



**Challenges in implementing continuous
support during intrapartum care in public hospitals
in the North West Province**

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DECLARATION

I hereby solemnly declare that this dissertation, entitled Challenges in implementing continuous support during intrapartum in public hospitals in the North West Province, 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 Committee 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.

Nobelungu Sylvia Spencer

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“I know the plans I have for you’, declares the Lord, ‘plans to prosper you and not to harm you, plans to give you hope and a future’.”

- Jeremiah 29 vs. 11

First and foremost let the Glory be to God, our heavenly Father who enabled me to do this good work.

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ABSTRACT

Continuous support during intrapartum is undeniably beneficial. It increases the mother's chance of giving spontaneous vaginal birth, which is not physically traumatic. This indicates the effectiveness of continuous support during intrapartum. According to a Cochrane review conducted such support has no identified adverse effects (Hodnett *et al.*, 2009:2). It is important that implementation of continuous intrapartum support should be promoted by the midwives in order to improve the quality of care given to labouring women.

The objective of the study is to explore and describe the challenges in implementing continuous intrapartum support in public hospitals in the North West Province. The findings of this study will contribute to the formulation of recommendations to promote continuous intrapartum support in public hospitals in the North West Province.

Focus group interviews were conducted to collect data from 33 (thirty-three) registered midwives who have worked in labour rooms for 2 years or more who are able to give in-depth and rich expressions of opinion. The focus group interviews were conducted in a natural setting in the labour unit to avoid inconvenience.

An explorative, descriptive and contextual qualitative approach using a non-experimental research design was used in order to reach the aim of the study, being to promote continuous support during intrapartum in public hospitals in the North West Province.

The study revealed that midwives have an understanding of the benefits of continuous intrapartum support, but its implementation is hindered by challenges. Recommendations are made to inform the different stakeholders involved in curbing the challenges in order for the implementation of continuous intrapartum support to be a success. These recommendations are directed at the nursing practice, nursing (midwifery) education, nursing research and policy.

Key words: continuous support, intrapartum, midwife, patient/mother.

OPSOMMING

Deurlopende ondersteuning gedurende intrapartum is onteenseglik voordelig. Dit verhoog die moeder se kans om spontaan vaginaal geboorte te skenk, wat nie fisies traumaties is nie. Dit is aanduidend van die effektiwiteit van deurlopende ondersteuning gedurende intrapartum. Volgens 'n Cochrane oorsig het die praktyk geen geïdentifiseerde negatiewe gevolge nie (Hodnett *et al.*, 2009:2). Dit is belangrik dat die implementering van deurlopende intrapartum ondersteuning deur vroedvroue bevorder word om die kwaliteitsorg wat aan vroue in kraam, gegee word te verbeter.

Die doel van die studie is om die struikelblokke in die implementering van deurlopende intrapartumondersteuning in publieke hospitale in die Noordwesprovinsie te ondersoek en te beskryf. Die bevindinge van die studie kan bydra tot die formulering van riglyne om deurlopende intrapartum ondersteuning in publieke hospitale in die Noordwesprovinsie te bevorder.

Fokusgroep onderhoude is gehou om data in te samel vanaf 33 (drie-en-dertig) geregistreerde verloskundiges wat vir 2 of meer jaar in kraamsale gewerk het en dus in staat is om in-diepte en ryk opinies te deel. Die fokusgroep onderhoude is gevoer in 'n natuurlike omgewing in die kraamsale om ongerief te verhoed.

'n Verkennende, beskrywende en kontekstuele kwalitatiewe benadering is gevolg met 'n nie-eksperimentele navorsingsontwerp om sodoende die doelwit van die studie te bereik, naamlik om deurlopende ondersteuning gedurende intrapartum in publieke hospitale in die Noordwesprovinsie te bevorder.

Die studie toon dat vroedvroue 'n begrip het van die voordele van deurlopende intrapartum ondersteuning, maar dat daar struikelblokke is wat die implementering daarvan verhinder. Aanbevelings word gemaak om die verskillende belanghebbendes in te lig om sodoende die struikelblokke uit die weg te ruim sodat deurlopende ondersteuning 'n sukses kan wees. Hierdie aanbevelings is toegespits op die verpleegpraktyk, verpleegopleiding (verloskunde), verpleegnavorsing en –beleid.

Sleutelwoorde: deurlopende ondersteuning, intrapartum, vroedvroue, pasiënt/moeder.

ABBREVIATIONS

B

BBI Better Births Initiative

D

DoH Department of Health

DENOSA Democratic Nursing Association of South Africa

I

ICM International Confederation of Midwives

ICN International Council of Nurses

M

MMR Maternal Mortality Rate

MRC Medical Research Council

N

NW DoH North West Department of Health

NWU North-West University

NCCEMD National Committee on Confidential Enquiries into Maternal Deaths

O

OSD Occupational specific dispensation

P

PEW Pregnancy Education Week

S

SSA Statistical census survey in South Africa

SANC South African Nursing Council

W

WHO World Health Organization

LIST OF CONTENTS

DECLARATION	.....	ii
ACKNOWLEDGEMENTS	.....	iii
ABSTRACT	.....	v
OPSOMMING	.....	vi
ABBREVIATIONS	.....	vii
List of Contents	.....	viii
LIST OF TABLES	.....	xii
LIST OF FIGURES AND BOXES	.....	xiii
CHAPTER 1	GROUNDING OF THE RESEARCH	1
1.1	INTRODUCTION	1
1.2	BACKGROUND, RATIONALE AND PROBLEM STATEMENT	1
1.3	AIM AND OBJECTIVES	5
1.4	PARADIGMATIC PERSPECTIVE	5
1.4.1	Meta-theoretical Assumption	5
1.4.2	Theoretical assumptions	7
1.4.3	Central theoretical argument	8
1.4.4	Theoretical/operational description	9
1.4.5	Methodological Assumptions	11
1.5.	RESEARCH DESIGN	11

1.6.	RESEARCH METHOD	12
1.6.1	Context.....	12
1.6.2	Setting	15
1.6.3	Population	16
1.6.4	Sampling	16
1.7.	DATA COLLECTION	16
1.8.	DATA-ANALYSIS	17
1.9.	RIGOUR.....	17
1.10.	ETHICAL CONSIDERATIONS	19
1.11.	RESEARCH REPORT LAYOUT.....	20
1.12	SUMMARY	21
CHAPTER 2	RESEARCH METHODOLOGY	22
2.1	INTRODUCTION.....	22
2.2	RESEARCH METHODS AND DESIGN.....	22
2.2.1	Research design	23
2.2.2	Research Methods	24
2.2.3	Data collection.....	27
2.3	RIGOUR.....	29
2.4	ETHICAL CONSIDERATION.....	34

2.5	EMBEDDED LITERATURE.....	37
2.6	SUMMARY	38
CHAPTER 3	RESEARCH FINDINGS AND EMBEDDED LITERATURE.....	39
3.1	INTRODUCTION	39
3.2	DEMOGRAPHIC PROFILE.....	39
3.3	DATA ANALYSIS.....	40
3.4	EMBEDDED LITERATURE.....	41
3.5	RESULTS AND FINDINGS	42
3.6	THEMES AND SUBTHEMES	44
3.6.1	THEME 1: Staff shortage	56
3.6.2	THEME 2: Antenatal care	63
3.6.3	THEME 3: Labour companion	67
3.6.4	THEME 4: Policies and guidelines	69
3.6.5	THEME 5: Communication / relationship.....	71
3.6.6	THEME 6 : Resources	74
3.7	SUMMARY	76
CHAPTER 4	CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS ..	77
4.1	INTRODUCTION	77
4.2	CONCLUSIONS.....	77

