to identify challenges encountered in implementing continuous support during childbirth in public hospitals in the NWP of South Africa.

The objective of this study was:

- To explore and describe the role of the midwife, providing antenatal and intrapartum care, in facilitating continuous support during childbirth according to the views of midwives working in one selected public hospital and one selected CHC in the NWP.

1.5 PARADIGMATIC PERSPECTIVE

The research paradigm is an accepted set of beliefs or values about the nature of reality, how different entities interact with this reality, and how to go about studying them. It therefore guides the research process (Botma *et al.*, 2010:41; Brink *et al.*, 2006:24).

According to Grove *et al.* (2009:57) assumptions are statements that are taken for granted or considered to be true, even though they have not yet been scientifically tested.

1.5.1 Meta-theoretical assumptions

Meta-theoretical assumptions refer to the philosophical orientation of the researcher and cannot be tested. They refer to the researcher's beliefs about the person as a human being, society, a discipline such as nursing, the purpose of the discipline, as well as the general orientation about the world and about the nature of research (Botma *et al.*, 2010:187).

The meta-theoretical assumptions underlying this study are based on the Christian faith and include assumptions about man, environment, health and nursing (and midwifery). The philosophical perspectives of the researcher, supported by the Bible, are explained in sections 1.4.1.1 - 1.4.1.4 of this chapter.

1.5.1.1 Man/person

A **person** is seen as a human being biologically, psychologically and socially created by God who functions holistically with a body, soul and spirit. In the context of this study, the concept man refers to a midwife working in the respective maternity units, any person providing continuous support to a woman during different stages of childbirth and the woman receiving such continuous support during childbirth. A person experiences a constant interaction with the environment.

1.5.1.2 Environment

The researcher sees the world through a Christian perspective and thus a God-created planet given to man to cultivate and care for. In this study, this assumption requires the researcher to believe that people (also midwives) should give their best in utilising the available structure and resources to provide the best possible care to women during childbirth.

This is in line with Genesis 1:28 “God blessed them, and God said to them, be fruitful and multiply, and fill the earth and subdue it; and have dominion over the fish of the sea and over the birds of the air and over every living thing that moves upon the earth” (Bible, 2007 NLT). This structure and environment must be utilised in the best possible way to promote continuous support during childbirth.

1.5.1.3 Health

Health is seen as a continuum of functioning. Health does not only imply/indicate/describe the absence of illness or disease but is a state of spiritual, mental and physical wholeness and well-being (World Health Organisation [WHO], 2006). Optimum health can be promoted by providing continuous support during childbirth. Facilitation of continuous support can also prevent illnesses.

1.5.1.4 Nursing and midwifery

Nursing (and midwifery) can be seen as both a profession and a calling. Matthew 7:12 states the following: “So in everything, do to others what you would have them do to you, for this sums up the Law and the Prophets” (Bible, 2007 NLT). In the context of this study the midwife will provide or facilitate the best possible support to women during childbirth. The art of midwifery

will be used to promote continuous support by giving the best possible continuous support by the person **(man)** in the context of support with the available resources **(environment)** to promote well-being **(health)** of the women **(man)** during childbirth.

1.5.2 Theoretical assumption

Theoretical assumptions reflect on the researcher's valid knowledge of theoretical or conceptual framework (Botma *et al.*, 2010:187). The theoretical framework adopted for the current study was based on the philosophy and model of midwifery care of the International Confederation of Midwives (ICM, 2014). The ICM describes key roles of the midwife that are unique to midwifery-based care. The ICM's philosophy of care states that midwives believe that midwifery care takes place in partnership with women and is personalised, continuous and non-authoritarian. As a result, midwifery care actively promotes and protects women's wellness (during pregnancy, childbirth and postpartum) and enhances the health status of their babies.

1.5.3 Central theoretical argument

The formulation of recommendations to promote the midwives' role in facilitating continuous support during childbirth, could promote continuous support during childbirth in public hospitals in the NWP.

1.5.4 Theoretical concept clarifications

Concepts of importance to this study will be briefly discussed in this section, as they might have different meanings and interpretations or connotations in different settings or contexts.

- **Facilitating/facilitation:** The process of making something less difficult or assisting in a certain process (Merriam-Webster's Medical Dictionary, 2007). Facilitation in this study implies actions a midwife can take to implement continuous support during childbirth.
- **Continuous support during childbirth:** Continuous support, for the purpose of this study, is defined as providing one-to-one support to a woman by a support person of choice, uninterrupted throughout the childbirth process starting early during this process (Bohren *et al.*, 2017:2). Continuous support in this study implies constant care throughout the childbirth process by a support person chosen by a woman in labour.
- **Midwife:** A midwife is someone who has been well trained to attend to the needs of women and new-born babies during pregnancy, during birth and after birth. She can fulfil a variety of roles: clinician, client advocate, and health educator. The ICM (2014) defines a midwife as a specifically educated and trained proficient person who has the necessary licensure or registration according to legislation applicable in her country of practice. Midwives work in

different settings: women's homes, communities, Antenatal clinics, hospitals and maternity centres (ICM, 2014). The scope of practice in the Nursing Act 33 of 2005 rule 786 states that the midwife should provide continuous support and care to a woman, her child and family throughout all stages of pregnancy, labour and the puerperium (South African Nursing Council [SANC], 2005).

1.5.5 Methodological assumptions

Methodological assumptions refer to the researcher's beliefs about good scientific practice (Botma *et al.*, 2010:188). The Botes Model (Botes, 1991:19) of Research in Nursing, based on the basic concepts of social research (Mouton & Marais, 1988:192-195), was applied to the current study. This model introduces three orders of nursing activities. Table 1.1 illustrates the relationship between philosophy and nursing practice (Botes, 1991:23).

Table 1.1 Relationship between philosophy and nursing practice

Third order	The philosophy of nursing (Meta-theoretical activity)
Second order	Nursing Science (Methodological activity/ the practice of science)
First order	Reality The nursing practice (pre-science interpretations)

The first order is the practice of the discipline namely nursing practice. In this study, the reality is midwifery practice. This is where the problems are identified, and research conducted. The source of the current study's research topic, namely the facilitation of continuous support during childbirth, originated from the first order or midwifery practice.

The second order, the theory of nursing, refers to the research process. In the current study, the research process includes the setting of aims and objectives to guide the study to understand the role of the midwife in facilitating continuous support during childbirth.

The third order, the paradigmatic perspective of the researcher, connects the beliefs that were discussed on meta-theoretical level in section 1.4.1 of this dissertation to the study at hand.

1.6 RESEARCH DESIGN

The research design will be briefly introduced in this section, but will be discussed in more detail in chapter three. This study adopted an **explorative**, **descriptive** and **contextual** design using

a **qualitative** research approach to explore and describe the role of the midwives who provide antenatal and intrapartum care, about the facilitation of continuous support during childbirth.

An **explorative design** was suitable to explore the perspectives of the midwives regarding their role in the facilitation of continuous support during childbirth (Brink *et al.*, 2006:102) as the perspectives of midwives in this area of research are still relatively new. The adopted research approach was **descriptive** as it described the everyday term of continuous support during childbirth, based on facts relevant to the topic (Sandelowski, 2000:334). The study was also **contextual** in nature because the results were specific to a level one hospital and a CHC in a specific district of the NWP and therefore could not be generalised to other settings, without repeating similar studies in other settings. The study was **qualitative** as the data were collected by conducting semi-structured individual interviews, using words to gain a detailed picture about the midwives' perceptions concerning their role in facilitating continuous support during childbirth in their natural settings. The setting was not manipulated or controlled (Botma *et al.*, 2010:208; Sandelowski, 2000:334).

1.7 RESEARCH METHOD

The research method will be briefly introduced in this section, but it will be discussed in more detail in chapter 3. In this section the context, population, sampling, data-collection and data-analysis will be discussed.

1.7.1 Context

The research was conducted in the Ngaka Modiri Molema District of the NWP, the fourth smallest province of the nine South African provinces, comprising 8.7% of the country's land (South Africa [SA], 2012:18). The Ngaka Modiri Molema District, one of four districts of the NWP, is mostly rural in nature and comprises the following municipalities, Ditsobotla, Mahikeng, Ratlou, Tswaing and Ramotshere Moiloa (see Figure 1.1). The district is situated in the extreme North Western part of the NWP, bordering Botswana. The district covers a total of 116 320 km². There are approximately 92 villages in the district with a population of 869 112 in 2014/2015. The population distribution is 5% urban and 95% rural (Ngaka Modiri Molema District Health Expenditure Review [NMM DHER] 2014/15:10).

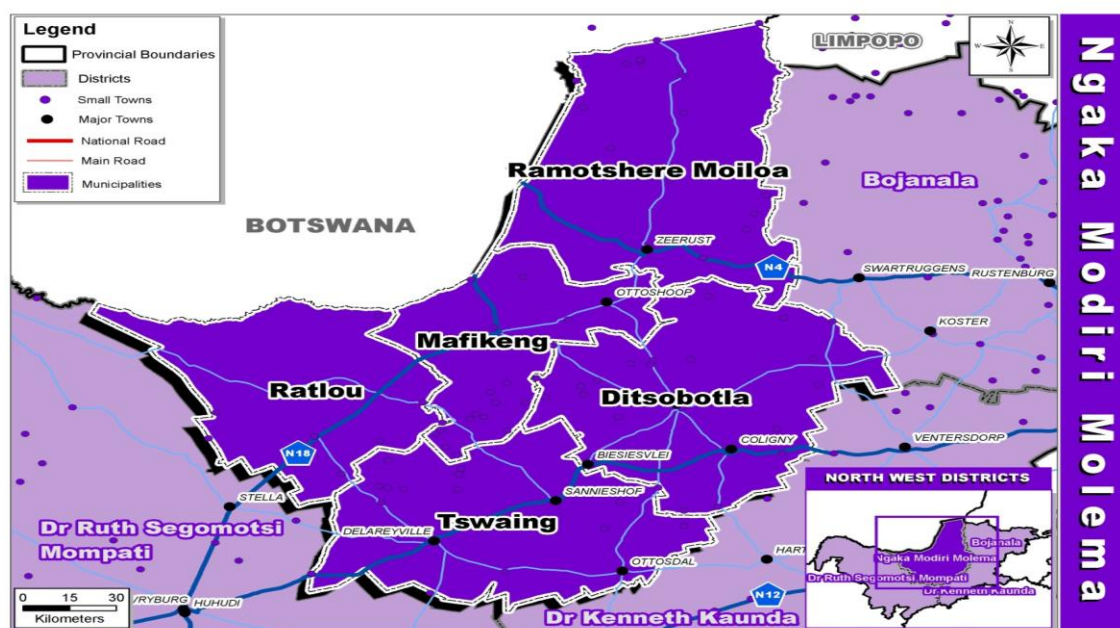


Figure 1.1 Map of the North West Province's Districts

One district hospital and one CHC in the NWP were used for data-collection. The participating hospital is situated in a rural area. Eighteen midwives were working in the hospital's maternity units and attended to 2258 births in a year period between 2014-2015, according to the 2014/2015 statistics accessed through the hospital's records. The hospital is the referral hospital for 13 clinics and three CHCs. This hospital provides ANC as well as intrapartum care and also has a high-risk ANC clinic.

The selected CHC is also situated in a rural area in the Ngaka Modiri Molema district. This centre provides both antenatal and intrapartum care. A total of 18 professional nurses/ midwives worked in the CHC, attending to pregnant women, while seven midwives specifically work in the maternity unit. These midwives attended to 588 births in a year period between 2014-2015, according to the 2014/2015 statistics that were directly accessed from the hospital records.

1.7.2 Population and sampling

The target population comprised midwives providing care to women during the antenatal or intrapartum period who were working in one district hospital and one CHC in the NWP. It would have been ideal to include more hospitals in the sample but due to time and budget constraints, this was impossible. All the midwives who complied with the inclusive selection criteria comprised the all-inclusive sample.

1.7.3 Data-collection

The researcher conducted face-to-face, semi-structured individual interviews. The semi-structured interviews were voice-recorded and transcribed verbatim for the purpose of data-analysis. Field notes were taken directly after each interview. The researcher continued with the interviews until data-saturation had been reached. The following interview schedule was used:

Introductory question:

Who do you think can provide continuous support to a woman during childbirth?

The follow-up interview questions were:

1. What are your views on the role of the midwife, providing antenatal care, in facilitating continuous support during childbirth?
2. What are your views on the role of the midwife, providing intrapartum care, in facilitating continuous support during childbirth?
3. What are your views regarding advocacy for continuous support during childbirth?
4. What facilitates continuous support during childbirth?
5. What hinders continuous support during childbirth?

1.7.4 Data-analysis

After the interviews were transcribed, data were analysed thematically to identify, analyse and report themes from the data (Braun & Clarke, 2006:77). A thematic chart was constructed and key words and phrases used by the participants were entered under the main themes and categories. The researcher and co-coder analysed the data independently and had a discussion to reach consensus about the identified themes and categories.

1.8 RIGOUR

Trustworthiness is applicable to this study and was enhanced by applying the following epistemological standards: truth value, applicability, consistency and neutrality with a fifth standard of authenticity (Botma *et al.*, 2010:232). The criteria and strategies that were followed to adhere to the rigour of a qualitative study will be explained in chapter 3.

1.9 ETHICAL CONSIDERATIONS

Respect, justice and beneficence guided the adherence to ethical practice during the research process. The principle of respect was emphasised in the recently updated South African document on “Ethics in Health Research” (Department of Health [DoH], 2015:15). The participants had the right to participate with self-determination. The participants were treated with dignity and their safety, well-being and best interest were protected at all times. Pseudonyms were used for all the participants in the collected data, which ensured that individual participants’ contributions to the interviews could not be identified. The participants were free to withdraw at any time without incurring any negative consequence whatsoever. An information session was held at a time convenient to the participants. Informed consent forms were used to ensure voluntary participation.

Conducting research requires honesty and integrity in order to recognise and protect the rights of human subjects. Grove *et al.* (2009:159) list these rights as the right to self-determination, the right to privacy, the right to anonymity and confidentiality, the right to fair treatment and the right to protection from discomfort.

After obtaining approval from the INSINQ Focus Area Scientific Committee and the Human Research Ethics Committee (HREC) of the North-West University (NWU), goodwill permission was obtained from the following persons before data-collection commenced:

- The Director: Policy, Planning, Research, Monitoring and Evaluation of the Department of Health in the NWP;
- Managers of the participating facilities.

1.10 THE DISSERTATION’S STRUCTURE

Chapter 1: Grounding of the research

Chapter 2: Literature review on providing continuous support during childbirth

Chapter 3: Research methodology

Chapter 4: Findings and discussion

Chapter 5: Conclusions, limitations and recommendations

1.11 SUMMARY

This first chapter presented an overview of the study. The chapter subsequently elaborated on the background, rationale and problem statement, followed by a research question. It presented the aim, objectives and paradigmatic perspective. This was followed by a brief description of the research design and research methodology. Finally, the discussion addressed rigour and ethical considerations relevant to the current study. Chapter two will present a detailed literature review on providing and/or facilitating continuous support during childbirth.

CHAPTER 2: LITERATURE REVIEW ON PROVIDING CONTINUOUS SUPPORT DURING CHILDBIRTH

2.1 INTRODUCTION

This chapter aims to provide a detailed literature review, where the concept and components of continuous support during childbirth will be clarified as well as a consideration of persons who could provide continuous support during childbirth. The barriers and facilitators to providing continuous support during childbirth will be addressed. The important role of the midwife, in facilitating continuous support during childbirth that emerged from different studies, will also be discussed. Grove *et al.* (2009:97) defined a literature review as an organised written presentation of what has been published on a topic by scholars, including a presentation of research conducted in the selected field of study. The literature review thus provides scientific background to the study.

The literature study aimed to identify existing knowledge, related to continuous support during childbirth, in order to expand upon such knowledge. Gaps, identified in previous research reports, could set the tone for the current study focussing specifically on the South African context.

2.2 LITERATURE SEARCH STRATEGY

The initial search keywords were continuous support, midwife/midwives, labour/labor and childbirth. The searches were done on the Google Scholar, EbscoHost, Science Direct and Cochrane databases. Articles published in English dated from 1998 to 2017 were used to gain insight into the latest available relevant literature. Although mainly primary sources were used, in certain cases textbooks were also used for concept clarification. Relevant statement documents from organisations such as the DoH, WHO and ICM were also included. The literature study was an ongoing process from January 2015 to October 2017 with the assistance of a librarian from the NWU.