4.3	LIMITATIONS OF THE STUDY	78
4.4	RECOMMENDATIONS	78
4.4.1	Nursing practice	78
4.4.2	Nursing education	80
4.4.3	Policy	81
4.4.4	Nursing research	82
4.5	PERSONAL REFLECTION	83
4.6	SUMMARY	83
Reference list	.....	85
APPENDIX A	Ethical approval: NWU-00051-08-A1 (Prof HC Klopper).....	99
APPENDIX B	Ethical approval: North West Department of Health	100
APPENDIX C	Permission to conduct research at Klerksdorp Hospital	101
APPENDIX D	Permission to conduct research at Potchefstroom Hospital	102
APPENDIX E	Permission to conduct research at Taung District Hospital	103
APPENDIX F	Information leaflet and consent for non-clinical research...	104
APPENDIX G	Transcription of focus group interview	106
APPENDIX H	Field notes	113

LIST OF TABLES

Table 1.1:	Midwives-deliveries-ratio.....	15
Table 2. 1	Questions and criteria related to trustworthiness in qualitative research.....	29
Table 2.2	Strategies to enhance trustworthiness in this research	30
Table 3.1	Demographic data of participants: focus group K1 and K2... 	39
Table 3.2	Demographic data of participants: focus group P1 and P2 ...	40
Table 3.3	Demographic data of participants: focus group T1 and T2 ...	40
Table 3.4:	Summary flow chart of results.....	43
Table 3.5	To explore and describe the challenges related to implementing continuous labour support in public hospitals in the North West Province	44
Table 3.6	Themes and sub-themes with quotes.....	46

LIST OF FIGURES AND BOXES

Figure 1.1:	Framework for evaluating quality of care in maternity services, ten elements of care (Hulton <i>et al.</i>, 2000:9).	8
Figure 1.2	Map of the nine provinces of South Africa	13
Figure 1.3	Orientation map of the North West Province, (SA, 2012b:18).....	14
Box 3.1	Workload	57
Box 3.2	Staff patient ratio	59
Box 3.3	Staff experience.....	61
Box 3.4	Burden of interns / student / agency nurses	62
Box 3.5	Health educations.....	63
Box 3.6	Traditional medicine.....	65
Box 3.7	Cultural / spiritual factors	66
Box 3.8	Family support.....	67
Box 3.9	Doula Program.....	68
Box 3.10	Hospital	69
Box 3.11	Clinic	70
Box 3.13	Language	71
Box 3.14	Attitude of staff.....	72
Box 3.15	Attitude / expectation of patient / family	73
Box 3.17	Infrastructure	74
Box 3.18	Medication	75
Box 3.19	Stock and medical equipment	75

CHAPTER 1

GROUNDING OF THE RESEARCH

1.1 INTRODUCTION

Continuous support during intrapartum is undeniably beneficial. It increases the woman's chances of a spontaneous vaginal birth, which is not physically traumatic. According to a Cochrane review conducted continuous support during intrapartum has no identified adverse effects (Hodnett *et al.*, 2009:2). Continuous labour support can be an effective method of non-pharmacological pain relief (McGrath *et al.*, 1998; Simkin & Bolding, 2004:489). The comfort of the continuous support promotes the steady release of endorphins, and dramatically decreases the amount of pain the woman in labour experiences.

Continuous support during intrapartum is not common in state hospitals in the North West Province. This study investigates the challenges that midwives meet when it comes to implementing continuous support during intrapartum. Knowledge about the perceptions of the major roleplayers will contribute to strategies to promote continuous support of labouring woman.

This chapter presents the background, rationale and problem statement. This is followed by the aim and objectives, the research design and methods. Finally the strategies to ensure the rigour of the study, as well as the ethical considerations are addressed.

1.2 BACKGROUND, RATIONALE AND PROBLEM STATEMENT

It is ideal that the woman's environment during the intrapartum period should be enabling. One way of ensuring an enabling environment is continuous support. All mammals (inclusive of human beings) need to feel secure when giving birth. Animals have strategies not to feel observed during the period surrounding birth such as postponing the delivery if there is a predator around (Odent, 2008:14). Every effort should be made to ensure that a woman's birth environment is empowering, that she is afforded privacy, and that respect is communicated. Intrapartum should not be characterized by routine interventions that add

risk without clear benefit (Hodnett *et al.*, 2009:11). The environment should be calm and loving as neuro-hormones with 'morphine-like' actions are secreted in a calm reassuring environment. Many mammals give birth in a dark, calm and quiet environment without any interruption. The environment should lend itself to privacy and tranquility. Human beings also seek such settings (Odent, 2008:14). The labouring woman should be provided with an environment suitable for labouring, in other words a positive emotional environment that helps a woman feel relaxed, calm and confident. This can only be provided by those giving support and care throughout the intrapartum period. This environment is important to both the woman and her partner and it should be as supportive and comfortable as possible (Moore, 1997: 49).

Optimal support for the mother will make her feel safe, but she also has to feel positive about her relationship with the father, so it will help if he feels more involved and empowered. Labour support enhances labour physiology and allows the mother to feel in control and competent. This reduces reliance on a medical intervention such as caesarian section. The satisfaction with the childbirth experience is higher (Hodnett *et al.*, 2009:2, Scott *et al.*, 1999:1257, Brainbridge, 2010:57).

In addition, labour support can lead to decreased use of pharmacological pain relief since the woman experiences physical presence and verbal interaction with labour support (SA, 2007: 37; Hodnett *et al.*, 2009: 3; Scott *et al.*, 1999:1261). Labour support promotes bonding with the baby and early father-baby attachment, which has a positive influence on child wellbeing and cognitive development. The mother is also empowered to build her relationships with her partner, as their joined experience of this unique situation deepens their relationship because they share the labour process (Fraser, Cooper & Nolte, 2009:494). McGrath *et al.* (1998: 9) and Fraser *et al.* (2009: 494) emphasize that continuous labour support enhances shorter labour.

A review of research by the Cochrane Pregnancy and Childbirth Group already stated in 1995 that continuous one-to-one support of a woman during labour and childbirth is clearly 100% beneficial (Hodnett *et al.*, 2009:3). This finding has been confirmed by World Health Organization (WHO). Continuous support creates a strong feeling of security and satisfaction and has a positive effect on the outcome of labour (Fraser *et al.*, 2009:478).

The "Better Births Initiative" (BBI) promotes continuous intrapartum support as central to improving maternal and infant healthcare (Hodnett *et al.*, 2009:4). It is one of the best practices of intrapartum labour care and forms an important part of BBI (Hodnett *et al.*,

2009:4). Each woman should have the companionship and aid of another person during labour (Trotter *et al.*, 1992:137).