2.3 CONTINUOUS SUPPORT DURING CHILDBIRTH AS A CONCEPT

In this section, an overview of continuous support during childbirth will be described by clarifying the concept continuous support, discussing the components of support as well as the persons that could provide continuous support. In conclusion, the barriers and facilitators that might influence the provision of continuous support will be discussed.

2.3.1 Concept clarification

The concept of women being cared for during childbirth dates back to the beginning of time. Studies on continuous support during childbirth date as far back as 1980 and numerous studies have been conducted since then (Albers, 2007:208).

Childbirth is a huge event in the life of any woman and is influenced by numerous factors. During childbirth there is potential to create bonds and provoke personal transformations. Hence continuous support during childbirth is a practice that was recognised that could enhance the humanisation of the childbirth process (Dodou *et al.*, 2014:263). To enhance the humanisation of childbirth, a model of care is required that provokes emotional and physical support and forms an essential structure of childbirth practices.

Continuous support during childbirth can be regarded as being non-pharmacological and non-medical care of a woman throughout the childbirth process. “Continuous” is defined as “without interruption”. This continuous support should be one-to-one care and should preferably be provided by a support person of choice. Such a support person could be a lay or trained person but such support should commence early during the childbirth process. Every woman should ideally receive one-to-one support during established childbirth unless the woman requests privacy (Bohren *et al.*, 2017:2; Simkin & Bolding, 2004:490; National Institute for Health and Care Excellence [NICE], 2015). The WHO (2006) recommends continuous support rendered by a person to improve labour outcomes and enhance women’s satisfaction with health services.

The physiology of the childbirth process supports the need of continuous support during childbirth. When a woman encounters stress during childbirth, the increased stress hormones (catecholamines) decrease the uterine contractility and also decrease placental blood flow. Hence women who receive continuous support during childbirth might be empowered and be in better control of the childbirth process compared to their counterparts without continuous support (Rosen, 2004:24; Lothian, 2004:4).

Evidence from a Cochrane review by Bohren *et al.* (2017:2) indicates that continuous support during childbirth has numerous measurable positive impacts on key birth outcomes when compared to intermittent support. Continuous support during childbirth is associated with using less pharmacological analgesia, performing fewer caesarean sections and surgical birth interventions, increased numbers of normal births, reductions in the duration of labour and/or increased levels of satisfaction with health services during childbirth. The quality of continuous support can outweigh other components of the birthing experience, including the number of medical interventions, pain relief and birth method. Continuous support may include helping the woman to avoid and/or reduce pharmacological pain relief interventions if that is her preference,

or helping her to choose the best option available to her (Bohren *et al.*, 2017:2; Enkin *et al.*, 2006:269; Zhang, 1996:740;). Continuous support during childbirth contributes to the overall physical and emotional well-being of the woman and therefore raises the self-esteem of the woman giving birth leading to better birth outcomes and a better birth experience (Dodou *et al.*, 2014:263).

2.3.2 Components of support during childbirth

The four categories of support that should be provided to women during childbirth are **emotional** support; **informational** support; **physical** support and **advocacy** (NICE, 2015; Larkin & Begley, 2009:50; Bowers, 2002:742; Bäckström & Wahn, 2011:67). These categories of continuous support behaviours are illustrated in Figure 2.1 (Bianchi & Adams, 2013:25).

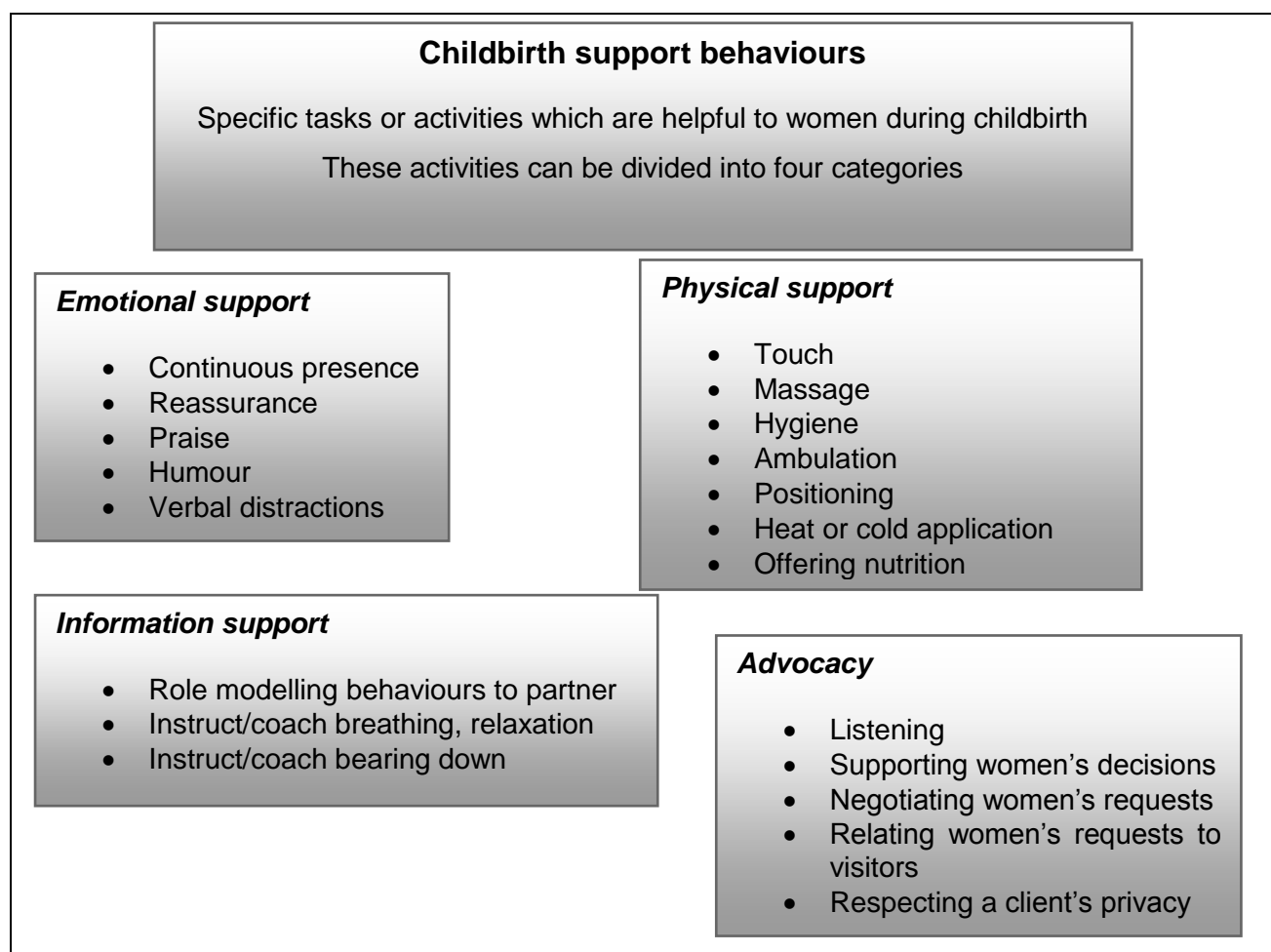


Figure 2.1 Four categories of support during childbirth

Emotional support can reflect the woman's experience of care. These activities can include eye contact, reassurance, encouragement, guidance and praise (Enkin *et al.*, 2006:267). Support not only includes a presence but requires specific support behaviours from the support person.

Information support and advice may reduce anxiety and fear that might contribute to adverse effects during labour. Information support includes listening to women's views, instructing them to breathe correctly and to relax as well as informing women about routines, procedures and progress. Many aspects of the hospital environment could induce stress. The setting and the staff members might be strange to the patient. This could be addressed by educating and orientating the woman continuously throughout pregnancy and the childbirth process (Enkin *et al.*, 2006:269) by providing information and advice, anticipatory guidance and explanation of procedures. In this way women could be empowered to make informed decisions. Effective educational activities should commence early during pregnancy and be sustained until after the infant's birth.

Physical support can include physical comforting, assistance in carrying out coping techniques, using touch, massaging - hot and cold, hydrotherapy, positioning and movement as well as promoting adequate fluid and energy intake. In addition to emotional comfort the woman should also be physically comfortable at all times (Declerq *et al.*, 2006:30). These comfort measures should be provided in response to the individual woman's unique needs and wishes and might vary from culture to culture and from individual to individual (Enkin *et al.*, 2006:268).

Advocacy includes assisting the women to make informed choices, being the client's voice when required and assisting during conflict resolution. The support person should provide guidance to the woman and her partner and facilitate communication, assisting the woman to express her needs and wishes. There is a direct link between information support and advocacy. By giving information and educating the woman in labour, she will be better equipped to make informed decisions. Advocacy during childbirth implies respecting the woman's decisions and helping to communicate her wishes (on her behalf) to the rest of the health care team (Simkin & Bolding, 2004:490; Bohren *et al.*, 2017:3; Albers, 2007:208; Declerq *et al.*, 2006:30).

2.4 PERSONS WHO CAN PROVIDE CONTINUOUS SUPPORT DURING CHILDBIRTH

The central feature concerning the support person is that this should be a person of the woman's own choice (Enkin *et al.*, 2006:267). A survey conducted amongst Russian women, regarding the presence of a companion during labour, reported that due to a wide range of cultural differences impacting on childbirth, a woman should have a choice regarding the presence of a support person (Bakhta & Lee, 2010:201).

Persons who can provide continuous support during childbirth can be divided into three groups: professionals responsible for clinical care, individuals specifically designated to provide support other than clinical care and the woman in labour's partner, family or friends.

A midwife (meaning 'with woman') is the ideal person to provide continuous support during childbirth (Aune *et al.*, 2014:90). If a midwife cannot provide optimal continuous support because she must provide clinical care to several women simultaneously, she can encourage other persons to provide continuous support.

Terms such as doula, labour assistant, birth companion, labour support specialist, professional labour assistant and monitrice refer to support persons who are not involved in clinical care and who are not related to the woman in childbirth (Simkin & Bolding, 2004:490). A doula, a Greek word meaning "woman who serves", is specifically trained to focus on support during childbirth who can be part of the hospital staff or be in private practice and specifically contracted to support a woman during the intrapartum period (Green *et al.*, 2007:27). Doulas differ from other support persons because they are solely committed to being with the woman during childbirth 100% of the time (Bianchi & Adams, 2013:24). Doulas can undergo formal or informal training but they are not trained to perform clinical tasks. A midwife can also act as a doula if the clinical tasks are left to another midwife. Informal training includes working alongside an experienced doula and formal training includes going for formal training sessions and being certified by an organisation such as the Doula Organization of South Africa (Doula Organisation of South Africa [DOSA], 2011).

Another solution could be a female relative, such as the woman's mother, mother-in-law or sister. In a study done in Jordan, a developing country similar in many aspects to South Africa, data were collected by conducting interviews (Kresheh, 2010:22). In the non-randomised comparison study, the intervention group received support during childbirth from a female relative, while the control group received usual care without specific support during childbirth. They concluded that childbirth support provided by a female relative was a beneficial practice and improved the women's feelings about their childbirth experiences. Benefits of support during childbirth included that women who had support were less likely to need pharmacological pain relief interventions and therefore had better birthing experiences than their counterparts without such support. The female companions in that study (Kresheh, 2010:23) did not need formal training but might lack reliability and commitment. Madi *et al.* (1999) conducted a randomised controlled trial in Botswana among primigravida women. A female relative, who did not receive any training in providing labour support, was paired with a woman during childbirth. The results indicated reductions in the number of caesarean sections, anaesthesia/analgesia uses, amniotomies, vacuum extractions and oxytocin uses for labour augmentation in the group who received continuous support.

The father of the infant might sometimes also be present during childbirth. However, the father might not necessarily be the ideal support person for the mother, as he might experience his own emotional, psychological and physical support needs, rendering him incapable of focussing

on the new mother's needs (Iliadou, 2012:386; Kresheh, 2010:22). A study conducted in Nepal that involved 231 women (Sapkota *et al.*, 2013:1270), concluded that women should be accompanied by their husbands during the intrapartum period. This will lead to reduced maternal anxiety and lower levels of depression, overall enhancing the emotional well-being of the women.

Although support by a family member or significant other proved beneficial for women in childbirth, Bohren *et al.* (2017:2) concluded from syntheses of results from 27 trials that "continuous support from a person who is present solely to provide support, is not a member of the woman's social network, is experienced in providing labour support, and has at least a moderate amount of training, appears to be most beneficial". The review also found that the outcomes were better when the support person was female and not a member of the hospital staff (Bohren *et al.*, 2017:2).

2.5 FACTORS INFLUENCING CONTINUOUS SUPPORT DURING CHILDBIRTH

There are certain factors that influence continuous support during childbirth in positive or negative ways. These influencing factors will be discussed under barriers and facilitators of continuous support during childbirth.

2.5.1 Barriers impacting on the provision of continuous support during childbirth

Despite research evidence that continuous support during childbirth enhances birth outcomes, these practices might not be implemented and some facilities might not permit the presence of a support person during the birthing process.

Research on the implementation of support during labour in South Africa was done as part of the 'Better Birth Initiative' (BBI) that was introduced to maternity staff through a multi-dimensional educational intervention (Smith *et al.*, 2004:117). In a pilot randomised control trial, Brown *et al.* (2007:7) reported an initial positive response from staff to the childbirth companion intervention. However, there was no difference between intervention and control hospitals in relation to whether a companion was allowed by nurses, or other evidence-based practices like encouraging movement, fluid and food offered, or humane care. The study was done in 10 public hospitals where 200 women in each hospital had been surveyed. They concluded that most women who gave birth in South African public hospitals at that time did not have continuous companionship during childbirth (Brown *et al.*, 2007:7).

A study in the NWP (Spencer *et al.*, 2018:1025), reported that focus group interviews revealed that midwives were knowledgeable about intrapartum support. However, organisational and personal challenges prevented them from implementing such support for women during

childbirth. At organisational level, challenges included human resources, policies and guidelines as well as the architectural outlay of the maternity units. The personal challenges related to communication issues and attitudes of nurses, patients and their families. Carlton *et al.* (2009:51) also reported inadequate nurse-patient ratios due to staff shortages posed a barrier to the provision of continuous support during childbirth. Other barriers identified by Carlton *et al.* (2009:53-54), who conducted their study at four different birthing centres, included system barriers, provider barriers, linguistic barriers and maternal barriers. The study conducted by Diniz *et al.* (2014) in Brazil amongst 23 940 women, concurred with Carlton *et al.*, (2009) that maternal and institutional factors played a role in the implementation of continuous support during childbirth.

2.5.1.1 System-related barriers

System-related barriers include institutional policies and protocols, staffing ratios and infrastructure.

A low midwife to patient ratio, implies limited time available to provide quality care, making it difficult to provide one-to-one care (Carlton *et al.*, 2009:53) as required for rendering continuous care during childbirth.

Four studies (Carlton *et al.*, 2009; Diniz *et al.*, 2014; Brown *et al.*, 2007; Spencer *et al.*, 2018) reviewed barriers impacting on the implementation of continuous support during childbirth and reported unfavourable midwife-patient ratios to be an important barrier. The ICM Triennial Report (ICM, 2014:19) highlighted a global shortage of health professionals attending to women during childbirth. This report also stipulated that at least 57 countries were experiencing staff shortages and that approximately four million additional health workers were required to meet the demands of health services (ICM, 2014:19).

The ideal ratio of midwife per population, or staffing norms per patient, could be difficult to determine as numerous compounding factors could impact on such calculations (NICE, 2015:6, United Nations Population Fund [UNFPA], 2014:10). Worldwide there is a shortage of midwives attending to the large number of births, the ratio being one midwife to 289 births per year. With regard to maternity care in general (including ANC), the guidelines of the NICE (2015:15) of the United Kingdom recommended calculating the desired number of midwives for a specific service considering factors like the historical data about the number and care needs of women who had accessed the maternity services over a sample period (for example, the preceding 12 months). Other aspects like the women's risk factors, acuity and dependency, the estimated time taken to perform all routine maternity care activities, the skills mix available as well as the number of

adverse events that occurred must also be considered (NICE, 2015:13). However, one-to-one care is considered essential for women in established labour.

The NICE guidelines recommended that the calculations for the midwifery staffing establishment should be based on the historical average maternity hours multiplied by the predicted maternity service demands. This would indicate the total number of predicted maternity care hours required. In the district hospital that participated in the current study, during 2014/2015 the number of births was 2 258 births. This creates a ratio of 1:125 midwives to births per year if the 18 midwives available were being considered. In the participating CHC the number of births was 588 with four midwives, implying a ratio of 1:147 midwives to births per year.