The type and degree of support required will vary from woman to woman, but every woman can benefit from individualized attention and sensitive nurturing during the intrapartum period (Hodnett *et al.*, 2009:2). Different people can provide continuous support for women in childbirth, like a midwife, doula, partner/father, family and friends. Ideally the woman should decide who will offer her continuous labour support. She may choose a friend or relative who is experienced with childbirth or hire a doula, which is a labour support professional (Page *et al.*, 2007:337).

Traditionally women in labour were surrounded by other women from their family (generally woman who had already given birth) such as a friend or family member experienced in childbirth may be able to provide continuous support, which serves as reassurance to the woman in labour. The advantage is that they know the woman intimately and have already built a relationship with her. These women do not need formal training; they only need to be willing (Green *et al.*, 2007:28). In cases where a woman elects to use a family member or friends for continuous support, the possible disadvantage is reliability in terms of commitment to be present in the labour room. They may not be well-motivated.

Research shows that women find the presence of their partners / husbands reassuring, as they are able to provide emotional support (Dellmann, 2004:20; Somers-Smith, 1999:103). The labouring women also express their satisfaction with the psychological support their partners provide, which shows caring, empathy and sympathy (Somers-Smith, 1999:105). In the United States of America fathers-to-be are usually expected to accompany their partners through labour and delivery (McGrath *et al.*, 2008:35). The partner can assist by providing physical comfort with things like touch and massage.

During continuous labour support the partner assumes the role of a coach, actively taking control of the labour process, of a teammate responding for requests of control and of a witness observing the birth (Dellmann, 2004:22). Some of the fathers can assume the role of being an advocate, men armed with information on their partner's and their own rights, who fight for what they want to happen. The father's role in alleviating stress during the intrapartum period includes that he relieves the health professional's pressure by being there, because he has prior knowledge about his partner that the midwife does not have. However, some men need support themselves (Somers-Smith, 1999:105).

Traditionally, one of the core components of labour (including antenatal, intrapartum and puerperium) support has been to provide continuous, supportive presence to women in labour, so the ideal person to provide continuous labour support would be the midwife. Indeed, the word midwife means “with woman”. A midwife is able to identify and address unique physical, social and emotional needs (Moore, 1997:87). She is supposed to provide continuous hands-on assistance during the intrapartum. The advantage is that a midwife can offer highly individualized and nearly continuous care because she is a trained professional with special expertise in supporting women through a healthy pregnancy and birth (Moore, 1997:87). Support from professional midwives would be ideal, but is difficult in practice as midwives are often responsible for more than one laboring women simultaneously (Hodnett *et al.*, 2009:3; Green & Hotelling, 2010:1). Midwives in hospitals generally work in shifts, so the support person could change one or more times during the intrapartum, which is not the ideal way of providing continuous labour support.

A person that can support a woman irrespective of shift changes is a doula, defined as the trained labour companion who provides both the woman and her husband or partner continuous emotional and physical support throughout the entire intrapartum period, and to some extent, afterwards (Green *et al.*, 2007:27; Lagendyk & Thurston, 2005:15; Scott *et al.*, 1999:1258). Some doulas do undergo training recognized by the Doula Organization of South Africa, but they are not trained to perform any medical or nursing tasks (Doula SA, 2009:1). In South Africa there are two types of doulas: doulas paid by clients and those who work for a non-governmental organizational and who are not remunerated.

The disadvantage of electing for a doula as a support person is that it has cost implications that are carried by the health system or clients, in some instances it may be the barrier to access support. Doulas may consider this as an irregular income, since it depends on the preference of a woman during the intrapartum period. The advantage of a doula is that she remains available next to the woman throughout the process, unless the woman requests time alone (Green *et al.*, 2007:27). The important role of the doula is to help the woman have positive memories of the birth experience (Green *et al.*, 2007:27). Doulas know to create an environment where mothers feel completely protected and safe; they build her confidence in her body’s abilities in birthing her baby. Recent World Health Organization (WHO) guidelines recommend that doulas be provided at the woman’s request and state that supportive care during the intrapartum is essential (Lagendyk & Thurston, 2004:15).

However, during my exposure to practice as clinician and clinical accompanist of midwifery learners, I observed that continuous support is uncommon in the public hospitals in North West province. In light of all the benefits of continuous labour support, the question arises:

- What are the challenges in implementing continuous support during intrapartum in public hospitals in the North West province?

1.3 AIM AND OBJECTIVES

The aim of this study is to promote continuous support during intrapartum in public hospitals in the North West Province.

1.3.1 To reach this aim the objective of this study is to explore and describe the challenges in implementing continuous labour support in public hospitals in the North West Province.

1.3.2 The findings of this study will contribute to recommendations to promote continuous support during labour in public hospitals in the North West Province.

1.4 PARADIGMATIC PERSPECTIVE

1.4.1 Meta-theoretical Assumption

The meta-theoretical assumptions that underlie this study are founded on the Christian faith and include assumptions regarding man, the environment, health and illness.

1.4.1.1 Man

Man is a human being created in the image of God and functions holistically as a body, mind and spirit (Bible, 1999). Man cannot live alone, but lives in constant interaction with other human beings in a community with the direct command to rule the world, together

with the responsibility to be accountable for all actions. A pregnant woman as a human being has a free will and the ability to make informed decisions about the safe birth of her baby.

She looks to the midwife and doctor for guidance in this regard. However, her constant interaction with the environment (the midwife, doctor, family and friends in the community) greatly influences her views, experiences and perceptions regarding childbirth and the role that they take during continuous intrapartum support (George, 2002:412).

1.4.1.2 Environment

The world was created by God and given to man to cultivate and care for it. Man shares the world with other living beings and functions in an interdependent relationship with the external world, other human beings and the immediate environment, as well as his own internal environment consisting of the body, mind and spirit. Man's lifestyle can therefore, be influenced in either a positive or negative manner by the environment, posing possible threats to man's health and well-being. For this study the environment includes both the *social* and *physical structure* of the health facility, which can influence the clean and safe birth of a baby.

Attention to the *physical environment* (adequate infrastructure and maintenance of buildings), can provide a safe environment for the labouring woman. The *social environment* entails skilled and competent midwives attending to the mother during the intrapartum, giving her emotional support and adequate information during this period. The positive practice environment will have a positive impact on the health and illness of the mother which includes treating patients with dignity and respect (George, 2002:413).

1.4.1.3 Health and illness

Health does not only refer to the absence of illness or disease, but to a state of spiritual, mental and physical wholeness and well-being experienced by man (de Haan, 2005:3). Illness can be described as ranging from minimum to severe illness, implying the presence of either physical, mental, social and spiritual risks and/or problems. Health can be promoted by continuous labour support and illness can be prevented and limited by gaining knowledge through health education, quality antenatal and delivering quality intrapartum care.

The health status of each individual is dependent on many factors of which generic, environmental and individual lifestyle factors are important. Safe childbirth practices are important determinants in the reduction of maternal and perinatal deaths, considering the increasing maternal mortality rate prevalent in the South African context (Beksinska, 2006:297).

The presence of either good health or illness has long term effects that directly determines the quality of life of each individual and needs to be taken seriously from as early as during childbirth (George, 2002:412). The wholeness increase if feeling empowered, safe and cared for.