In South Africa the ideal staffing establishment is difficult to calculate because the midwife must perform numerous other duties, besides assisting women during childbirth.

2.5.1.2 Provider-related barriers

Provider-related barriers refer to the practice of practitioners (midwives) aiming to satisfy other members of the healthcare teams' expectations. It is a challenge to provide optimal care to the mother and the infant and at the same time comply with all the expectations of different healthcare team members. Some midwives might consider analgesia to be essential and that women cannot handle childbirth, compromising their supportive skills (Carlton *et al.*, 2009:53). The unit culture plays a significant role especially in the case of less experienced midwives. The unit culture and peer pressure could influence the passing on of trends and attitudes (towards continuous support) to new staff members in a unit.

2.5.1.3 Linguistic barriers

Linguistic barriers refer to language barriers occurring if the woman and the care provider do not understand each other's languages, especially when the understanding of exact needs and wishes are affected. The use of an interpreter could be time consuming (Carlton *et al.*, 2009:53) and expensive.

2.5.1.4 Maternal barriers

Maternal barriers include unrealistic expectations of some women. These women might be inadequately prepared emotionally and physically before the childbirth process started and they might be influenced by their families (Diniz *et al.*, 2014: S1). Socio-cultural beliefs of women and their families could also pose a challenge should women question the continuous childbirth support process if they believe that the birthing process should be private or that they should give birth to their babies alone at home (Michael *et al.*, 2006:49).

2.5.2 Facilitators of continuous support during childbirth

The idea that hospital births are safer than home births continues to be supported by some clinical health professionals, hence they want the hospital environment to be clinical. If the facilitating factors would be considered, measures required to promote continuous support during childbirth would become apparent (Enkin *et al.*, 2006:267). The contexts in which the research of Carlton *et al.* (2009) and Diniz *et al.* (2014) were conducted differ from that of the current study, but some of these barriers and facilitators could also be applicable to the South African context.

2.5.2.1 Interpersonal factors

Interpersonal factors refer to the relationship between the mother and the midwife or any other support persons. Women appreciate a trusting relationship with the midwife during childbirth. Being physically present during childbirth does not necessarily mean that the woman's needs have been understood. The support person should show personal, interpersonal and empathetic characteristics which will establish a trusting relationship and therefore facilitate continuous support during childbirth (Dahlberg *et al.*, 2015:408; Borrelli *et al.*, 2016:108).

2.5.2.2 Environmental factors

Environmental factors refer to a conducive environment, which is important for the successful implementation of continuous support during childbirth. A conducive environment can be referred to as a platform to provide optimal care for the mother and the infant which will lead to the facilitation of continuous support during childbirth (Carlton *et al.*, 2009:51).

The architectural outlay of the unit must also be conducive to ensure space and privacy for a birth companion to provide continuous support during childbirth. A homelike environment will enhance the midwife's ability to provide continuous support (Lothian, 2014:6).

2.5.2.3 Institutional factors

Institutional factors refer to the institutional-related initiatives, policies procedures and protocols and whether they support the implementation of continuous support during childbirth. The optimal use of initiatives like mom-connect and BBI could enhance the implementation of continuous support during childbirth (Smith *et al.*, 2004:117; Brown *et al.*, 2007:7).

If the formulation and implementation of policies and procedures are in place in a unit it will facilitate continuous support during childbirth. A study that was done in Brazil regarded the presence of a companion to be so important that a law by the name of the "Companion Law"

was promulgated to oblige health services to ensure that a support person of the mother's choice should be present during childbirth (Brüggemann *et al.*, 2014:270).

The National Guidelines for Maternity Care in South Africa (SA, 2016:41-42) state that family and friends should be allowed to provide companionship during labour and that companionship should be promoted but no provision is made in the official maternity case record to record these actions.

2.6 THE ROLE OF THE MIDWIFE IN FACILITATING CONTINUOUS SUPPORT DURING CHILDBIRTH

Midwives play a vital role in promoting a normal birth and positive birth experience. The midwife could facilitate continuous support during childbirth through advocacy and education.

The midwife's advocacy role is central to midwives' practice (Dahlberg *et al.*, 2015:408; Hadjigeorgiou & Coxon, 2014:983). Advocacy comprises part of the midwives' ethical obligations that are sometimes taken for granted. The childbirth process is a unique process compared to other physiological conditions for which assistance are needed. It starts during the antenatal stage and continues until the post-natal period, requiring advocacy by the midwife throughout the different stages. Dodou *et al.* (2014:263) stated that advocacy is part of the midwife's role to provide humanised care. Most pregnant women are healthy individuals capable of making decisions regarding childbirth. However, these women might surrender their autonomy during childbirth because of institutional and personal influences. During childbirth, a woman is in a constant relationship with her unborn infant. The mother is therefore focussing on her unborn infant and needs some advocacy as she might be unable to conceptualise her choices and decisions. By doing this the midwife promotes continuous support and therefore a positive childbirth experience (Simmonds, 2008:361; Dahlberg *et al.*, 2015:408).

In a public maternity setting, where numerous barriers for providing continuous support during childbirth might be encountered, advocacy for continuous support during pregnancy should be sustained. Midwives are the ideal persons to provide this advocacy. A phenomenological study conducted during 2004 in America among midwives asked: "if midwives have such good outcomes, why then are they not the primary providers of women's health care in the United States?" The answers concluded that midwives were negotiators, not dictators. They believed that the power rested within the mothers and not within themselves (Kennedy *et al.*, 2004:15).

Another key way in which a midwife could facilitate continuous support during childbirth is by providing education. It is important to address the knowledge gap between known effective interventions, evidence-based practice and the care delivered. Another way to facilitate continuous support during childbirth is by training others (non-midwives) to provide continuous

support during childbirth (Meyer *et al.*, 2001:57). A study, conducted in Uttar Pradesh, India by Hirschhorn *et al.* (2015:117) evaluated the use of the WHO's Safe Childbirth Checklist (SCC) to train birth attendants. This resulted in behavioural changes occurring even in small facilities encountering multiple challenges (Hirschhorn *et al.*, 2015:117). Coaching of birth attendants could be regarded as being an essential part of the midwives' role in facilitating continuous support. It would also assist the midwife in providing continuous support during childbirth. The midwife would then provide support in a secondary capacity and play a central role in coaching the birth attendant who the woman prefers during childbirth (Hirschhorn *et al.*, 2015:117). The implementation of 'skilled birth attendants' greatly benefits communities with limited or no access to trained professionals, by contributing to decreased maternal mortality rates (Renfrew *et al.*, 2014).

2.7 CONCLUSION

It can be said that continuous support during childbirth does not appear to be practised as often nor as widely as the literature suggest that it should be done. If the apparent benefits of continuous support and the absence of any known risks are considered, every effort should be made to ensure that all women should receive continuous support throughout the childbirth process. Midwife-patient ratios in South Africa have no clearly specified targets. These ratios are inadequate because they are not specifically related to midwives but to nurses in general. Ideally midwives would be the appropriate persons to provide one-to-one continuous labour support but this might be impossible. The midwife should then act in a facilitating role which was further investigated in the current study.

Chapter three presents a detailed account of the research methodology.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research design and methods used to explore and describe the role of the midwife in facilitating continuous support during childbirth. The perspectives of the midwives working in one selected district hospital and one CHC in the NWP were explored and described. The research design describes the paths of logical reasoning followed, while research methods refer to the techniques used to structure a study and to collect and analyse information in a systematic manner (Grove *et al.*, 2009:43; Polit & Beck, 2006:509). The rigour and the ethical considerations that were considered during the study will also be discussed.

3.2 RESEARCH DESIGN

The study followed an **explorative**, **descriptive** and **contextual** design using a **qualitative** research approach (Grove *et al.*, 2009:44; Sandelowski, 2010:77).

The design was **explorative** in nature as the aim of the research was to understand the factors that influenced the phenomenon under study - in this case the perspectives of the midwives regarding their role in facilitating continuous support during childbirth at the selected public hospital and CHC in the NWP (Brink *et al.*, 2006:102).

Qualitative **descriptive** research was used to describe the events in everyday terms of those events (Sandelowski, 2000:334). The researcher aimed to provide a clear picture of the role of the midwife, providing antenatal and intrapartum care, in facilitating continuous support during childbirth, according to the midwives' perspectives.

This research was **contextual** in nature as the focus was on a specific district hospital and one CHC in the NWP and cannot be generalised to other contexts (Brink *et al.*, 2006:64) without repeating the study at other sites.

The study was **qualitative** as the collected data were 'words' used during semi-structured individual interviews to gain a detailed picture about the midwives' perspectives on a specific topic (Botma *et al.*, 2010:208; Sandelowski, 2000:334). In the current study, the topic was the midwives' role in facilitating continuous support during childbirth in the participants' natural setting which was not controlled or manipulated.

3.3 RESEARCH METHODS

The research methods are described in terms of the methods used to collect the sample (sampling), collect the data as well as to analyse the data.

3.3.1 Population and sampling

Sampling refers to the process the researcher uses to select a sample from a population in a way that represents the population of interest, to obtain information regarding a specific phenomenon (Brink *et al.*, 2006:124). Population described in section 1.6.2.

A stepwise process was followed to select the institutions from which the participants were sampled:

1. Selection of Ngaka Modiri Molema District in the NWP;
2. Selection of a sub-district in the Ngaka Modiri Molema District;
3. Selection of Ditsobotla sub-district;
4. Selection of a level one hospital and a CHC.

The selected hospital and CHC were typical of these kinds of institutions in the district.

In order to be included in the current study's sample, the participants had to:

- be registered as midwives with the South African Nursing Council (SANC);
- have at least six months' experience as a midwife;
- be directly involved in providing care to women during the antenatal or intrapartum period;
- be able to communicate in English.

The following persons were not eligible to participate:

- student nurses or other categories of nurses (who were not registered midwives) working in the antenatal or intrapartum units;
- midwives with less than six months' experience;
- midwives not providing care to women during the antenatal or intrapartum periods; and
- persons unable to communicate in English.

An all-inclusive sample was used to select as all the potential participants who were available and gave informed consent until data saturation had been reached.

The sample size was determined by two guiding principles: appropriateness and adequacy (Botma *et al.*, 2010:199). Appropriateness was ensured by the identification of the best suited participants to inform the research, implying providing the information required to meet the current study's objectives. The current study's sample included midwives providing antenatal and intrapartum care in the participating facilities. These persons could provide the best possible information to answer the research question as they were working in the research setting and had everyday knowledge of the topic on hand. There was no apparent reason to believe that the information provided by them would not be reliable.

The adequacy was ensured by gathering sufficient information to reach data saturation. Data saturation could be regarded as the point in research where no new or relevant information emerges (Botma *et al.*, 2010:200). Interviews were conducted until data saturation had been reached when no new information emerged during successive interviews. The research plan determined that at least five interviews would be conducted in each identified facility until data saturation had been reached. No new themes emerged after five interviews had been conducted with both groups from the two participating facilities but two more interviews were conducted with each group to ensure that data saturation had indeed been reached. Therefore a total of 14 interviews were conducted. Table 3.1 portrays the number of midwives eligible for participation in the study, the number of midwives who gave informed consent and the number who had actually been interviewed to reach data saturation.

Table 3.1 Sample used during data-collection

	Number of midwives eligible for participation	Number of midwives who gave consent for participation	Number of midwives who were interviewed
Hospital	18	9	7
CHC	16	10	7
Total number of interviews that were conducted			14

Not all the midwives, who complied with the inclusion criteria, were willing to sign informed consent to participate in the study and were therefore not included in the sample. Furthermore, not all of the midwives who consented to the study were interviewed as data saturation was reached before all the midwives had been interviewed. The midwives who were interviewed at the hospital are referred to as Group 1 and the midwives who were interviewed at the CHC are referred to as Group 2.

3.3.2 Data-collection

Face-to-face semi-structured individual interviews were used to collect data. The different steps that were followed during data-collection will be discussed in this section.

3.3.2.1 Permission to conduct research

Prior to conducting interviews, permission was obtained from relevant authorities to conduct the research. In this section the approval for data-collection, the recruitment of the participants and the information sessions will be discussed.

- **Approval for data-collection**

Permission was firstly obtained from the HREC of the NWU, Potchefstroom Campus (Appendix A). Permission was obtained from the Department of Health of the NWP (Research, Planning and Monitoring Committee) before data-collection commenced (See Appendix B). The study was discussed with the district's Acting Deputy Director and with the District Clinical Specialist Team (DCST). The Department of Health of the NWP granted permission on condition that they would receive an electronic copy of the final research report or a summary of the recommendations which could assist them to improve their services. Permission was then obtained from the Chief Executive Officer (CEO) of the selected hospital and the Sub-District Manager of the CHC (See Appendices C & D). The following documents were provided to the CEO and Sub-District Manager prior to obtaining approval:

- HREC Approval (Appendix A);
- Provincial Department of Health approval (Appendix B);
- Interview schedule (Appendix F).
- **Recruitment of participants**

The participants were recruited with recruitment posters (See Appendix I) on the notice boards in the ANC and intrapartum units of the two participating facilities. The interested participants were then recruited by the communication officer of each facility, inviting them to an information session. He arranged the information sessions on behalf of the researcher and acted as the mediator.

- **Information sessions**

The mediator arranged convenient times with the prospective participants. Eight information sessions were held in the boardroom of the hospital and in the office of the operational manager of the CHC. The researcher explained the purpose of the study and what would be expected

from the participants. Informed consent (Appendix E) was also explained during this session and time was allowed for questions. The researcher answered questions and provided clarity about raised concerns. The following documents were presented to the interested participants:

- Provincial DoH approval (Appendix B);
- CEO/Sub-District Manager approval (Appendices C & D);
- Informed consent document (Appendix E).

The prospective participants had 24 hours to consider their participation. The signed informed consent forms were placed in a box in the office of the communication officer.

3.3.2.2 Interviews

Data were collected during individual, face-to-face, semi-structured interviews conducted with 14 midwives who had signed informed consent forms. A semi-structured interview is a carefully planned interview where the focus is on the collection of data and discussions determined by the researcher (Botma *et al.*, 2010:208). The interview was the best method of data-collection in this case because it provided a broad range of information and could uncover new perspectives (Botma *et al.*, 2010:210; Sandelowski, 2000:338). The planning of the interviews, the conducting of the interviews, the field notes and transcriptions will be discussed in this section.

- **Planning of interviews**

The interviews were conducted by the researcher who had received specific training to acquire interview skills (Brink *et al.*, 2006:152) by means of role play sessions. An interview schedule (Appendix F) was developed, based on the research question and refined with the inputs of subject specialists. The interview schedule could also be referred to as the 'interview protocol' or 'topic guide' comprising a set of three to six predetermined open-ended questions to guide, but not to dictate, the interview (Botma *et al.*, 2010:209). The researcher familiarised herself the interview questions so that she could concentrate during each interview on exactly what the participant was saying.

Arrangements were made with each participant for a suitable time and venue for the interview. The facilities were notified in advance that the researcher would conduct the interviews in the hospital's boardroom and in the office of the CHC's operational manager. These venues were selected because they are private and spacious and were not too hot or too cold. A sign was placed on the door to ensure privacy and avoid disruptions. The chairs were arranged so as not to face each other squarely so that the participant should not be intimidated by the interviewer, but close enough to have a feeling of rapport. There were no interruptions during the interviews (Botma *et al.*, 2010:205).

- **Conducting of interviews**

Biographical information was collected when the interview started to make the participants feel at ease. The following biographical information was obtained and recorded on the field notes:

- Age;
- Gender;
- Nationality;
- Qualifications; and
- Duration of experience as a midwife.

The researcher started each interview with a short reminder of the purpose of the current study, the role the interview played in the research, the estimated duration (20-30 minutes) of the interview and the confidentiality of the interview. The voice recording and the taking of field notes were also explained. Informed consent was confirmed on the voice recording. Participants were also reminded that they were free to withdraw at any time. The researcher started with an introductory question (Appendix F). The data collected were voice-recorded after the researcher had confirmed the participant's permission to do so.

The quality of the interview depends mainly on the skills of the researcher. The interviewer used listening, paraphrasing, reflecting, clarifying, probing, summarising, encouraging and acknowledging as minimal verbal responses (Botma *et al.*, 2010:205-206). The researcher (who conducted all the interviews) established rapport with each interviewee by listening attentively and therefore creating a feeling of respect. This created a trust-relationship between the interviewer and interviewee. The interviewer orientated the interviewee about their progress throughout each question so that the interview did not end abruptly.