1.4.2 Theoretical assumptions

The theoretical framework of the study is based on the research of Hulton *et al.*, (2000) namely, “A framework for evaluation of quality of care in maternity services”. The framework allows quality of care to be separated into two constituent parts: the quality of the provision of care within the institution and the quality of the care as experienced by users (Hulton *et al.*, 2000:9), [see figure 1.1]

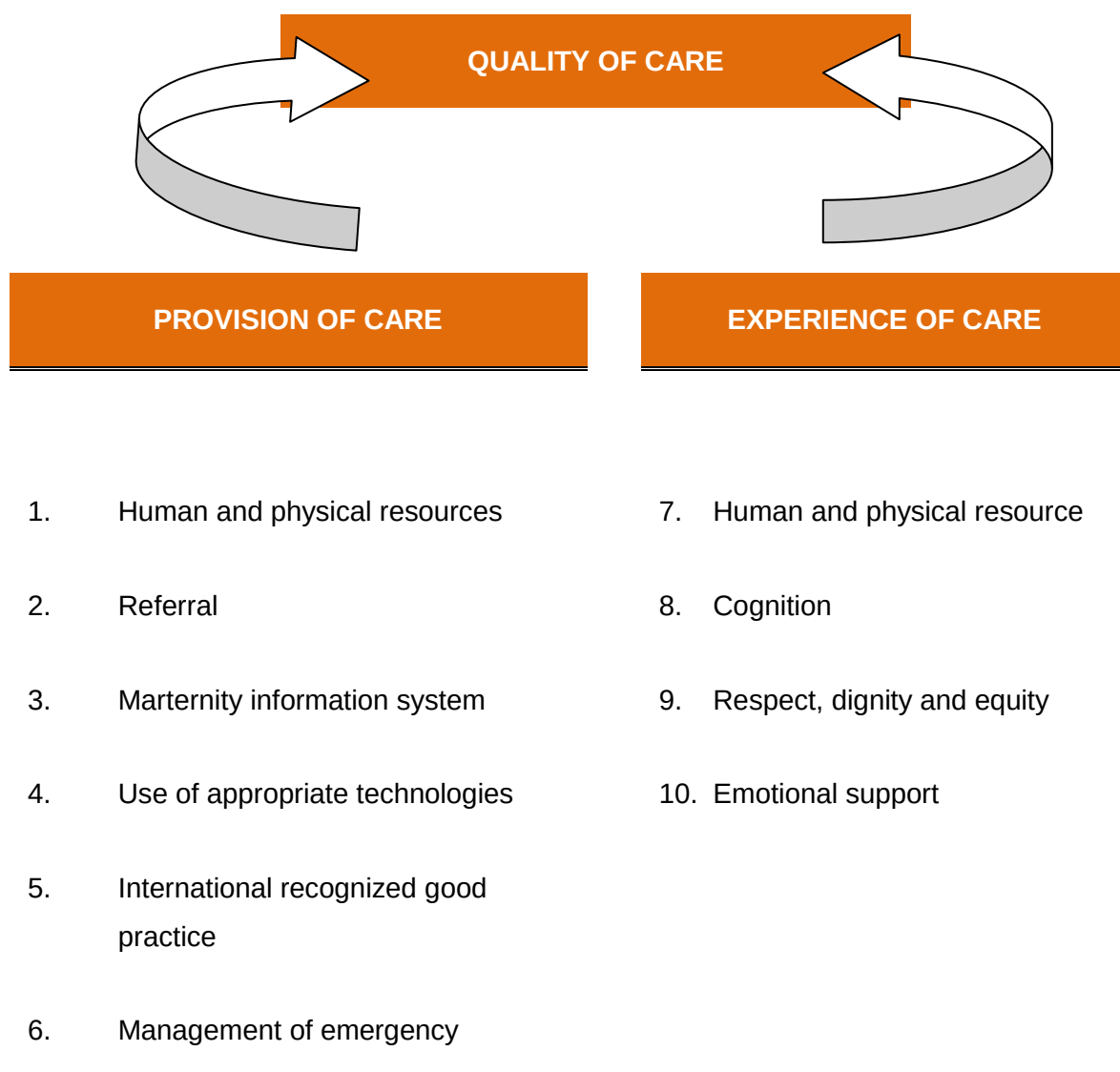


Figure1.1: Framework for evaluating quality of care in maternity services, ten elements of care (Hulton *et al.*, 2000:9).

In this study focus is on the continuous support during intrapartum in public hospitals in the NWP.

1.4.3 Central theoretical argument

The formulation of recommendations to promote continuous intrapartum support will minimize the challenges encountered by midwives on the way to implementing intrapartum support in public hospitals in the North West Province.

1.4.4 Theoretical/operational description

Concepts tend to have different meanings and different interpretations. The concepts used in this research study are defined below (quality of care, intrapartum period, quality intrapartum care, midwife, patient/mother, support/continuous support).

- **Quality of care**

Quality of care in health care can be described as “striving for and reaching excellent standards of care” (Feld, 2007; Wang, 2010). Quality of care involves not only evaluating the outcome, but reducing the risk. The use of appropriate tests and treatments continually improve personal health care in all fields of medicine (Feld, 2007; Wang 2010). Continuous improvement of patient care is the driving force behind standards and quality health care, thus continuous intrapartum support will enhance quality care (Wang, 2010).

- **Intrapartum**

The intrapartum period starts with the onset of labour and end in birth (Peiperl, 2000). This period consists of four stages: the first stage is labour, which is divided into three phases namely, the latent phase (0-3cm cervical dilatation), the active phase (4-10cm cervical dilatation) and the transitional phase (8-10 cm cervical dilatation). The second stage of labour lasts from full cervical dilatation until the birth of the baby. The third stage of labour lasts from the birth of the baby until the delivery of the placenta (Fraser *et al.*, 2009:549). The fourth stage of labour lasts from the delivery of the placenta until the first 6 weeks, but in this study it is until the discharge from the hospital.

- **Quality intrapartum care**

The intrapartum care that a midwife provides is determined by the midwife's perception of the pregnant woman's physical condition (anatomy and pathophysiology). This is combined with personal experience and the training that the midwife received from competent lecturers and mentors who provide a knowledge base to guide personal practice (Fullerton *et al.*, 2005:2). The intrapartum context addresses social, environmental, ethical and cultural issues that influence the intrapartum care of the pregnant woman (Fullerton *et al.*, 2005:3). Du Preez (2011) formulated a comprehensive definition for quality intrapartum care: "Quality intrapartum care must be based on the best possible evidence, given the resources (organisational, human and financial), to provide

an uplifting birth experience both for the mother and midwife in a safe and positive practice environment, in which the patient is treated with dignity and worth while delivering a healthy neonate and reducing maternal mortality” (Du Preez, 2011:16).

- **Midwife**

Midwife means ‘with woman’ (Fraser *et al.*, 2009:3). The International Confederation of Midwives’ (ICM) provides an apt definition of a midwife, quoted by Sellers (2012:12): “A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.” In South Africa and in the context of this research, a midwife is a clinically skilled and academically trained person who has achieved the academic requirements of an institution of higher education. After successful completion of the academic requirements, the midwife is registered with the South African Nursing Council (SANC, 1990) under regulation R2488, which outlines the scope of practice for South African midwives (Du Preez, 2011:17).