The transcription of the first interview was submitted to the supervisor for review. After discussion, the interviews continued. The researcher conducted seven interviews at each participating facility although data saturation had been reached after five interviews from each respective facility.

- **Field notes**

Detailed field notes (an example of field notes from one of the interviews is available in Appendix H) were compiled immediately after each interview session by the researcher. The different types of field notes according to Botma *et al.* (2010:218-219) are:

- Descriptive notes;

- Reflective notes (methodological, theoretical, personal);
- Demographic notes.

Descriptive notes are objective notes to describe the physical setting or particular events that happened during the interview. Reflective notes include the personal thoughts of the researcher and these field notes focused on the methodological, theoretical and personal aspects of the interview. The methodological notes refer to the methods used during observation. Theoretical notes were about the researcher's thoughts concerning what was happening and how to make sense of that. The personal notes included the researcher's feelings and experiences while conducting the interview.

The demographic notes included all the demographic information such as time, place and date of each interview as well as demographic notes about the participant (Botma *et al.*, 2010:218-219).

The field notes provided a written explanation of what the researcher felt, heard, saw, thought and experienced during the entire interview process. This provided a retrospective overview of the interview process (Botma *et al.*, 2010:217).

• **Transcriptions**

A transcription can be referred to as a verbatim typed document of a voice-recorded interview to allow data-analysis. Voice-recorded interviews are major sources of data in qualitative studies (Botma *et al.*, 2010:214). The researcher preferred to transcribe the interviews herself in order to become closely familiar with the data. The researcher transcribed each interview shortly after conducting it while the discussion was still fresh in her memory. The transcriptions were verified by a second person who had signed a confidentiality undertaking. This person verified the transcriptions by listening to a recording while reading its transcription (Botma *et al.*, 2010:214). (See Appendix G for an example of a transcribed interview). While transcribing large spaces were left in the left and right hand margins. The left margin was used for the personal notes of the researcher while the right one was used for the identified themes and categories.

3.3.3 Data-analysis

The purpose of data-analysis is to make sense of the data gathered. This included the preparation of the data for analysis, conducting the analyses, understanding the data in a deeper manner, representing the data and making interpretations of the data (Botma *et al.*, 2010:220). Data-analysis was a continuous process throughout the research.

3.3.3.1 Conducting analysis

The data were analysed using thematic analysis which is a method of identifying, analysing and reporting themes emerging from the data (Braun & Clarke, 2006:77). A thematic chart was constructed and key words and phrases used by the participants were entered under the relevant main theme. The researcher and co-coder analysed the data independently and had a discussion to reach consensus about the identified themes and categories.

Data were analysed according to the six generic steps of Creswell (2009:184): This process acted as a guideline for both analysts.

The following six generic steps of Creswell (2009:185-186) were followed:

1. Organising and preparing the data by transcribing the interviews, typing of field notes, scanning through material optically and sorting/arranging the different types of data.
2. Developing a general sense of the data by reading through the data and writing notes and general thoughts of the data in the margin.
3. Content analysis, using open coding as described by Tesch (1990, in Creswell, 2009), was used as a method for the detailed data analysis. These eight steps include:
 - Reading carefully through the transcriptions to get a sense of the whole and writing down some ideas in the margin.
 - Picking the shortest or most interesting document and asking yourself “What is it about?” Ideas were again written in the margin.
 - Repeating step two and making a list of topics that came to mind while reading through multiple participants’ data.
 - Taking this topic list back to the data, abbreviating the topics into codes and writing them down next to the appropriate text segments to see whether new categories and codes emerged.
 - Creating categories through identifying descriptive wording for the identified topics. Reducing categories if they related to each other while drawing lines between categories to demonstrate interrelationships.
 - Deciding on the final abbreviations for codes and alphabetising these codes.
 - Performing a preliminary analysis by assembling the data that belong together in each category.

- Recoding the existing data in cases, where necessary.
4. Identifying and describing the themes. The coding process was used to create a description of six themes from the categories. The themes refer to the major findings and were used to create the headings for presenting and discussing the study's findings.
 5. Presenting the findings by means of a narrative passage. This included a detailed discussion of several themes and discussing them with interconnecting themes.
 6. Interpretations were made about the meaning of the data. This was the final step in data analysis where the interpretation was made. This was the researcher's personal interpretation in combination with literature and theory.

3.3.3.2 Literature comparison

The analysed data were verified by means of a literature comparison. The literature does not guide or direct the study but becomes an aid as soon as patterns have been identified. This approach is congruent with the inductive process of qualitative research (Creswell, 2009:25).

3.4 RIGOUR

Rigour can be seen as the scientific value of the study because the research outcomes are associated with it (Grove *et al.*, 2009:58) and therefore it refers to the soundness of the research (Klopper, 2008:69). Strategies used in the current study to ensure trustworthiness were **credibility**, **transferability**, **dependability** and **confirmability** (Botma *et al.*, 2010:32).

The four epistemological standards namely: **truth value**, **applicability**, **consistency** and **neutrality** (Botma *et al.*, 2010:32) were adhered to by implementing the strategies mentioned in section 3.3 of this dissertation. The standards and strategies based on the principles of Botma *et al.*, (2010:233) and Klopper and Knobloch (2010:317-318) are displayed in Table 3.2:

Table 3.2 Strategies used to ensure trustworthiness

Epistemological standards	Strategies
Truth value	Credibility
If the researcher established confidence in the truth of the research findings	<ul style="list-style-type: none"> • All the midwives had an equal chance to participate. An all-inclusive sample was used. • An experienced, well prepared interviewer conducted the interviews.

Epistemological standards	Strategies
	<ul style="list-style-type: none"> • Recordings were taken to remind the researcher of the participants' own words so as not to forget or misinterpret the data. • Field notes were taken directly after each interview to capture significant observations. • Data collection continued until data saturation has been reached to ensure that the findings would be credible. • During data-analysis there were two independent coders and the themes and categories were finalised during a consensus discussion between the two coders concerning the findings. • Literature control was implemented once the final themes had been identified to compare the findings with those of previously published studies. • The interviews were transcribed by the researcher herself.
Applicability	Transferability
How the findings can be applied to different contexts	<ul style="list-style-type: none"> • A rich/dense description was provided about the sample, context, method of data-collection and data-analysis so that future researchers could decide whether the findings could be applied to other contexts.
Consistency	Dependability
Whether comparable results will be obtained if the study is duplicated	<ul style="list-style-type: none"> • Detailed descriptions were done to explain the whole research process, providing an audit trail. • A co-coder was used and a consensus discussion followed the independent data-analyses done by the researcher and the co-coder.

Epistemological standards	Strategies
Neutrality	Confirmability
The unbiased and objective status of the researcher during the research	<ul style="list-style-type: none"> • The original interview schedule, the recordings, transcriptions and field notes are in safe keeping in case an audit trail should be required. • The researcher declared the limitations of the study and adhered to the specified ethical considerations.

3.5 ETHICAL CONSIDERATIONS

This section will provide an overview of the ethical considerations. The research proposal for this study was approved by the Human Research Ethics Committee (HREC) of the NWU, Potchefstroom Campus (Ethics number: NWU 00014-16-S1). See Appendix A.

Ethical aspects were considered commencing at the proposal development phase and continuing throughout the process of sampling, data-collection, data-analysis and writing the report (dissertation). Data-collection only commenced after ethical clearance had been granted.

3.5.1 Probable experience of the participants

The participants were interviewed individually. They might have felt uncomfortable or unsure about what to expect. However, precautions were taken to make sure that they were as comfortable as possible by selecting a suitable time and place for each participant's interview. Participants were fully informed about the nature of the current study - both verbally and in writing and also had opportunities to ask questions. The contact details of the researcher as well as the HREC were available if participants wanted to ask questions at another time. The researcher checked that the room was not too warm or too cold, that the chairs were comfortable and that drinking water was available. Refreshments were provided during the information sessions and interviews.

3.5.2 Choice of techniques

Participants were selected because of their involvement in antenatal and intrapartum care to ensure that the data would be as rich as possible. These participants were working directly with patients and would be able to provide the best answers in response to the research question. Individual semi-structured interviews were used as the data-collection method to obtain a variety of perspectives. Focus groups could also be valuable but might have caused disruptions in

providing patient care, considering the serious staff shortages during the data collection phase of the current study.

3.5.3 Dangers/risks and precautions

The only risk was the possible discomfort as discussed under the probable experience of the participants in section 3.5.1 of this dissertation. There was also a fair balance of risks and benefits. In this way, the principle of equality was being adhered to (DoH 2015:14).

3.5.4 Benefits for participants

The participants did not benefit directly from the current study but childbearing women and the community at large might benefit indirectly from the study's results, potentially contributing to the promotion of providing continuous support during childbirth. The study could also indirectly benefit the midwifery profession by enhancing their job satisfaction levels and the scientific community due to the addition of new knowledge.

3.5.5 Risk-benefit ratio

The benefits outweighed the risks. The principles of beneficence and non-maleficence were adhered to (DoH, 2015: 14).

3.5.6 Expertise, skills and legal competencies

The project head (the supervisor of the researcher) and researcher had the necessary background knowledge, expertise, qualifications and professional registrations to implement the relevant research techniques. The student received additional training in conducting interviews through role-play sessions. Feedback was provided after the first interview had been conducted and, if necessary, additional training could have been provided. The curriculum vitae of the supervisor and post-graduate student (researcher) accompanied the ethical application forms. The principal investigator had a primary responsibility to ensure the safety and well-being of participants, the scientific integrity of the proposal and responsible implementation of that protocol throughout the study (DoH, 2015:17).

3.5.7 Legal authorisation

Ethical approval was obtained from the HREC of the Faculty of Health Sciences of the NWU (Appendix A) and the Department of Health of the NWP (Appendix B) before data-collection commenced.

3.5.8 Goodwill permission

The goodwill permission of the following persons was requested after the approval of the HREC had been obtained:

- Director: Policy, Planning, Research, Monitoring & Evaluation of the Department of Health of the NWP (Appendix B);
- Managers of the two participating facilities (Appendices C & D).

3.5.9 Participants' recruitment and informed consent

The participants were recruited by a mediator who was the communication officer of each participating facility. The mediator did not have undue influence on the entire process because he was not in a power-relationship with the midwives. The mediators were trained by the researcher during their information session on how to act ethically correctly. The role of the mediator was to assist with the recruitment, obtaining informed consent and co-signing the consent forms after receiving them from the participants. The mediators invited all potential participants to attend the information sessions. Posters with details of the study, including the contact details of the researcher, were displayed on the notice boards in the facilities to recruit and remind the prospective participants about the information sessions.

The information sessions took place during mutually agreed times and places that suited the prospective participants. The researcher was present to provide the potential participants with clear and comprehensive information regarding the study and informed them that they were free to choose whether to participate in the study and that they could discontinue their participation without incurring any negative consequences. They did not need to provide reasons for withdrawing from the study. Potential participants had opportunities to ask questions from the researcher. Thereafter, the informed consent forms, containing all the relevant information as well as the relevant contact details, were distributed by the mediator. Sealable envelopes were distributed wherein the informed consent forms had to be placed after signing.

Potential participants had 24 hours to consider whether they wanted to participate. They were reminded to ask a witness to co-sign the informed consent form with them. The signed informed consent forms had to be placed in the sealed envelope and deposited in a box in the office of the communication officer of each participating facility. The mediator, as the person who obtained the informed consent, and the researcher co-signed the forms after receiving them from the participants. Participants were asked to sign two copies of the informed consent document so that each participant could keep a copy with the study's information and the contact details of the researcher.

3.5.10 Voluntary participation

The communication officers, who acted as mediators, were not in power-relationships with the potential participants that might have caused them to feel pressurised to participate. Information about the voluntary nature of their participation was clearly stated in the informed consent forms. The researcher provided the participants with clear and comprehensive information regarding the study and informed them that they were free to choose to participate or to stop participation during the process without harm and without providing reasons for withdrawing from the study.

3.5.11 Criteria for participants' selection

Specific inclusion and exclusion criteria were specified to ensure that the selected participants would be able to provide rich data in response to the research question. Potential participants were ensured that they were not selected on any bases other than the inclusive and exclusive criteria.

3.5.12 Incentives and remuneration of participants

The midwives received no incentives to participate. The participants did not incur any expenses due to their participation in the current study.

3.5.13 Misleading of participants

Participants were not misled but received full information about the study both verbally and in writing.

3.5.14 Plan to disseminate the study's findings

The current study's research findings would be made available to the participants during a formal information session after the study had been completed. A report of the study will be provided after examination to the Department of Health of the NWP. The results will further be disseminated to the scientific community as a journal article and/or conference presentation.

3.5.15 Privacy/confidentiality

A convenient, private, interruption-free venue was used at the two selected settings to ensure privacy of the participants during the interviews. A notice was placed on the door to ensure that the interview was not disrupted. The participants' names were removed during transcription and pseudonyms were used. The transcriber signed a confidentiality undertaking.

3.5.16 Storage and archiving of data

Voice recordings were erased after the transcriptions had been done and back-ups of the data had been created. All hard copies of informed consent forms, transcriptions and field notes will be stored for a period of five years in a locked cupboard in the office of the director of the INSINQ focus area. Only the researcher and supervisor will have access to the hard copies of the data. After the period of five years the hard copies will be shredded by the administrative officer of INSINQ.

Electronically captured data will be stored on a password-protected computer to which only the researcher has access. All electronic data were backed-up on an external hard drive that will be kept locked up in a cupboard in the locked office of the researcher for five years after which it will be deleted.

3.5.17 Scientific integrity

The researcher referred to all sources used, thereby refraining from plagiarism. All ethical considerations, based on those outlined by the NWU ethics application form, were adhered to during the current study.

3.6 SUMMARY

In Chapter 3 the research design and research methods were presented. The sampling, data-collection and data-analysis procedures were discussed. Finally, rigour and ethical considerations were addressed.

Chapter 4 presents the findings and the discussions of what the data analysis revealed concerning the midwife's role in facilitating continuous support during childbirth in facilities in the NWP.

CHAPTER 4: RESEARCH FINDINGS AND DISCUSSION

4.1 INTRODUCTION

In this chapter, the current study's findings will be presented and discussed. The discussions will be supported with participants' direct quotations. The research findings will be compared with those of similar studies. The research objective was to explore and describe midwives' perspectives about their role in facilitating continuous support during childbirth in the participating public hospital and CHC in the NWP.

4.2 DEMOGRAPHIC PROFILE

The demographic data of each participant were collected before the interview commenced. This data were combined in a table presenting the demographic data of the participants in Table 4.1.

Table 4.1: Demographic profile of the participants (n=14)

Demographic aspect	Group 1 (hospital)	Group 2 (CHC)	Total	Percentage
Age:				
20-29	0	1	1	7.2
30-39	2	5	7	50.0
40-49	2	1	3	21.4
50-59	3	0	3	21.4
Gender:				
Female	6	5	11	78.6
Male	1	2	3	21.4
Qualification:				
Diploma	5	6	11	78.6
Degree	2	1	3	21.4
Population group:				
White	1	0	1	7.1
African	6	7	13	92.9
Experience as a midwife:				
> 5 years	4	1	5	35.7
< 5 years	3	6	9	64.3

Most participants (n=7; 50.0%) were 30-39 years old. Although their ages ranged from 29 to 57 years, the mean age was 40 years. Only three participating midwives (n=3; 21.4%) were males while 11 (78.6%) were females. Out of the 14 participants, 11 (78.6%) had diplomas while three (21.4%) had degrees in nursing and midwifery. Most participating midwives (n=13; 92.9%) were African and most (n=9; 64.3%) had less than five years' experience as a midwife in an antenatal and/or intrapartum unit.

4.3 RESULTS AND FINDINGS

The field notes revealed that the participants felt passionate about providing continuous support during childbirth. No negative emotions were expressed. The participants were well acquainted with the topic.

The interview schedule that was used comprised an introductory question and follow-up questions.

Introductory question:

- Who do you think can provide continuous support to a woman during childbirth?

Follow-up questions

1. What are your views about the role of the midwife, providing antenatal care, to facilitate continuous support during childbirth?
2. What are your views about the role of the midwife, providing intrapartum, care to facilitate continuous support during childbirth?
3. What are your views regarding advocacy for continuous support during childbirth?
4. What facilitates continuous support during childbirth?
5. What hinders continuous support during childbirth?