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births for which she herself takes responsibility and to provide care for the newborn and the infant. A midwife may practise in a variety of settings, including the home, community, hospitals, clinics or health units (ICM, 2011:2; Fraser *et al.*, 2009:5).

- **Patient / Mother**

For the purpose of this study the patient / mother will mean a woman who has to deliver a baby by normal vaginal birth or caesarian section in a public hospital.

- **Support / Continuous support**

Supportive care during the intrapartum period can involve many factors, like: emotional care, comfort measures, information and advocacy. Continuous support is one-to-one support to a woman by a support person of choice, uninterrupted during intrapartum period (Hodnett *et al.*, 2009:2).

1.4.5 Methodological Assumptions

The methodological assumptions of this research study are based on the research model of Botes (1992: 36-42). The Botes model provides a broad approach to the research process and provides an opportunity to be creative within a clearly defined framework. The research activities are arranged on three levels. The first level is the nursing practice from which problems are derived and the research is conducted. The second level is research activities that focus on the promotion, maintenance and restoration of health. It includes research that promotes the practice environment in which the midwives work, as well as the clinical setting where the pregnant woman receives intrapartum care. The third level represents the paradigmatic perspective of the researcher from which the research is conducted.

1.5. RESEARCH DESIGN

The study follows an explorative, descriptive and contextual qualitative approach using a non-experimental research design (Burns & Grove, 2005:44).

Qualitative: Qualitative research is conducted to gain insight and to discover meaning about a particular experience, situation, cultural event or historical event (Burns & Grove, 2005:352; Brink *et al.*, 2006: 113; Polit & Beck, 2006:60). In this study the studied event is the continuous intrapartum support in labour room.

The qualitative research approach stresses the socially constructed nature of reality and the close relationship between the researcher and the participants in a given situation, and helps the researcher explore the working experience of the study population under in an attempt to explore and describe midwives' challenges in implementing continuous support during the intrapartum period (Denzin & Lincoln, 2005:10-12). The researcher decided which participants to include yielding the richest data given the research question. The method of data gathering also depends on who the participants are (midwives) (Polit & Beck, 2006:55).

Descriptive: A descriptive design was used to explore and describe the phenomena of real-life situations. The research aims to provide a clear picture of what the current situation regarding continuous intrapartum support is in the maternity unit at Level 1 and Level 2 hospitals in the North West province (Brink *et al.*, 2006:102; Creswell, 2008:142; Polit & Beck, 2006:217).

Explorative: This type of research aims to understand the factors that influence the research phenomenon at hand. In this research it involved exploring the current status at Level 1 and level 2 hospitals in the North West province (Brink *et al.*, 2006: 102; Cresswell, 2008:561).

Contextual: This research is contextual in nature as the focus is on level 1 and level 2 hospitals in the North West Province (Brink *et al.*, 2006: 64; Cresswell, 2008:485).

1.6. RESEARCH METHOD

1.6.1 Context

The research was conducted in the North West province. In the "*Saving Mother's Report during the triennium 2008-2010*" a total of 229 maternal deaths were reported for this province, compared to the previous "*Saving Mothers triennium report of 2005-2007*" which indicated an increase of 85 maternal deaths (SA, 2011:10). Despite the urbanized population and the availability of relatively sophisticated health facilities, the primary causes of maternal deaths are very similar to that of other provinces. This is a cause for concern, as it implies that the quality of care rendered is not on standard (SA, 2009:295). Therefore the research envisaged that the implementation of continuous support during intrapartum may impact on the quality of intrapartum care rendered.

According to "**Saving Mothers: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa 2005-2007**" (SA, 2009:296), level 2 hospitals showed an increase in their Maternal Mortality Rate (MMR) and level 1 hospitals had a drop in MMR. The focus of this research is on both level 1 and level 2 hospital as 57.4% of all maternal deaths in the North West Province occur in level 2 hospitals (SA, 2009:296). These level 2 hospitals act as referral hospitals for level 1 hospital and community health centres. One challenge the North West Province faces is that it does not have a level 3 hospital, which means that the burden on level 2 hospitals to carry all intrapartum complications is considerable (Du Preez, 2011:27). The availability of continuous intrapartum support can help midwives in this already burdened situation.

South Africa has nine provinces, one of which is the North West province (see Figure 1.2). Statistics South Africa (SA, 2012) reported that South Africa's population grew by 530 000 from June 2009, and now has a total of 48,60 million people. South Africa has a unique

distribution of citizens that makes up its population. The North West Province has a population of 3.2 million (SA, 2012b:18).



Figure 1.2 Map of the nine provinces of South Africa

Blacks make up 79, 3% (39 136 200) of the population as provided by Stats SA Mid-Year report (2011). Coloured South Africans and white South Africans are more or less equally represented in the population, namely 9,0% (4 433 100) and 9,1% (4 472 100) respectively. Indians/Asians comprise 2% (1 279 100) of the population. Of this population an estimate of 51% (about 25, 66%) are women. According to Stats SA (2011) about 31% of the population are younger than 15 years of age and 7, 6% (3, 8 million) are older than 60 years. The infant mortality rate was estimated at 46, 9 per 1 000 live births (SA Stats, 2011). In South Africa the biggest percentage of the population ($\pm 80\%$) are serviced by

the public sector, which depend on free health care services, which include free maternity services (IMCSA, 2008).

The North West Province is the fourth smallest province, taking up 8.7% of South Africa's land (SA, 2012b:18), and the largest part of the population lives in mainly rural areas (SA, 2012). The North West province is divided into four health districts (see figure.1.3), namely:

- The Dr Kenneth Kaunda
- Ngaka Modiri Molema
- Bojanala
- Dr Ruth Segomotsi Mompati district (SA, 2012b:18).