4.4 CATEGORIES, THEMES AND SUB-THEMES

After data-analysis two main categories were identified, namely facilitating continuous support during childbirth and roles in facilitating continuous support during childbirth. Category one has been divided into two themes with a total of 11 sub-themes. The second category has two main themes with a total of nine sub-themes. These categories and subcategories present the participants' perspectives on the role of the midwife to facilitate continuous support during childbirth.

The categories, themes and subthemes are presented in Table 4.2.

Table 4.2: Thematic chart - Categories, themes and sub-themes

Category 1: Facilitating continuous support during childbirth	
Theme 1.1: The midwife's role in facilitating continuous support during childbirth while providing antenatal care	Theme 1.2: The midwife's role in facilitating continuous support during childbirth while providing intrapartum care
Sub-themes: (5) 1.1.1. Building good relationships 1.1.2. Introducing mom-connect at the first contact 1.1.3. Encouraging mother-to-mother support 1.1.4. Encouraging support persons to accompany women during ANC visits 1.1.5. Providing health education	Sub-themes: (6) 1.2.1. Encouraging a support person of choice to be present 1.2.2. Educating and explaining everything to the mother 1.2.3. Providing emotional, moral and physical support 1.2.4. Displaying good attitudes by staff members 1.2.5. Utilising clinical and/or non-clinical staff and mom-connect strategies 1.2.6. Communicating a woman's wishes for the presence of a support person and being the patient's spokesperson
Category 2: Roles in facilitating continuous support during childbirth	
Theme 2.1: Facilitating factors related to continuous support during childbirth	Theme 2.2: Impeding/hindering factors related to continuous support during childbirth
Sub-themes: (5) 2.1.1. Trust relationships 2.1.2. Conducive environment to support the childbirth experience 2.1.3. Optimal use of initiatives 2.1.4. Positive attitudes of all involved 2.1.5. Electronic support systems	Sub-themes: (4) 2.2.1. Institutional rules and regulations 2.2.2. Infrastructure and working conditions 2.2.3. Patient-related matters 2.2.4. Staff-related matters

CATEGORY 1: FACILITATING CONTINUOUS SUPPORT DURING CHILDBIRTH

In this section, category 1 and its themes and sub-themes will be explained. The first category is based specifically on how the midwife could facilitate continuous support during childbirth. Each sub-theme is supported by extracts from the original transcripts. Each extraction is referenced by the number of the group (group 1 refers to participants from the hospital and group 2 refers to participants from the CHC) and the number assigned to each participant. These themes and sub-themes will be discussed and contextualised within relevant literature.

THEME 1.1: THE MIDWIFE'S ROLE IN FACILITATING CONTINUOUS SUPPORT DURING CHILDBIRTH WHILE PROVIDING ANTENATAL CARE

The first theme is related to the midwife's role in facilitating continuous support during childbirth while providing antenatal care and was divided into five sub-themes:

- Building good relationships;
- Introducing mom-connect at the first contact;
- Encouraging mother-to-mother support;
- Encouraging support persons to accompany women during ANC visits; and
- Providing health education.

The question that was used here to obtain the data from the participants was:

What are your views on the role of the midwife, providing ANC, in facilitating continuous support during childbirth?

Sub-theme 1.1.1: Building good relationships

The participants indicated that the midwife could facilitate continuous support during childbirth by building a good relationship with the mother starting during the antenatal period.

"I think that is where that relationship between the midwife and mothers starts already and the trust between them and they know that this person will be here for me, up to the end" (P 1.1).

This idea is supported by Dahlberg *et al.* (2015:415) where the women in their study appreciated a trusting relationship with the midwife. This is also important for the emotional aspect of a positive childbirth experience. Borrelli *et al.* (2016:108) concluded that in order to establish a trusting relationship between the midwife and the woman the principles of a kaleidoscopic midwife should be followed. This metaphor implies that a midwife should be 'multi-coloured' and adjust according to each woman's needs (Borrelli *et al.*, 2016:108).

The midwife was specifically mentioned by The participating midwives also mentioned that good relationships should be built with clinical staff such as doctors. The participants felt that the midwife would be the best person to provide continuous support during childbirth and, if possible, it should be done on a one-on-one basis.

“The midwife can support continuously.” (P 2.1.).

“To me the midwife plays a key role and she is the main person who can be relied on to provide support to that woman in labour.” (P 1.5)

A midwife is the ideal person to provide continuous support but, if impossible, then the midwife should facilitate continuous support by another suitable person. If a midwife cannot provide optimal support because she needs to provide clinical care to several women, she could encourage other people to provide continuous support during childbirth (Aune *et al.*, 2014:90). A person who can provide continuous support, if not a member of the woman’s social network, but experienced with a moderate amount of training might be the most beneficial support person (Bohren *et al.*, 2017:2).

Sub-theme 1.1.2: Introducing mom-connect at the first contact

Mom-connect is part of a range of initiatives that were introduced by the South Africa’s DoH to improve the quality of health services. This was part of the drive to reach Millennium Development Goals (MDGs) 4 and 5, to reduce maternal mortality. The MDGs were replaced by the Sustainable Development Goals (SDGs). Mom-connect was launched in August 2014 to provide information to mothers who are pregnant or in labour via SMS (Short Messaging Service). The ANC clinics register pregnant women on the electronic database. Once registered, they receive free SMS messages related to the specific stage of pregnancy (Barron *et al.*, 2016:S201-202).

“Again even mom-connect, when you connect the patient, she can even send a SMS to mom-connect., they will explain to the patient you must do this like breathing exercises...” (P 1.3.)

“...There is this thing that is newly introduced - mom-connect is whereby this patient is able to connect, I don’t know if it’s through internet, concerns when pregnant, in labour, after delivery so she get guidance or help or assistance on everything she’s asking or she want clarity on” (P 1.5).

The concept of mom-connect was mentioned in the majority of the participants’ comments. They felt that mom-connect could indirectly facilitate continuous support by electronically communicating with the pregnant women.

Sub-theme 1.1.3: Encouraging mother-to-mother support

The participants felt that the midwife could facilitate continuous support during childbirth during the antenatal period by encouraging mother-to-mother support. During childbirth, the woman could be supported by someone who has previously experienced childbirth. This could reduce the midwives' burden. The pregnant woman should be accompanied by her selected support person (who has already experienced childbirth) during her ANC clinic visits so that the midwives can educate the support person.

"Here the midwife can give information because we have few midwives. Midwives can give information to the health support promoters, this mother-to-mother support people and encourage mothers to come with other mothers for the antenatal visits" (P1.2.)

Mother-to-mother support groups is an initiative that was started by the WHO (World Health Organisation)/ UNICEF (United Nations Children's Emergency Fund) IYCN (Infant and Young Child Nutrition) Project in 2002 to improve infants' and children's nutrition, mainly breastfeeding. Mothers who participated in these mother-to-mother support activities were more likely to breastfeed exclusively (Muruka & Ekisa, 2013:31-32).

If the same principles could be followed for providing continuous support during childbirth, mother-to-mother support could have a wider impact in helping midwives to facilitate the provision of continuous support during childbirth.

Sub-theme 1.1.4: Encouraging support persons to accompany women during ANC visits

This sub-theme could be linked to the previous theme, but in this case the participants felt that the support person should be a person of choice. Such a person should accompany the pregnant woman during ANC clinic visits to receive information from midwives.

"Even in the antenatal period the midwife still can include the family with the woman to understand the whole process of labour" (P 2.7).

Women rely on different types of support persons to provide specific types of support. Mothers or mothers-in-law can provide instrumental, informational and emotional support (Diamond-Smith *et al.*, 2016:114 & 121).

The woman should be allowed to choose any support person that she prefers.

"...Any person the woman chooses can give her support, uhm, usually it will be someone she trusts. Maybe a grandmother, a mother, a good friend. So it will be really someone she trusts enough to be part of the birthing experience that can support her." (P 1.1.)

"I think the best person to give support to a woman it's actually the closest family" (P 2.5.)

Different women might rely on different people to provide specific types of support. Mothers or mothers-in-law could provide instrumental, informational and emotional support (Diamond-Smith *et al.*, 2016:114 & 121).

Sub-theme 1.1.5: Providing health education

The participants felt that all the support persons and the pregnant women should be educated during the antenatal period so that they can be indirectly supported. This implies that even if left alone, the pregnant woman would know what to do.

"In antenatal care the patient can come along with the mother or the partner to be educated what's going to happen during labour, what's going to happen after labour..." (P 2.1.)

"I think it is very key to educate them during antenatal throughout so that they understand" (P 2.2.)

"The mother should be allowed to ask questions..." (P 1.2)

Health education can be seen as the provision of information and advice, anticipatory guidance and explanation of procedures. These educational activities must commence early during pregnancy and continue throughout pregnancy, childbirth and the postnatal period in order to be effective. These educational activities include guidance for the woman, her selected support person and/or her partner, facilitation of communication and therefore assisting the woman to express her needs and wishes (Simkin & Bolding, 2004:490; Bohren *et al.*, 2017:3; Albers, 2007:208; Declerq *et al.*, 2006:30).

"The most important thing is that we should encourage the woman to book as early as possible" (P 2.3.)

"...health education is the cheapest tool we can use to support this mother" (P 1.7.)

This last comment was expressed by a participant who felt that encouraging patients to commence ANC clinic visits early (during the first trimester of pregnancy) is indirectly part of the health education process. (In South Africa, midwives use the term "booking" to imply "commencing with ANC clinic visits"). Pregnant women might be unaware of the importance of early commencement of ANC clinic visits $A = \pi r^2$ if they are not educated about this aspect.

Health education should be provided to the support person and to the woman during childbirth. A midwife should educate the woman and the support person to advocate for themselves. They

should know to what rights they are entitled to exercise and what the support person would be allowed to do and when she should summon help from the midwife.

“Advocating not just by talking but also putting into action via teaching stuff, making sure that patients who cannot read and write are taught in their language so that in the end of the day everybody on board is on the same page as far as advocating for continuous support is concerned...” (P 1.7.)

“...maybe some ideas on what you have already told them and maybe that sister can just add on to some information that is still short and I think we need to also give them information on the progress of labour. How they are going and coping mechanisms and relaxation techniques...” (P 1.1.)

Midwives are important sources of childbirth-related information. A pro-active approach should be followed by providing “too much verbal information” rather than “too little information” during health education sessions. This could enable women to make informed decisions during childbirth (Baron *et al.*, 2017: 38).

THEME 1.2: THE MIDWIFE’S ROLE IN FACILITATING CONTINUOUS SUPPORT DURING CHILDBIRTH WHILE PROVIDING INTRAPARTUM CARE

The second theme is related to the midwife’s role in facilitating continuous support during childbirth while providing intrapartum care. This theme was divided into six sub-themes:

- Encouraging a support person of choice to be present;
- Educating and explaining everything to the mother;
- Providing emotional, moral and physical support;
- Displaying good attitudes by staff members;
- Utilising clinical and/or non-clinical staff and mom-connect strategies; and
- Communicating a woman’s wishes for the presence of a support person and being the patient’s spokesperson.

The question that was asked to obtain the data from the participants was:

What are your views on the role of the midwife, providing intrapartum care, to facilitate continuous support during childbirth?

Sub-theme 1.2.1: Encouraging a support person of choice to be present

This sub-theme links to sub-theme 1.1.4 (Encouraging support persons to accompany women during ANC visits) but in this case the participants stressed that this should be a support person

of the patient's choice. The central feature is that the woman should not be left alone at any time during childbirth and that the support person should be a person chosen by the woman (Enkin *et al.*, 2006:267).

"I think the midwife can facilitate it by allowing the woman to be part of it. To be there with her during the labour up to the part where she delivers. If she decides that it must be a mother or a friend to allow this person to be there. It can be any person she chooses" (P 1.1).

Sub-theme 1.2.2: Educating and explaining everything to the mother

The participants highlighted that education and explanation should continue even during the intrapartum stage of childbirth and could be regarded as providing indirect continuous support.

"...just to explain the procedure to the client, what is going to happen for the client to relax, not to be surprised, especially for those first time mothers..." (P 1.4.)

"...health education is the cheapest tool we can use to support this mother" (P 1.7.)

Many aspects of the hospital environment could cause stress. The setting and the staff might be unfamiliar and strange to the patient. This could be prevented by educating and orientating the woman and the support person during childbirth (Enkin *et al.*, 2006:269).

Sub-theme 1.2.3: Providing emotional, moral and physical support

The support person of choice could provide emotional, moral and physical support when the midwife is unavailable. A support person of choice would enable the midwife to focus on essential midwifery duties (NICE, 2015; Larkin & Begley, 2009:50; Bowers, 2002:742; Bianchi & Adams, 2013:25).

"The midwife whilst delivering this woman - the person who is supporting this mother who is labouring is able to help midwife in this continuous support. By supporting this woman emotionally and physically..." (P 1.2.)

Sub-theme 1.2.4: Displaying good attitudes by staff members

If the midwives should display a good attitude towards providing continuous support during childbirth, it would make the practice environment more conducive and promote the provision of continuous support during childbirth. This could be considered to be part of the BBI initiative to enhance a positive childbirth process.

"...they must display a good attitude, to make a woman feel free and labour to be enjoyable at the same time the midwife must make sure that the client understands what is going to happen..." (P 1.4.)

The Better Births Initiative (BBI) is a focused set of standards that aim to improve the quality and humanity of obstetric care. These standards are based on the best available evidence, and can be implemented using existing resources. The following principles form the basis of the BBI:

- Humanity - women treated with respect;
- Benefit - care based on the best available evidence;
- Commitment - health professionals committed to improving care;
- Action - effective strategies to change current practice.

Sub-theme 1.2.5: Utilising clinical and/or non-clinical staff and mom-connect strategies

All sources of support should be utilised to provide continuous support during childbirth. This will not only take a load off the midwife, but it will ensure that the woman is never left unattended and is supported at all times during childbirth.

“...because of the shortage of staff, must teach one of the non-nursing staff members how to do when the midwife is busy” (P 1.3.)

“...I think the cleaners also must be taught how to take care of the patient during the intrapartum because we are having shortage of staff so if there is something that they're unable to do it, they must call the midwife, because the midwife cannot stay for a long time at the labour ward” (P 2.1.)

Non-clinical staff could be utilised in cases where the midwife is unable to provide continuous support during childbirth.

“Non-clinical staff as long as that person is working in a hospital for instance cleaners should also be trained to understand, like for instance confidentiality, cleaners are also mothers. They know how to take care of the patient but not necessarily physically.” (P1.7.)

“All of the staff, even the admin clerks they must also be conversant in terms of how we should help this woman.” (P 2.3).

Even though much research has been done about the use of doulas, limited participants (midwives) mentioned doulas during the current study.

Mom-connect was mentioned again by the participants seeing that mom-connect could also assist during the intrapartum phase. Virtually every person has access to a cell phone and they continue receiving SMS messages until the child is one year old. One of the components of mom-connect is that the women can ask for additional information about any topic during childbirth (Barron *et al.*, 2016:S203).

“...There is this thing that is newly introduced - mom-connect is whereby this patient is able to connect, I don't know if it's through Internet, concerns when pregnant, in labour, after delivery so she get guidance or help or assistance on everything she's asking or she want clarity on” (P 1.5).

Sub-Theme 1.2.6: Communicating a woman's wishes for the presence of a support person and being the patient's spokesperson

The participants indicated that it is the responsibility of the midwife to communicate the woman's wishes for support or the presence of a support person. In cases where the woman in labour might be unable to speak on her own behalf, the midwife should advocate for continuous support during childbirth.

“We as midwives it is our responsibility and duty to advocate for our mothers and uhm, I think we can do that by communicating the woman's wishes” (P 1.1.)

“You bring all the structures that would assist this woman to say let's support her from now until she gave birth and you also advocate to cleaners, to enrolled nursing assistants...” (P 2.2.)

“Like we speak on behalf of the patient, you try to uh, maybe explain the situation of the mother to the doctor...” (P 2.4.)

Advocacy is one of the ethical obligations of a midwife (Dodou *et al.*, 2014:263) and it is part of the midwife's role to provide humanised care. The study by Hadjigeorgio and Coxon (2014:983) indicated that advocacy was vital for improving maternal and new born outcomes. The ICM identified a gap in research about midwives' perceptions concerning advocacy (Hadjigeorgio & Coxon, 2014: 984).

CATEGORY 2: ROLES IN FACILITATING CONTINUOUS SUPPORT DURING CHILDBIRTH

This category links to the aim of this study to promote continuous support by identifying the facilitators and barriers that could influence the provision of continuous support during childbirth. This category was divided into two themes:

- Facilitating factors related to continuous support during childbirth; and;
- Impeding/hindering factors related to continuous support during childbirth.

THEME 2.1: FACILITATING FACTORS RELATED TO CONTINUOUS SUPPORT DURING CHILDBIRTH

Knowledge regarding the factors that facilitate continuous support during childbirth could help the midwife to improve continuous support during childbirth by enhancing the facilitating factors. The question that was asked to identify the sub-themes was: What facilitates continuous support during childbirth?

Five sub-themes were identified:

- Trust relationships;
- Conducive environment to support the childbirth experience;
- Optimal use of initiatives;
- Positive attitudes of all involved; and
- Electronic support systems.

Sub-theme 2.1.1: Trust relationships

Participants expressed the view that good relationships based on trust between the midwife, the mother and the support person could facilitate continuous support during childbirth. However, this should be regarded as being an on-going journey.

“She knows the nurse, even that person, she trust those people more than anything because they are there for her since antenatal clinic until the last day of delivery” (P 1.3.)

As mentioned in sub-theme 1.1 in category one trusting relationships are part of building good relationships. This standpoint was supported by Dahlberg *et al.* (2015:408) when they stated that women appreciated a trusting relationship with the midwife enabling the midwife to facilitate continuous support during childbirth.

Sub-theme 2.1.2: Conducive environment to support the childbirth experience

A conducive environment is needed to facilitate the childbirth experience for the women according to the current study's participants. Carlton *et al.* (2009:53) referred to a conducive environment as a platform for providing optimal care to the mother and the infant, facilitating continuous support during childbirth.

“...also the facilities that we have. You know, if we have a private room. You can do whatever with this woman, you can hold her hand at times. You can spend time with her but now our facilities don't allow that so you just do what you have to do and you leave” (P 2.5.)

Sub-theme 2.1.3: Optimal use of initiatives

The participants mentioned two specific initiatives namely the mom-connect initiative and the Better Birth Initiative (BBI) which might influence the provision of continuous support during childbirth.

“This thing called mom-connect can also teach the woman about facilitating support. I cannot be with a woman twenty-four seven so maybe mom-connect can do certain things for me and then I continue when I meet the woman face-to-face” (P 2.5.)

The mom-connect initiative was also mentioned as part of facilitating during pregnancy in sub-theme 1.1.2. Introducing mom-connect at first contact. However, the current study’s participants felt that mom-connect could also facilitate continuous support during childbirth in a continuous indirect way when the midwife is unable to do so.

“This mother-friendly initiative that the other name is the Better Birth Initiative it facilitates a lot...” (P 1.2.)

The participants’ view was that if the Better Birth Initiative would be followed the right action to be taken would be followed at the right time and optimal continuous support during childbirth would be ensured. The researchers, who developed the BBI, conducted research on the implementation of support during childbirth through a multi-dimensional educational intervention. They concluded that support was not provided to women during childbirth in South African public hospitals (Smith *et al.*, 2004:117; Brown *et al.*, 2007:7).

Sub-theme 2.1.4: Positive attitudes of all involved

The positive attitudes of all involved, including the woman, the support person and the midwife could facilitate continuous support during childbirth as it would enhance the commitment of all concerned parties to facilitate the provision of such support. This was also mentioned in sub-theme 2.4 as part of the BBI (Smith *et al.*, 2004:117).

“Our attitude that is one ministerial marching order. We need to have a positive caring attitude” (P 2.2.)

Sub-theme 2.1.5: Electronic support systems

As mentioned in sub-themes 1.2 mom-connect is an electronic SMS system used to support pregnant women by providing information. Consequently, the SMS mom-connect system could also provide continuous support during childbirth.

“I think mom-connect. Mom-connect it teaches the woman before pregnancy, after pregnancy, during pregnancy. The woman just makes please call and those ladies will explain everything to the woman” (P 1.7.)

“This thing called mom-connect can also teach the woman about facilitating support. I cannot be with a woman twenty-four seven so maybe mom-connect can do certain things for me and then I continue when I meet the woman face-to-face” (P 2.5.)

THEME 2.2: IMPEDING/HINDERING FACTORS RELATED TO CONTINUOUS SUPPORT DURING CHILDBIRTH

Knowledge about the factors impacting negatively on the provision of continuous support during childbirth could help the midwife to address such barriers and to facilitate the provision of continuous support. The question that was asked to identify the hindering factors was: What hinders continuous support during childbirth?

Four sub-themes were identified:

- Institutional rules and regulations;
- Infrastructure and working conditions;
- Patient-related matters; and
- Staff-related matters.

Sub-theme 2.2.1: Institutional rules and regulations

Institutional rules and regulations seemed to pose huge problems for the participants. Some institutions reportedly only permitted a support person to be present in a certain capacity and/or required the support person to leave at a certain stage during the childbirth process. This raised the concern that this requirement would result in interrupted support during childbirth, negating the ideal of providing continuous support.

“I think if we as an institution don’t have too many rules and regulations, on who is supposed to support the woman and who not, who we allow to be with her. I think if we can do that, it will facilitate support for her in labour” (P 1.1.)

These institutional rules and regulations could be classified as system barriers relating to the application of high-risk protocols without giving the woman a chance as to what she wants to do. The unit culture plays a significant role especially for less experienced nurses. The unit culture could lead to trends and attitudes being passed on from senior to junior midwives (Carlton *et al.*, 2009:53).

Sub-theme 2.2.2: Infrastructure and working conditions

If the practice environment does not allow a support person's presence due to infrastructure and working conditions it would impact negatively on the provision of continuous support. This structural problem is due to the limited amount of labour rooms with limited available space. This aspect is also linked to the conducive environment already discussed in category two sub-theme 1.2.

"You see each mother needs her own privacy, so our structure doesn't allow that...There are labour rooms with two beds..." (P 1.2.)

Sub-theme 2.2.3: Patient-related matters

Some cultures might not accept a male as a support person. This might impact negatively on the provision of continuous support if only a male person might be available to provide continuous support.

"Our cultural diversity, mean where the other culture doesn't want a male, the accoucheurs, male midwives to deliver their wives, such things they hinder continuous support" (P 1.2.)

Socio-cultural beliefs of women and their families could also pose challenges for providing continuous support during childbirth if they should believe that the birthing process must be private or that they should deliver alone at home (Michael *et al.*, 2006:49).

Sub-theme 2.2.4: Staff-related matters

Participants stated that staff shortages caused difficulties for the provision of continuous support during childbirth. The current study's participants were unable to provide or facilitate continuous support during childbirth due to time pressures, staff shortages and the lack of resources.

"Shortage of staff, you may find that I am the only midwife at night with the assistant nurses..." (P 1.3.)

"I think it is availability of human resource because most of the time you find yourself, maybe you find two woman who are in labour and you have to attend to them simultaneously of which it is very difficult so it will be helpful if our institutions they try to bring in the doulas or the grannies at home, anyone who is interested to assist" (P 1.4.)

Low midwife to patient ratios leads to limited time to provide quality care. It is therefore difficult to provide one-to-one care (Carlton *et al.*, 2009:53). The figures provided in the State of the World's Midwifery Triennial Report (Bernis & Edjang, 2014:170) highlighted a global shortage of health professionals, as at least 57 countries encountered shortages requiring approximately four million additional health workers to meet the expectations (Bernis & Edjang, 2014:170).

4.5 SUMMARY

This chapter presented and discussed the findings of the current study, supported by relevant quotes from the participants. The findings were confirmed and supported by a literature control. The research findings portrayed the participants' perspectives on the midwife's role in facilitating continuous support during childbirth.

Chapter 5 will discuss the conclusions, limitations and recommendations of the current study in order to promote continuous support during childbirth in selected public hospitals in the NWP.

CHAPTER 5: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter, the conclusions based on the current study's findings will be presented and the limitations will be discussed. Recommendations, regarding the facilitation of continuous support during childbirth in public health settings in the NWP, will be formulated based on the current study's findings.

5.2 CONCLUSIONS OF THE STUDY

Fourteen face-to-face interviews were conducted in total. Data saturation was reached after 10 interviews and an extra four was conducted to re affirm this saturation. Although the provision of continuous support during childbirth is beneficial, it is not implemented due to a variety of challenges. The participants displayed a good understanding of the topic. By identifying the role of the midwife, in facilitating continuous support during childbirth, this type of support could be promoted enabling more women to benefit from its potential benefits.

The data analysis produced two main categories namely facilitating continuous support during childbirth and roles in facilitating continuous support during childbirth. In category one two themes were identified as determining the importance of the role of the midwife in facilitating the provision of continuous support during childbirth. The first theme concerned the midwife's role in facilitating the provision of continuous support during childbirth, while providing antenatal care. The second theme addressed the midwife's role in facilitating the provision of continuous support during childbirth, while providing intrapartum care.

There were two unexpected findings. Firstly, few participants specifically mentioned doulas although studies (Green *et al.*, 2007:27; Bianch & Adams, 2013:24) illustrated the potential contributions of doulas to the provision of continuous support during childbirth. The reason for not mentioning doulas could be because doulas had not been introduced at the two facilities where the current study was conducted. Doulas had not been introduced due to financial limitations of the government and patients and doulas were not mentioned in the specific guidelines of the DoH. The use of doulas is also not included in the current midwifery courses (SANC, 2005; SA, 2016). Although very few participating midwives mentioned doulas as persons who could provide continuous support during childbirth, a few midwives indicated that non-clinical staff members, including cleaners, could provide such continuous support. The participants did not indicate how this could be implemented.

The second unexpected finding related to the value the participants placed on the use of mom-connect which is a technological resource providing human action. Mom-connect could provide continuous support to a woman. The participants agreed that this could help the midwife to facilitate continuous support during childbirth but that mom-connect could not replace the midwife's role in providing continuous support.

The second category concerned the roles in facilitating continuous support during childbirth. The first identified theme related to facilitating factors related to continuous support during childbirth. The second theme addressed the impeding/hindering factors related to continuous support during childbirth.

In the two above-mentioned main categories that were identified with a total of four themes and twenty sub-themes (see Table 4.2) the complexity of the issue was illustrated by identifying the midwife's role in facilitating continuous support during childbirth. By identifying which factors hindered continuous support, the provision and/or facilitation of continuous support could be enhanced if hindrances/obstructions could be addressed effectively.

5.3 LIMITATIONS

Limitations could be theoretical and methodological barriers impacting on a study that might decrease the generalisability of the findings. These limitations could restrict the applicability of a study's findings to a general context (Grove *et al.*, 2009:609).

The following limitations were identified in the current study:

- The interview questions were long, necessitating the repetition of some questions to ensure that the participants focussed on the actual question.
- The study was only conducted in one public hospital and one CHC in the NWP, limiting the generalisability of the findings.
- Only interested participants who met the inclusion criteria participated voluntarily in the current study. This could have led to biased results as there could be no guarantees that the midwives who refused to participate in the current study had similar perspectives on providing and/or facilitating continuous support during childbirth as those portrayed by the participants.

5.4 RECOMMENDATIONS

The recommendations include ideas that emerged from the current study's findings (Grove *et al.*, 2009:707) and apply to midwifery practice, education, research and policy:

5.4.1 Recommendations for midwifery practice

The following recommendations can be made regarding midwifery practice:

- All patients should be aware of the advantages of the facilitation of continuous support during childbirth.
- Advocating for the mother's wishes and allowing a support person of choice in the delivery room with the midwife.
- All hospitals should implement the mom-connect initiative as it could assist in the provision of continuous support during childbirth.
- Community members could be recruited and informally trained to provide continuous support during childbirth on a voluntary basis to facilitate the provision of continuous support during childbirth.
- Promotional material regarding continuous support during childbirth should be made available to all pregnant women and women during childbirth to facilitate continuous support.
- Midwives with a passion for providing continuous support during childbirth should be placed in these specific hospital units and CHCs to facilitate the implementation of continuous support during childbirth.
- Staff shortages should be addressed to facilitate the implementation and facilitation of continuous support during childbirth.
- The duties for specific categories of staff members should be clearly spelled out. Non-clinical staff members, including cleaners, should not be expected to perform duties (such as providing continuous support to women during childbirth).

5.4.2 Recommendations for nursing and patient education

The following recommendations can be made regarding midwifery education:

- The benefits of providing continuous support during childbirth should be integrated in the curriculum of undergraduate and postgraduate midwifery students.
- All staff members (clinical, non-clinical, auxiliary administrative) should be trained about the value of providing continuous support during childbirth enabling the midwife to facilitate such support.

- Practical implementation strategies for ensuring continuous support or pointers on how to practically provide continuous support and what it entails.

5.4.3 Recommendations for future research

The following recommendations can be made regarding future research:

- Studies should be done on the role of the midwife in facilitating continuous support during childbirth in different provinces, including both private and public health facilities.
- The development and evaluation of interventions for facilitating the provision of continuous support during childbirth should be pursued as ongoing national research projects.
- The relationship between geographical data (i.e. midwife's age, level of qualification, length of experience, etc) and the perception regarding continuous support during childbirth.

5.4.4 Recommendations for policy

The following recommendations can be made regarding policy:

- The facilitation of continuous support during childbirth must be part of the national, provincial and local health policies and protocols.
- Continuous support during childbirth should be part of the required documentation on the maternity record and form part of standard operating procedures. This should emphasise its importance.
- Midwives (and their managers) should be accountable for ensuring that every woman has continuous support during childbirth and for facilitating such support, if unable to provide such support themselves.
- Policies where support persons are limited to only some aspects of labour or not allowing certain support persons in the labour room should be revised.

5.5 SUMMARY

Chapter 5 presented the conclusions, limitations and recommendations of this study. The findings of the current study added new knowledge specifically about the provision and/or facilitation of continuous support during childbirth. The need for further knowledge is addressed by the limitations and recommendations that were highlighted in this chapter.

This current study aimed to identify the midwives' perspectives on the facilitation of the provision of continuous support during childbirth in one public hospital and one CHC in the NWP. The participating midwives supported the idea of the midwife facilitating continuous support during childbirth, realising the aim of the study of promoting such support to meet the needs of women during childbirth. Some challenges to implement and facilitate continuous support during childbirth were identified. These barriers related to institutional rules and regulations, infrastructure and working conditions, patient-related matters and staff-related matters. These barriers or hindrances could impact negatively on the provision and/or facilitation of continuous support. On the contrary trust-relationships, a conducive environment encouraging continuous support during childbirth, optimal use of initiatives and positive attitudes of all concerned could impact positively on the provision and/or facilitation of continuous support during childbirth.

LIST OF REFERENCES

- Albers, L.L. 2007. The evidence for physiologic management of the active phase of the first stage of the labour. *Journal of midwifery and women's health*, 52:207-215.
- Aune, I., Amundsen, H.H. & Aas, L.C. 2014. Is a midwife's continuous presence during childbirth a matter of course? Midwives' experiences and thoughts about factors that may influence their continuous support of women during labour. *Midwifery*, 30(1):89-95.
- Bäckström, C. & Wahn, E.H. 2011. Support during labour: first-time fathers' descriptions of requested and received support during the birth of their child. *Midwifery*, 27(1):67-73.
- Bakhta, Y. & Lee, R.H. 2010. A survey of Russian women regarding the presence of a companion during labor. *International journal of gynecology and obstetrics*, 109:201.
- Baron, R., Heesterbeek, Q., Manniën, J., Hutton, E.K., Brug, J. & Westerman, M.J. 2017. Exploring health education with midwives, as perceived by pregnant women in primary care: A qualitative study in the Netherlands. *Midwifery*, 46(1):37-44.
- Barron, P., Pillay, Y., Fernandes, A., Sebidi, J. & Allen, R. 2016. The MomConnect Health initiative in South Africa: Early impact on the supply side of MCH services. *Journal of public health policy*, 37(S2):S201-S212.
- Bernis, L. & Edjang, S. Ed. 2014. The state of the world's midwifery. A woman's right to health. www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0.../SOWM_2014.PDF Date of access: 21 August 2016.
- Bianchi, A.L. & Adams, E.D. 2013. Doulas, labor support, and nurses. *International journal of clinical evidence*, 19(4):24-30.
- Bible. 2007. New Living Translation. Carol Stream, IL: Tyndale.
- Bohren, M.A., Hofmeyer, G.J., Sakala, C., Fukuzawa, R.K. & Cuthbert, A. 2017. Continuous support for women during childbirth: the Cochrane collaboration. *Cochrane database of systematic reviews* 2017. <http://www.cochranelibrary.com.CD003766>. Date of access: 24 July 2017.
- Borrelli, S.E., Spilby, H. & Walsh, D. 2016. The kaleidoscopic midwife: a conceptual metaphor illustrating first-time mothers' perspectives of a good midwife during childbirth. A grounded theory study. *Midwifery*, 39(1):103-111.