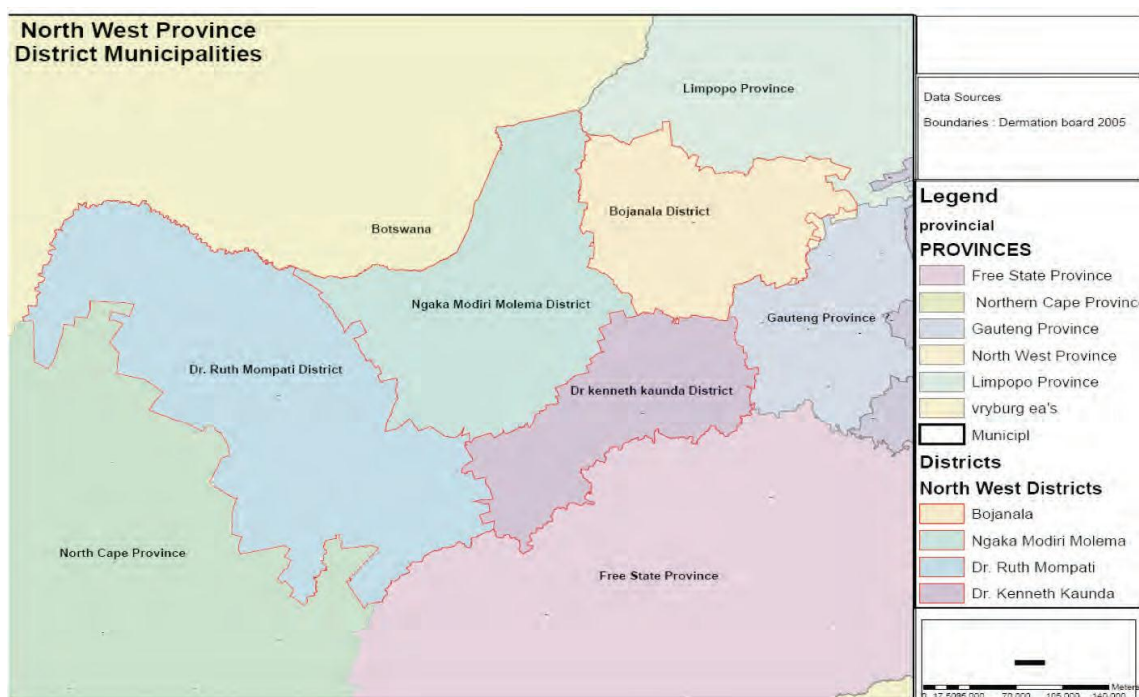


Figure 1.3 Orientation map of the North West Province, (SA, 2012b:18).

According to the Statistical census Survey in South Africa (SSA), the North West province has a population of about 3,2 million (SA, 2012b:18). The total female population is estimated at 1 847 798, of whom 990 000 are females of the reproductive age of between 15-49 years.

1.6.2 Setting

Two level 2 hospitals and one level 1 hospital in the North West province were selected as they represent a large, medium and small hospital. The sizes of the community that these hospitals serve vary in size and ethnicity. The three public hospitals were selected using the following criteria:

The large hospital was selected (Hospital A) because it is a level 2 hospital. It has 13 registered midwives working in the intrapartum unit. They conduct 5427 annual deliveries according to the 2011 statistics. The population of Klerksdorp, where this hospital is situated, is 398 676 (SA, 2012:5).

Hospital B represents a medium hospital because it is a level 2 hospital. It has 12 registered midwives working in the intrapartum unit and they conduct 3100 annual deliveries. Potchefstroom, where this hospital is situated, has a population of 162 762 (SA, 2012:5).

Hospital C was selected as a small hospital because it is a level 1 hospital and is situated in a rural area. The hospital has 11 registered midwives and they conduct 2270 annual deliveries. Taung, where this hospital is situated, has a population of 18 289 (SA, 2012:5).

Table 1.1: Midwives-deliveries-ratio

Hospital	A	B	C
Midwives	13	12	11
Deliveries	±5427	±3100	±2270

1.6.3 Population

All midwives working in the maternity units in the three selected public hospitals in North West province were regarded as the population of this study.

1.6.4 Sampling

The study made use of purposive sampling to identify the willing and available participants. The researcher recruited participants who are knowledgeable about the subject at hand, in other words midwives working in labour wards. The focus is on the quality of the information from the person and these participants can provide the rich data needed to gain insight and discover new meaning in an area of study (Burns & Grove, 2005:358; Brink *et al.*, 2006:133). The inclusion criteria were that the respondent must be registered with the South African Nursing Council as a registered midwife and must have been working in the maternity obstetrics unit of one of the selected hospitals for two years and more.

1.7. DATA COLLECTION

In order to explore and describe the perspectives of the midwives working in the North West public hospitals, focus group interviews were used as data collection method. Focus groups have the advantage of that a member reacts to what is said by others, potentially leading to richer or deeper expressions of opinion (Brink *et al.*, 2006:152). The focus group interview is an excellent way to get people together to create meaning among themselves, rather than individually. One major benefit of focus groups is that it allows the researcher to probe and gathering data in a natural setting, which in turn allows the researcher to gain deeper meaning and understanding (Brink *et al.*, 2006:152; Kingry *et al.*, 1990:124).

The aim was to have at least one focus group in each public hospital that comprise 5-10 members until data saturation is reached (Brink *et al.*, 2006:152; Kingry *et al.*, 1990:124). The focus group interviews were conducted by the researcher, who had to acquire the interview skills that would enable the facilitation of probing during the group session (Brink *et al.*, 2006:152; Kingry *et al.*, 1990:124). The researcher underwent the necessary training from the supervisor to minimize bias and to ensure that data collection adheres to the highest standards of research ethics. The data collected were then recorded and transcribed (Creswell, 2008:226). The researcher continued with focus group interviews

until data saturation was reached. The researcher took detailed field notes during the focus group sessions. Attention was paid to the constantly evolving dynamics in the group (De Vos *et al.*, 2005:307).

1.8. DATA-ANALYSIS

Data were analysed according to themes (Polit & Beck, 2006:59). This technique is designed to elicit a rich description of responses from which a wide variety of raw data is drawn. The researcher started by identifying main themes that were interlinked and used to build a descriptive theory of the phenomenon. The themes were arranged in main, and subthemes. The researcher aimed to capture the richness of themes as they emerged from the participants' discussion. These themes unify the nature of the experience into a meaningful whole (Polit & Beck, 2006:74). Verbatim (word-for-word) transcription of the interview was done. Data analysis was an ongoing process while the interview was still fresh in memory (De Vos *et al.*, 2005:299). The researcher identified quotes to support reflected themes. The researcher's co-coder encoded the same data independently and met with the researcher for a consensus discussion to ensure trustworthiness [See table 2].

1.9. RIGOUR

The strategies that were used in this study to ensure trustworthiness applied to the criteria identified by Lincoln and Guba (1985:290) namely credibility, dependability, confirmability and transferability (Polit & Beck, 2006:332). This model is recommended for qualitative research to enhance the rigour of the research without compromising its relevance. According to Burns and Grove (2009:54) rigour is a scientific value because the research outcome is associated with it.

- **Credibility**

Credibility deals with the focus of the research and refers to the confidence in how truthful the data and the processes of analysis were (Polit & Beck, 2006:332). The truth value is usually derived from the discovery of human experiences as they are lived and perceived by informants. Truth value is subject oriented (Krefting, 1991:217). The researcher's job becomes one of representing those multiple realities revealed by informants as accurately as possible. According to Sandelowski (as quoted by Krefting, 1991:217) a study is

credible when it represents such accurate descriptions or interpretations of human experience that people who also share that experience would immediately recognize the description (Polit & Beck, 2006: 332).

- **Dependability**

Dependability reflects the stability of data over time. If the participants are asked the same questions and the same follow-up questions, do the same subjects in a similar context offer similar answers (Polit & Beck, 2006:335)? In this study the criteria concerned are stability, consistency, and equivalence regarding the extent to which the repeated administration of a measure will produce the same data by different people (Krefting, 1991:225; Polit & Beck, 2006:335).

- **Confirmability**

Confirmability is the criterion of neutrality, which refers to whether the findings are grounded in the data and whether they were researched objectively (Polit & Beck, 2006:336). A clear description of each stage of the research process enhances this study's confirmability.

- **Transferability**

Transferability refers to the level to which the findings can be transferred to other similar setting or groups (Polit & Beck, 2006:336). The researcher provides a detailed database and thick description of the experiences of the midwives, so that someone else can determine whether the research findings of this study are applicable to another context or setting.

- **Strategies to ensure the trustworthiness of the study**

Specific strategies can be used throughout the research process to increase the worth of qualitative projects. The strategies include four qualitative criteria of trustworthiness.

- **Credibility strategies: (Interview technique)**

With regard to the interviewing technique, credibility is enhanced by the replication of questions that should remain the same (Krefting, 1991:222; de Vos *et al.*, 2005:345).

- **Dependability strategies: (code-recode procedure)**

The process of coding-recoding entails that a co-coder was appointed. The coding of one segment was done independently by a researcher and a co-coder. The researcher and the co-coder came together to reach consensus. The segment was recoded later on during the process to check its dependability (Krefting, 1991:225; Polit & Beck, 2006:332).

- **Transferability strategies: (sample selection)**

In this study the midwives at the three selected hospitals constitute the potential participants who have knowledge of the subject under study (Krefting, 1991:223; Polit & Beck, 2006:332).

- **Confirmability strategies: (Auditability)**

In this study the raw data, data analysis products and process notes are available for auditing.

1.10. ETHICAL CONSIDERATIONS

Conducting research requires honesty and integrity in order to recognize and protect the rights of human subjects. Burns and Grove (2005:181) 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 and harm.

The permission to conduct the research was obtained from the following people:

- Ethics committee of the North-West University
- Head of the Department of Health in North West Province
- Chief Executive Officers and Deputy Directors of Nursing of the selected hospitals

After obtaining approval from the School of Nursing Science's ethical committee and the Ethics Committee of the North-West University [Appendix A], the researcher requested permission to do the research study in the province from the North West Province; Department of Health (NWDoH) research committee [Appendix B] and from the selected hospitals [Appendix C,D,E].

Informed consent: The researcher provided the participants with clear and comprehensive information regarding the study and informed them that they are free to choose to participate or to stop in the process without harm. Consent forms were given to request their consent to voluntary participation in the study (Brink *et al.*, 2006:35; Burns & Grove, 2005:193) [Appendix F].

Right to privacy: Confidentiality was assured in that contact was directly with the researcher. Interviews were audio-recorded. During the process of transcription, the participants' own names were not used. Transcripts, tapes and field notes are kept under lock and key and will not be divulged to any person except the researchers involved (Brink *et al.*, 2006:33; Burns & Grove, 2005: 186).

Right to protection from discomfort and harm: The right to protection from harm and discomfort is based on the ethical principle of beneficence, which dictates that one does good, and most importantly, does no harm (Burns & Grove, 2005:190; Brink *et al.*, 2006:32).

The researcher conducted the study in such a manner that she protected the participants from any harm, be it physical, emotional, social or economic in nature. The researcher attempted to bring about the greatest possible balance of the benefits in comparison with harm. Verbal and written permission were obtained from the midwives who agreed to participate and for the interviews to be tape recorded.

1.11. RESEARCH REPORT LAYOUT

Chapter 1: Grounding of the research

Chapter 2: Research methodology

Chapter 3: Research findings and embedded literature

1.12 SUMMARY

This chapter discusses the foundation of the benefits of continuous intrapartum support. The chapter subsequently elaborated on the background, rationale and problem statement, followed by a research question. It continued to present the aim, objectives, and meta-theoretical, theoretical and methodological assumptions. The chapter outlined the research design and research methodology as applicable for the research study. Finally, the discussion turned to the rigour and ethical considerations applicable to the research study. Chapter two offers a detailed account of the research methodology.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

This chapter explores and describes the challenges in implementing continuous support during the intrapartum period in public hospitals in the North West Province. This investigation is conducted by listening to the views of midwives in small, medium and large hospitals in the North West province.

The discussion of the research method, setting, population and sample, ethical considerations, data collection and data analysis is followed by an overview of rigour.

The research design and method serves as a roadmap for this specific project (Burns & Grove, 2005:231). This chapter deals with the “how” of this study and the research method used. The layout of the chapter is as follows:

2.2 RESEARCH METHODS AND DESIGN

According to Burns and Grove (2005:265) the research design involves the paths of logical reasoning followed, while the concept of research methods refers to the techniques used to structure a study and to gather and analyze information in a systematic fashion (Polit & Beck, 2006:509). The research method is described in terms of the target population for this study, the method used to select the sample (the subset of a population selected to participate in a study), the methods of data collection and data analysis.

- Research design [2.2.1]
- Research methods [2.2.2]
 - Sampling [2.2.2.1]
 - Population [2.2.2.2]
 - Sample [2.2.2.3]

- Sample size [2.2.2.4]
- Setting [2.2.2.5]
- Data collection method [2.2.3]
 - Pilot study [2.2.3.1]
 - Focus Group [2.2.3.2]
 - Field notes [2.2.3.3]
- Data analysis [2.2.4]
- Rigour [2.3]
- Ethical considerations [2.4]
- Embedded literature [2.5]
- Conclusion [2.6]

2.2.1 Research design

The research follows a qualitative, explorative, descriptive and contextual design to explore and describe the challenges in implementing continuous support during the intrapartum period in public hospitals in the North West Province. By so doing the researcher gained knowledge and a deeper understanding of the participants' lived experiences regarding continuous support during the intrapartum period. Based on the aim of this study and in order to achieve the objective an explorative, descriptive, contextual, qualitative design was selected as the appropriate design.

Qualitative research

The research design of this study is qualitative in nature in order to explore and describe midwives' challenges in implementing continuous support during the intrapartum period. Qualitative research is conducted to gain insight and to discover meaning related to a particular experience, situation, cultural event or historical event in this case the

continuous support during intrapartum period (Burns & Grove, 2005:352; Brink *et al.*, 2006:113; Polit & Beck, 2006:60). Maree (2007:257) adds that qualitative research refers to an inquiry process of understanding where the researcher develops a complex, holistic picture, analyses words and reports, considers the detailed views of participants and conducts the study in a natural setting (labour rooms). According to Burns and Grove (2005:732) the philosophical element of qualitative research is contextual in nature (Public hospital in the NWP).

Descriptive research

The purpose of descriptive research is to explore and describe the phenomenon in real life situations and to understand the phenomenon under the study (continuous intrapartum support) (Brink *et al.*, 2006:102; Creswell, 2008:142; Polit & Beck, 2006:217). Burns and Grove (2005:733) adds that a descriptive research design involves identifying and understanding the nature and attributes of nursing phenomena (intrapartum care) and sometimes the relationships among these phenomena (midwives).

Explorative research

This research involves exploring the dimensions of a phenomenon (Polit & Beck, 2006:500). The purpose of using the exploratory study design is to investigate and understand the phenomenon (continuous intrapartum support), and answer the research questions. The exploratory nature of qualitative research leads to development of new concepts or theory (de Vos *et al.*, 2005:268).

Contextual research

According to de Vos *et al.*, (2005:268) people's behaviour becomes meaningful and can be better understood when placed within the context of their lives and the lives of those around them. Without a context there is little possibility of exploring the meaning of an experience. The context of this research is the 3 (three) selected public hospitals in the NWP and the intrapartum continuous support that takes place during intrapartum period.

2.2.2 Research Methods

The research methods refer to the techniques used to structure a study and to gather and analyze information in a systemic fashion (Polit & Beck, 2006:509). The research methods

applied in this study are described in terms of the population, the sample, data collection, data analysis and the incorporation of literature.