- Botes, A. 1991. 'n Funksionele denkbenadering in die verpleegkunde. *Curationis*, 14(1):19-23.
- Botma, Y., Greeff, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. Research in health sciences. Cape Town: Heinemann.
- Bowers, B. 2002. Mothers' experiences of labor support: exploration of qualitative research. *Journal of obstetric, gynecological and neonatal nursing*, 31(6):742-752.
- Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2):77-101.
- Brink, H., Van der Walt, C. & Van Rensburg, G. 2006. Fundamentals of research methodology for health care professionals. 2nd ed. Cape Town: Juta.
- Brown, H., Hofmeyer, G.J., Nikoderm, V.C., Smith, H. & Garner, P. 2007. Promoting childbirth companionship in South Africa: a randomized pilot study. *BMC Medicine*, 5(1):7-14.
- Brüggemann, O.M., Ebsen, E.S., de Oliveira, M.E., Gorayeb, M.K. & Ebele, R.R. 2014. Reasons which lead the health services not to allow the presence of the birth companion: nurses' discourses. *Text context nursing*, 23(2):270-277.
- Carlton, T., Callister, L.C., Christaens, G. & Walker, D. 2009. Nurses' perceptions of caring for childbearing women in nurse-managed birthing units. *The American journal of maternal/child nursing*, 34(1):50-56.
- Creswell, J.W. 2009. Research design: qualitative, quantitative, and mixed methods approach. 3rd ed. London: Sage.
- Dahlberg, U., Persen, J., Skogas, A., Selboe, S., Torvik, H.M. & Aune, I. 2015. How can midwives promote a normal birth and positive birth experience? The experience of first-time Norwegian mothers. *Midwifery*, 29(1):407-415.
- Declerq, E.R., Sakala, C., Corry, M.P. & Applebaum, S. 2006. Listening to mothers II: Report of the second national U.S. survey of women's childbearing experiences. New York: Childbirth Connection.
- Diamond-Smith, N., Sudhinaraset, M., Melo, J. & Murthy, N. 2016. The relationship between women's experiences of mistreatment at facilities during childbirth, types of support received and person providing the support in Lucknow, India. *Midwifery*, 40(1):114-123.

Diniz, C.S.G., Orsi, E., Domingues, B.M., Torres, J.A., Dias, M.A., Lansky, S., Teixeira, N.Z., Rance, S. & Sandall, J. 2014. Implementation of the presence of companions during hospital admission for childbirth: data from the Birth in Brazil National Survey. *Saude Publica*, 30:1-14.

Dodou, H.D., Rodrigues, D.P., Guerreiro, E.M., Guedes, M.V., Do Lago, P.N. & Mesquita, N.S. 2014. The contribution of the companion to the humanization of delivery and birth: perceptions of puerperal women. *Esc Anna Nery*, 18(2):262-269.

DOSA see Doula Organization of South Africa

DoH see South Africa Department of Health.

Doula Organization of South Africa. 2011. Doulas of South Africa. <http://www.doula.org.za/Welcome.html> Date of access: 15 February 2016.

Enkin, M.W., Glouberman, S., Groff, P., Jadad, A.R. & Stern, A. 2006. Beyond evidence: The complexity of maternity care. *Birth*, 33(4):265-269.

Green, J., Amis, D. & Hottering, B.A. 2007. Care practice #3: continuous labor support. *Journal of perinatal education*, 16(3):25-28.

Grove, S.K., Burns, N. & Gray, J.R. 2009. The practice of nursing research: appraisal, synthesis, and generation of evidence, sixth edition. St. Louis: Elsevier Saunders.

Hadjigeorgiou, E. & Coxon, K. 2014. In Cyprus 'midwifery is dying...'. A qualitative exploration of midwives' perceptions of their role as advocates for normal childbirth. *Midwifery*, 30(9):983-990.

Hirschhorn, L.R., Semrau, K., Kodkany, B., Churchill, R., Kapoor, A., Spector, J., Ringer, S., Firestone, R., Kumar, V. & Gawande, A. 2015. Learning before leaping: integration of an adaptive study design process prior to initiation of BetterBirth, a large-scale randomized controlled trial in Uttar Pradesh, India. *Implementation science*, 10:117.

Hodnett, E.D., Gates, S., Hofmeyer, G.J. & Sakala, C. 2006. Continuous support for women during childbirth: the Cochrane collaboration. *Cochrane database of systematic reviews* 2006, Issue 17. <http://www.thecochranelibrary.com.CD003766>. Date of access: 1 February 2015.

Hodnett, E.D., Gates, S., Hofmeyer, G.J. & Sakala, C. 2013. Continuous support for women during childbirth: the Cochrane collaboration. *Cochrane database of systematic reviews* 2013, Issue 17. <http://www.thecochranelibrary.com.CD003766>. Date of access: 1 February 2015.

ICM **see** International Confederation of Midwives.

- Iliadou, M. 2012. Supporting women in labour. *Health science journal*, 6(3):385-391.
- International Confederation of Midwives (ICM). 2014. ICM international definition of the midwife. <http://www.internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/>. Date of access: 21 August 2017.
- Kennedy, H.P., Shannon, M.T., Chuahorm, U. & Kravetz, M.K. 2004. The landscape of caring for women: A narrative study for midwifery practice. *Journal of midwifery & women's health*, 49(1):14-23.
- Klopper, H.C. & Knobloch, S. 2010. 'Validity, reliability and trustworthiness', in K. Jooste (ed.), *The principles and practice of nursing and health care*, pp. 317-326, Van Schaik, Pretoria.
- Klopper, HC. 2008. The qualitative research proposal. *Curationis*, 31(4):62-72.
- Kresheh, R. 2010. Support in the first stage of labour from a female relative: the first step in improving the quality of maternity services. *Midwifery*, 26(6):21-24.
- Larkin, P. & Begley, C. 2009. Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery*, 25(2):49-59.
- Lothian J.A. 2004. Do not disturb: The importance of privacy in labour. *The journal of perinatal education*, 13(3):4-6.
- Madi, B., Sandall, R., Bennett, & MacLeod, C. 1999. Effects of female relative support in labor: A randomized controlled trial. *Birth*, 26(1):4-8.
- Merriam-Webster's Medical Dictionary. 2007. Facilitating. <http://dictionary.reference.com/browse/facilitating>. Date of access: 14 September 2017.
- Meyer, B.A., Arnold, J.A. & Pascali-Bonaro, D. 2001. Social support by doulas during labor and the early postpartum period. *Hospital physician*: 57-65.
- Michael, G.A., Kosia, A.M., Usman, A., Mufunda, J. & Nyarango, P. 2006. Knowledge, attitude and practice towards skilled care attendance among women of reproductive age group in Eritrea. *Journal of the Eritrean medical association*, 37(11):47-49.
- Mouton, J. & Marais, H.C. 1988. Basic concepts in the methodology of the social sciences. <http://www.hsrbpress.ac.za>. Date of access: 15 January 2016.

Muruka, C. & Ekisa, H. 2013. A case study on the impact of mother-to-mother support groups on maternal, infant and young child nutrition and care practices in Habaswein and Wajir South districts of North Eastern Kenya. *Food and nutrition science*, 2013(4):31-35.

National Institute for Health and Care Excellence (NICE). 2015. Safe midwifery staffing for maternity settings. <http://www.nice.org.uk/guidance/NG4/chapter/1-recommendations>. Date of access: 20 November 2015.

Ngaka Modiri Molema. 2014/2015. Guidelines for district health expenditure reviews in South Africa. A guide for managers in the health sector. <http://www.hst.org.za/uploads/files/dher>. Date of access: 1 June 2016.

NICE see National Institute for Health and Care Excellence.

NMM see Ngaka Modiri Molema.

North-West University. 2012. Referencing Guide. <http://library.nwu.ac.za/files/files/documents/quoting-sources.pdf> -. Date of access: 23 Jan 2016.

NWU see North-West University.

Polit, D.F. & Beck, C.T. 2006. Essentials of nursing research: methods, appraisals and utilization. 5th ed. Philadelphia, Pa.: Lippincott.

Rala, N. 2013. Barriers to quality care during intra partum in Buffalo City, Eastern Cape Province, South Africa. *African journal for physical health education, recreation and dance*, 19(4):152-159.

Renfrew, M.J., McFadden, A., Bastos, M.H., Campbell, J., Shannon, A.A., Cheung, N.F., Silva, D.R., Downe, S., Kennedy, H.P., Malata, A., McCormick, F., Wick, L. & Declercq, E. 2014. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet*. [http://dx.doi.org/10.1016/50140-6736\(14\)60789-3](http://dx.doi.org/10.1016/50140-6736(14)60789-3). Date of access: 22 Oct 2017.

Rosen, P. 2004. Supporting women in labor: Analysis of different types of caregivers. *Journal of midwifery & women's health*, 49(1):24-31.

SANC see South African Nursing Council.

SA see South Africa.

Sandelowski, M. 2000. Focus on research methods. Whatever happened to qualitative description? *Research in nursing & health*, 2000(23):334-340.

Sandelowski, M. 2010. What is in a name? Qualitative description revisited. *Research in nursing & health*, 2010(33):77-84.

Sapkota, S., Kobayashi, T. & Takase, M. 2013. Impact on perceived postnatal support, maternal anxiety and symptoms of depression in new mothers in Nepal when their husbands provide continuous support during labour. *Midwifery*, 29(11):1264-1271.

Simkin, P. & Bolding, A. 2004. Update on non-pharmacological approaches to relieve labour pain and prevent suffering. *Journal of midwifery and women's health*, 49(6):489-504.

Simmonds, A.H. 2008. Autonomy and advocacy in perinatal nursing practice. *Nursing ethics*, 15(3):360-370.

Smith, H., Brown, H., Hofmeyer, J.G. & Garner, P. 2004. Evidence-based obstetric care in South Africa – influencing practice through the 'Better Births initiative'. *South African medical journal*, 94(2):117-120.

South Africa. 2012. Maternal and perinatal health profile. African edition. www.statssa.gov.za/publications/P03094/P030942013.pdf Date of access: 1 September 2016.

South Africa. 2015. Ethics in health research. Principles, processes and structures. Pretoria: Department of Health. 95p.

South Africa. 2016. Guidelines for maternity care in South Africa: a manual for clinics, community health centres and district hospitals. 4th ed. Pretoria: Government printer. 146p.

Spencer, N.S., Du Preez, A. & Minnie, C.S. 2018. Challenges in implementing continuous support during intra partum care in public hospitals in the North West Province. *Health SA gesondheid*, 1025-9848.

UNFPA see United Nations Population Fund.

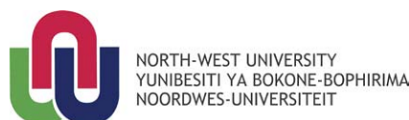
United Nations Population Fund. 2014. The state of the worlds' midwifery: A universal pathway. A woman's right to health. New York: United Nations. 218p.

WHO see World Health Organization.

World Health Organization. 2006. Constitution of the world health organization. http://www.who.int/governance/eb/who_constitution_en.pdf. Date of access: 30 October 2017.

Zhang, J., Bernasko, J.W., Leybovich, E., Fahs, M. & Hatch, M.C. 1996. Continuous labour support from labour attendant for primiparous women: A meta-analysis. *Journal of obstetrics and gynecology*, 88(4):739-744.

APPENDIX A: HREC APPROVAL



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Private Bag X6001, Potchefstroom,
South Africa, 2520

Tel: (018) 299-4900

Faks: (018) 299-4910

Web: <http://www.nwu.ac.za>

Institutional Research Ethics Regulatory Committee

Tel: +27 18 299 4849

Email: Ethics@nwu.ac.za

2016/05/26

ETHICS APPROVAL CERTIFICATE OF STUDY

Based on approval by **Health Research Ethics Committee (HREC)** at the meeting held on **10/02/2016**, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby **approves** your study as indicated below. This implies that the NWU-IRERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: The role of the midwife in facilitating continuous support during childbirth: a qualitative study														
Study Leader/Supervisor: Prof CS Minnie														
Student: J Jordaan														
Ethics number:														
N	W	U	-	0	0	0	1	4	-	1	6	-	A	1
Institution			Study Number					Year		Status				
<small>Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation</small>														
Application Type: Single study										Risk level:		Minimal		
Commencement date: 2016-05-16														
Continuation of the study is dependent on receipt of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation up to a maximum period of three years.														

Special conditions of the approval (if applicable):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HREC (if applicable).
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HREC. Ethics approval is required BEFORE approval can be obtained from these authorities.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The study leader (principle investigator) must report in the prescribed format to the NWU-IRERC via HREC:
 - annually (or as otherwise requested) on the monitoring of the study, and upon completion of the study
 - without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.
- Annually a number of studies may be randomly selected for an external audit.
- The approval applies strictly to the proposal as stipulated in the application form. Would any changes to the proposal be deemed necessary during the course of the study, the study leader must apply for approval of these amendments at the HREC, prior to implementation. Would there be deviated from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the study may be started.
- In the interest of ethical responsibility the NWU-IRERC and HREC retains the right to:
 - request access to any information or data at any time during the course or after completion of the study;
 - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.
 - withdraw or postpone approval if:
 - any unethical principles or practices of the study are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the HREC or that information has been false or misrepresented,
 - the required amendments, annual (or otherwise stipulated) report and reporting of adverse events or incidents was not done in a timely manner and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.
- HREC can be contacted for further information or any report templates via Ethics-HRECApply@nwu.ac.za or 018 299 1206.

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the IRERC or HREC for any further enquiries or requests for assistance.

Yours sincerely

Linda du Plessis

Digitally signed by Linda du Plessis
DN: cn=Linda du Plessis, o=NWU,
ou=Vaal Triangle Campus,
email=linda.duplessis@nwu.ac.za,
c=ZA
Date: 2016.05.27 12:28:55 +0200

Prof Linda du Plessis

Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

APPENDIX B: PROVINCIAL DOH APPROVAL



Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

3801 First Street
New Office Park
MAHIKENG, 2735

Enq: Nthabiseng Mapogo
Tel: 018 391 4504
nmapogo@nwpg.gov.za
www.nwhealth.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Ms. J. Jordaan
North West University

Physical Address
(Work/ Institution)



Subject : Research Approval Letter - The midwife's role in facilitating
Continuous support during childbirth: A qualitative study

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards

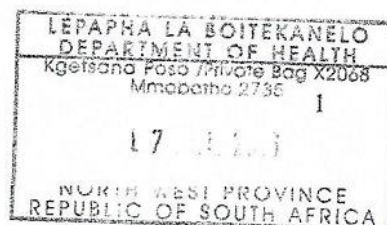
Dr. F.R.M. Reichel
Director: PPRM&E

07/07/2016
Date


Researcher

08/07/2016
Date


Healthy Living for All



APPENDIX C: PERMISSION FROM HOSPITAL CEO

 **health**
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

Thusong Hospital
Private Bag x6
Itsoeng, 2744
Tel: 018 338 2231/2/3/
018 338 2416
Fax: 018 338 2921

General De La Rey Hospital
Private Bag x12025
Lichtenburg, 2740
Tel: 018 632 3041/25/42
Fax: 018 632 4270

THUSONG/ GENERAL DE LA REY HOSPITAL COMPLEX
OFFICE OF THE CEO

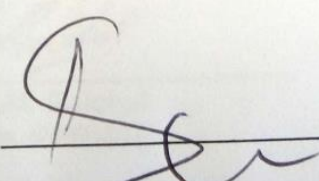
To: MS J JORDAAN
MASTERS DEGREE CANDIDATE AND RESEARCHER
NWU (POTCHEFSTROOM CAMPUS)

From: [REDACTED]
CHIEF EXECUTIVE OFFICER
[REDACTED]

Date: 28 JULY 2016

RE: PERMISSION TO CONDUCT RESEARCH AT [REDACTED]
[REDACTED]

Permission is hereby granted to conduct research titled, "The midwife's role in facilitating continuous support during childbirth: a qualitative study".

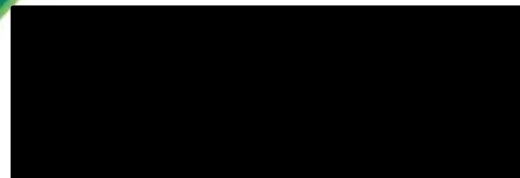
Regards

[REDACTED]
CHIEF EXECUTIVE OFFICER
[REDACTED]

APPENDIX D: PERMISSION FROM SUB-DISTRICT MANAGER



health

Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA



Enq: M. Molusi

Date : 30 August 2016

TO : Joha- Nita Jordaan



From



Subject : Approval

This serves as an approval granted to do your research at [REDACTED] on this topic
"The Midwife 's role in facilitating continuous support during childbearing "

Regards,



Ms. M. Molusi
Acting Sub-District Manager
Ditsobotla Sub-District

APPENDIX E: INFORMED CONSENT



PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM FOR MIDWIVES WORKING IN A SELECTED PUBLIC HOSPITAL OR COMMUNITY HEALTH CENTRE

TITLE OF THE RESEARCH PROJECT: The midwife's role in facilitating continuous support during childbirth: a qualitative study

REFERENCE NUMBERS:

PRINCIPAL INVESTIGATOR: Joha-Nita Jordaan

ADDRESS: 150 Nelson Mandela Drive
Lichtenburg
2740

CONTACT NUMBER: 076 219 4578

You are being invited to take part in a research project that forms part of my master's degree dissertation. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU 00014-16-S1)** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is this research study all about?

This study will be conducted in a Public Hospital and a Community Health Centre (CHC) in the North West Province and will involve semi-structured interviews with a researcher trained in research methodology. Eighteen participants from each institution will be included in this

study. A qualitative research design will be used to reach the aim of this study. The aim of this study is to promote continuous support during childbirth. The findings of this study will contribute to the guidelines to improve continuous support during childbirth. As a midwife providing care to women during the antenatal or intrapartum period, you are a very important source of information regarding the role of the midwife in facilitating continuous support during childbirth.

Why have you been invited to participate?

You have been invited to participate because you are working in a maternity unit or community health centre and met the inclusion criteria of the study.

Inclusion criteria

The participants must:

- be registered as midwives with the South African Nursing Council;
- have at least 6 months of experience as a midwife;
- be directly involved in providing care to women during the antenatal or intrapartum period;
- be working at one of the selected facilities;
- be able to communicate in English;
- be willing to be interviewed.

What will your responsibilities be?

You will be expected to participate in the interviews that will be held in your facility's boardroom. The interview will take some of your time. The interview will be conducted at a time and venue that is most suited for you. It can be conducted in the hospital in teatime, lunchtime or when it suits you. The interview will take approximately 30-60 minutes. You will be asked regarding the role of the midwife in facilitating continuous support to the mother during childbirth.

Will you benefit from taking part in this research?

Although the participant will not benefit directly from participating in the study, the results of this study will contribute to the guidelines to improve continuous support during childbirth in public hospitals in the North West Province. The aim will be to promote continuous support during childbirth in public hospitals and community health centres in the North West Province through identifying the role of the midwife.

Are there risks involved in your taking part in this research?

There are no risks foreseen in this study. The interview will take some of your time. The interview will be conducted at a time and venue that is most suited for you. It can be conducted in the hospital in teatime/ lunchtime or when it suits you. The interview will take approximately 30-60 minutes. Your permission is also asked to record the interview to be transcribed and analysed afterwards. The recordings will be locked away in a safe place and the final report will not be traceable back to any participant. Refreshments will be provided during the information session and on the day of the interviews.

What will happen in the unlikely event of some form of discomfort occurring as a direct result of your taking part in this research study?

Should you have the need for further discussions after any discomfort caused by the interviews an opportunity will be arranged for you to consult with the appropriate person.

Who will have access to the data?

Anonymity will be ensured by coding the participants and no names of participants will be made public. Confidentiality will be ensured by handling all information that you give strictly confidential. Once the information is analysed no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or the hospital.

Reporting of findings will be anonymous by giving codes to all the participants. Only the researchers, co-coder and transcriber will have access to the data. Confidentiality agreements will be signed by these persons. Data will be kept safe and secure by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. (As soon as data has been transcribed it will be deleted from the recorders). Data will be stored for 5 years.

What will happen with the data/samples?

This is a once off collection and data will be analysed by the researcher and reported by means of a research dissertation. The results will be dissemination back to the participants.

Will you be paid to take part in this study and are there any costs involved?

No you will not be paid to take part in the study but refreshments will be provided on the day of the interviews.

Is there anything else that you should know or do?

- You can contact Joha-Nita Jordaan at 076 219 4578 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

How will you know about the findings?

- The findings of the research will be shared with you during feedback sessions and the results will also be captured into a dissertation.

Declaration by participant

By signing below, I agree to take part in a research study titled: The midwife's role in facilitating continuous support during childbirth: a qualitative study.

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

Signed at (*place*) on (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) on (*date*) 20....

.....
Signature of person obtaining consent

.....
Signature of witness

.....
Signature of researcher

.....
Signature of witness

Signed at (*place*) on (*date*) 20....

APPENDIX F: INTERVIEW SCHEDULE

1. What are your views on the role of the midwife providing antenatal care in facilitating continuous support during childbirth?
2. What are your views on the role of the midwife providing intrapartum care in facilitating continuous support during childbirth?
3. What are your views regarding advocacy for continuous support during childbirth?
4. What facilitates continuous support during childbirth?
5. What hinders continuous support during childbirth?

Introductory question:

- Who do you think can provide continuous support to a woman in labour?

APPENDIX G: EXAMPLE OF A TRANSCRIBED INTERVIEW

I – INTERVIEWER

R- RESPONDENT

I – Good afternoon Mam. Just once again I am Joha-Nita Jordaan a master's degree student from the Potchefstroom University. I am doing this research study on continuous labour support. The title of the study is the midwife's role in facilitating continuous support during childbirth and the aim of this study is to promote continuous support during childbirth and now it will be done by face to face interviews according to an interview schedule. It will take approximately 30-60 minutes, uhm, of your time. All of this information, once again, is confidential and just to confirm on the tape-recorder. Have you signed voluntary consent?

R Yes, I did.

I Okay. Thank you and just a reminder. You are still free to withdraw at any time. Okay. Just to confirm again like I said previously that this interview is tape-recorded. So you are being tape-recorded now. Okay mam. Then I am going to go to an introductory question just to get us started. Who do you think can provide continuous support to a woman in labour?

R I think, uhm, any person the woman chose can give her support, uhm, usually it will be someone that she trusts. Uhm. Maybe it can be a grandmother, a mother, a good friend, uhm, so maybe if it is her choice to, to have a doulah. So it will be really someone she trust enough to be part of this birthing experience that can support her.

I Okay. Thank you for that. Through your discussion now I picked up that you said, uh, you mentioned only female persons.

R Yes, I did because I think the male, uhm, he will have his own stressors when he supports his wife during labour. So, uhm, even if he is there, uhm, he can also be part of her support system if it is her choice but the cultural, the people uhm, we are giving a service to in our region most of them, they, it is very seldom that they, it is their choice to have a male supporting them. Most of the time it will be a mother or a sister or a friend that they choose to be part of the experience.

I Okay, thank you. So just to summarise there. Through all of them that you were mentioning now you mentioned females because you feel that the male person needs a support system of his own.

R Yes

I And that this, uh labouring woman must feel comfortable with this, with this person providing support.

R Yes, definitely. I think it will be a uhm for her because we really need to think of her in confidentiality and we must respect her so I know in the labour rooms when we need to do investigations or examinations we would ask the males usually to leave the room and some of them feel quite scared so they would like their support system to be there so if it is a female I think it will even be better for herself for that one to stay there.

I Okay, thank you for that introduction, uhm, if I may go to the next question, uhm, what are your views on the role of the midwife providing antenatal care in facilitating continuous support during childbirth?

R During antenatal care I think if the, uhm, midwife can ask the woman what is her choice on who would she like to, be with her on this path to, during this pregnancy up to the birth of the baby. Uhm, who is the person she trusts and then maybe the midwife can allow that person to be part of the antenatal clinics, because we give health education sessions in the clinics so that the persons if it is the mother or a sister, or a friend that she trust can hear, say for instance when we talk about the danger signs or when you go into labour, so that this person can also get used to this, so that. I think it will just make the support so much better for, uh, this uhm pregnant woman. I think and then she will also feel comfortable and know that she can trust this person because she will know when she is needed.

I Okay. So you feel that continuous labour support should already start in the antenatal period.

R Yes, definitely, definitely. I think that is where, uh, where that, uhm, relationship between then starts already and the trust between them and they know that this person will be there for me, up to the end.

I Okay, thank you for that. If I can go to the next question. What are your views on the role of the midwife providing intrapartum care in facilitating continuous support during childbirth?

R I think the intrapartum care is maybe the most important time because, uhm, I believe the experience the woman will be having actually during labour is something that will remain with her for the rest of her life. So if she knows she had this support system and she had, her choices were respected and that she had this good experience during the, uhm, during intrapartum. I think the outcome will be so much better for the mother and the baby.

I Okay, and how do you think can the midwife facilitate this continuous labour support.

R I think the midwife can facilitates it by allowing the woman to be part. To be there with her during the labour up to the part where she delivers. If she decides that it must be a mother or a friend to allow this person to be there. The midwife can also by giving information to the supporting person, maybe how she can rub the back or those things, uhm, that can also facilitate support.

I Okay. So you feel that by allowing a person in to the labour room in the intrapartum period you can facilitate continuous support. Okay, thank you for that mam. Is there anything else you want to add on that intrapartum point?

R No, I just want to say, I wish that we can have the ideal world because I think every mother needs to have the supports she wishes for during labour and childbirth. So that is very important, that is a feeling I am having.

I Just a personal opinion there. The next question mam, what are your views regarding advocacy for continuous support during childbirth?

R I think we as midwives it is our responsibility and duty to advocate for our mothers and uhm I think we can do that by communicating the woman's wishes. Say for instances we give, handover to the next shift, maybe you can tell the sister who was supporting the woman during the day so that they can know there was someone and uhm maybe share some ideas on what you have already told them and maybe that sister can just add on to some information that is still short and I think we need to, uhm,

also, uhm, give them information on the progress of labour. How they are going, and coping mechanisms and relaxation techniques. I think if we as midwives can uhm advocate this uhm things for our labouring mother, the experience will be very good for the mother and the outcome for her and the baby will be good.

I Okay. Thank you for that. Uhm, so just in summary you feel that it is part of the midwives' duties and responsibility to advocate for a labouring woman.

R Yes yes, definitely. I think a labouring woman from my point of view from all the patients we nurse is, is someone who needs the most support from us and really advocacy because if you, uhm, because she is so fragile and vulnerable. So you really need to advocate for her to make this uh, an experience she will never forget in her life.

I Okay. Thank you, thank you for that. Uhm, if I can go to the next question. What facilitates continuous support during childbirth?

R I think if we as an institution don't have uhm too many rules and regulations, uhm, on, who is supposed to support the woman and who not, uhm, who we allow to be with her. I think if we can do that, it will facilitate support for her in labour.

I Okay. So through an institutional point of view you feel that there's, there's some ways that you can facilitate continuous support.

R Yes, yes we can.

I Okay. Anything else you want to add?

R No

I Thank you, and then if I can go to the next point on the other hand. What hinders continuous support during childbirth?

R In our institution I know there is a, uhm, there is notices to the entrance of the ward that is saying, uhm, a supporting system will only be allowed when a woman is in active phase of labour and it is clearly stipulated that, that person should leave as soon as the baby is born and stick to visiting hours, so I think the strict rule hinders really and uh, but I can also understand it because we are in a rural community so if we will just open the doors and allow, but I think that hinders and space. We are having in our one labour room, we have already two beds in there, so I think if we allow a person to

support there while another woman is labouring without having someone maybe it would be, there won't be any confidentiality between, because there is another person in the room and uhm there is also strict guidelines from the security point of view. I know that people is not, that when it is not visiting hours they are not allowed to come onto the premises and just walk into the wards, uhm, and I think, uhm, staff shortages is also something that hinders. Ja, ja.

I Okay, so the barriers you mentioned a few now. Uhm. Also institutionally you mentioned the infrastructure that there is a lack of space. You mentioned security rules and also uh, strict rules from your, from your facility. Uhm. Is there something else that you want to add or maybe elaborate on?

R And I think attitude of, of maybe a staff member can also hinders. If you are not a, I don't want to say that not a passionate midwife but if you are feeling that you don't have time for this person to support this lady now. I think that can also definitely hinders. So, I think uhm, maybe the attitude of the midwife is also something that can hinder.

I Okay, so that is another point. Mam we have come to the end of the interview. Just to summarize. We discussed your views on the role of the midwife providing antenatal care as well as intrapartum care in facilitating continuous support during childbirth and then also your views regarding advocacy for continuous support during childbirth. Here you mentioned that you feel it is the responsibility of the midwife. Then we came to what facilitates and what hinders continuous support during childbirth. Is there maybe anything else you want to add on one of the topics.

R No, no there is nothing

I Are you covered?

R Yes, thank you.

I Then in conclusion just thank you very much for your time and the results of this research study will be disseminated back to the Department of Health and then you will get feedback on that

R Thank you

I Thank you mam.

APPENDIX H: EXAMPLE OF FIELD NOTES

Descriptive notes:

The midwife has signed informed consent. She is registered at the South African Nursing Council (SANC) and is having 24 years' experience as a midwife. She is an advanced midwife working in the selected public hospital and is directly involved in providing antenatal and intrapartum care. The interview was done in the boardroom of the facility. The participant looked professional in her uniform. The age of the interviewer is 49 years and her nationality is a white South African. She can speak English well.

Reflective notes:

The participant looked very eager to start with the interview. She was ready to answer all the questions. She had a very calm attitude and listened carefully while the interviewer was talking. Her voice was audible. She didn't hesitate when answering the questions and it could be felt that she is very passionate about this component of midwifery. She even added some closing thoughts. An introductory question was asked and followed by the five questions of the interview schedule. Good eye contact was made throughout.

Demographic notes:

The interview was done 12 August 2016 at 12h00 in the boardroom of the facility by the researcher herself. The boardroom was warm and well lighted. The windows were opened to ensure adequate ventilation. It was quiet, the door was closed and a sign0 was placed on the door to avoid disturbances. The demographic conditions were conducive for a successful interview. The interview was conducted by the researcher herself. The researcher took field notes after the interview.

APPENDIX I: RECRUITMENT POSTER

PARTICIPATE IN RESEARCH TO IMPROVE CARE TO WOMEN DURING CHILDBIRTH

As part of my M Cur studies at the Potchefstroom Campus of the North-West University, I am looking for volunteers to be participants in a new study about:

The midwife's role in facilitating continuous support during childbirth

You can be a participant if you are;

- be registered as midwives with the South African Nursing Council;
- have at least 6 months of experience as a midwife;
- be directly involved in providing care to women during the antenatal or intrapartum period;
- be working at one of the selected facilities;
- able to speak English
- willing to be interviewed.

The results of this research will contribute to guidelines to improve continuous support to the mother during childbirth in institutions in the North West Province.

Participants are invited for individual one-on-one interviews that will take 30-60 minutes.

A mediator will contact interested midwives in the facilities where they are working.

For any enquiry about the research please contact:

Ms Joha-Nita Jordaan

Cell: 076 219 4578

E-mail: johanitajordaan@gmail.com

APPENDIX J: EDITORS LETTER

Valerie Janet Ehlers

Nurse Consultant and Researcher

Emeritus Professor and Research Fellow: University of South Africa

Associate Editor: International Nursing Review (2014-2017)

(B Soc Sc (University of Natal), Honours B Soc Sc, BA Cur, Honours BA Cur,
MA Cur, D Lit et Phil, Diploma in Development Administration, TAALKU-F for
Diploma in Translation- Unisa))

CONFIRMATION LETTER: EDITING OF A DOCUMENT

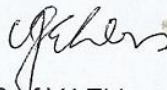
266 Pat Dyer Avenue
ERASMUSRAND
0181

PO Box 65075
ERASMUSRAND
0165
2 November 2017

Tel: 012 347 8287
Cell: 084 587 3303
e-mail: ehlersjh@mweb.co.za

2 November 2017	<p>I HEREBY CERTIFY THAT I HAVE EDITED THE FOLLOWING MASTER'S DISSERTATION:</p> <p>The role of the midwife in facilitating continuous support during childbirth: a qualitative study</p> <p>For student JJ Jordaan (st no 21619824)</p>
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Thank you


Prof VJ Ehlers