2.2.2.1 Sampling

Sampling refers to the researcher's process of selecting the sample from a population to obtain information regarding a phenomenon in a way that represents the population of interest (Brink *et al.*, 2006:124). In this research study the sample comprises of the midwives working in labour rooms.

In this study a purposive, voluntary sampling was used to select participants who met the set criteria and were willing to participate. The concept 'voluntary' for the purposes of this study means that the participants decide whether they want to participate or not. A purposive sample is based on the judgement of the researcher regarding the suitability of participants and is founded on the researcher's knowledge about the topic to be studied (Brink *et al.*, 2006:134; Cresswell, 2008:145; Burns & Grove, 2005:352).

2.2.2.2 Population

According to Burns and Grove (2005:342) the population or target group refers to a group of people who have the same characteristics. In this research the study population included all the midwives working in the maternity unit of a small, medium or large hospital in the NWP Province. [See Chapter 1; 1. 5.1]

2.2.2.3 Sample

A sample is a part or fraction of a whole, or a subset of a larger set, selected by the researcher to participate in a research study (Brink *et al.*, 2006:124). The researcher selected the sample from a population of all midwives working at level 2 hospitals and one level 1 hospital in the North West province to obtain information on a phenomenon relevant to the population of interest (Brink *et al.*, 2006:124).

Sample selection was based on a list of significant characteristics needed for membership in the target population, often referred to as eligibility criteria (Burns & Grove, 2005:342)

The inclusion criteria were the following:

- Midwives who are registered with the South African Nursing Council as registered midwives under regulation R2488 (SANC,1990)
- Midwives who have been working in the maternity unit for two years or more
- Participants who can speak English
- Participants willing to participate voluntarily and to give written consent.

2.2.2.4 Sample size

The sample size refers to the number of participants who were selected from the population and who became the participants in the data collection process (Brink *et al.*, 2006:136). In qualitative studies the sample size is determined when data saturation is reached (Burns & Grove, 2005:730). The total population for this study complied with the eligibility criteria and voluntarily accepted the invitation to participate in the study.

2.2.2.5 Setting

The setting refers to the place (physical setting) where the study took place. In this study the setting is two public hospitals and one public district hospital in the North West province which were selected as they represent a large, medium and small hospital. The members of the community of this province are of a variety. The three public hospitals were selected using the following criteria:

- The hospitals all serve as clinical teaching-learning facilities for midwives.
- One of the level 2 hospitals serves as the referral hospital of the obstetric complications and emergencies in North West Province.
- The hospitals are situated in urban and rural areas of the North West province.

2.2.3 Data collection

2.2.3.1 Pilot study

A pilot study was conducted on a group of midwives working in a maternity unit, on a sample of the population prior the data collection to investigate the feasibility of the proposed study and to determine if the participants understood the research question (Brink *et al.*, 2006:166). The question was:

- What are the challenges in implementing continuous support during the intrapartum period in public hospitals in the North West province?

The pilot study was conducted and indicated that the question was clear enough to remain the same.

2.2.3.2 Focus group

Data was collected from those candidates selected purposively for the study population and who complied with the selection criteria. In order to explore and describe the perspectives of the midwives working in the North West province public hospitals, focus group interviews were used as data collection method. Kruger and Casey (2000:5) describe a focus group interview as a "carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. Focus groups have the advantage of that a member reacts to what is said by others, thereby potentially leading to richer or deeper expressions of opinion (Brink *et al.*, 2006:152; Kingry *et al.*, 1990:124). The focus group interview is an excellent way to get people together to create meaning among themselves rather than individually. One major benefit of focus groups is that it allows the researcher to probe and gather data in a natural setting, which allows the researcher to reach deeper meaning and gain understanding (Brink *et al.*, 2006:152; Kingry *et al.*, 1990:124).

The research plan determined that there would be at least one focus group in each public hospital until data saturation was reached. Focus group interviews were conducted by the researcher, who has interview skills that could enable the facilitation of probing during the group session. The researcher received the necessary training before conducting the focus groups to minimize bias and to ensure that data collection adheres to the highest standards of research ethics. The data collected were recorded and transcribed (Creswell,

2008:226). The researcher continued with focus group interviews until data saturation was reached and made detailed field notes after the focus group session. Attention was also paid to the ever-evolving dynamics in the groups (De Vos *et al.*, 2005:307).

2.2.3.3 Field notes

The researcher made field notes as part of the data collection process. It is best that one person takes field notes so that important aspects of the discussion are captured like, non-verbal communication cues and the group's moods. These aspects may not be captured in the tape recordings. The field notes provide an opportunity to consider what the researcher observed and experienced outside the immediate context of the interview and this includes thought and ideas for consideration during data analysis (Polit & Beck, 2006:306). Descriptive field notes were written directly after the interview to describe events and conversations. Reflective fieldnotes were written to record the researchers' personal experiences and reflections while in the field (Polit & Beck, 2006:30).

[for example see Appendix H]

2.2.6 Data-analysis

Data were analysed using thematic analysis (Polit & Beck, 2006:59). This technique is designed to elicit rich responses from which a wide variety of raw data are drawn. The researcher begins by identifying main themes that are linked and used to build a descriptive theory of phenomenon. The themes are then arranged into main-, and sub-themes. The researcher captured the richness of themes emerging from the participants' descriptions and tried to formulate a meaningful whole from the different accounts (Polit & Beck, 2006:74). The researcher linked quotes to support reflected themes. The researcher and a co-coder analysed the same data independently and then entered into a consensus discussion to ensure trustworthiness.

A verbatim type (word for word) transcription of the interview was done (Kruger & Casey, 2000:142). The raw material comprised the written words after an interview. Comments were typed word for word without changing the words or correcting the grammar. Data analysis should be an ongoing process while the interview is still fresh in memory (De Vos *et al.*, 2005: 299).

2.3 RIGOUR

Strategies that will be used in this study to ensure trustworthiness by applying the criteria identified by Lincoln and Guba include credibility, dependability, confirmability and transferability (Polit & Beck, 2006:332; Lincoln & Guba, 1985:290). [See table 2.1]

Table 2.1 Questions and criteria related to trustworthiness in qualitative research

QUESTIONS ASKED BY GUBA AND LINCOLN (1989:290)	CRITERIA FOR EACH QUESTION BY GUBA AND LINCOLN (1989:290)
How can the research establish whether the findings in the context are true?	Confidence that the research findings are true. The truth value is obtained through the strategy of credibility.
How can the researcher determine whether the findings are applicable to other participants or to another context?	Applicability is the degree to which the findings can be applied to different participants and contexts. The strategy of transferability is used to generalize findings.
How repeatable are the research findings with the same participants and within the same context?	Consistency leads to similar findings when the participants and contexts are reproduced. Dependability as a strategy will establish consistency.
How can it be ensured that bias (by the researcher and/or participants) does not influence the research findings.	Neutrality by the researcher and findings from the participants ensure freedom from bias. The strategy of conformability is used to ensure neutrality.

Table 2.2 Strategies to enhance trustworthiness in this research

(Klopper, 2008:69-70; Krefting, 1991:215-221; Lincoln & Guba, 1985:290)

CRITERIA/STANDARDS	THREATS	STRATEGIES TO ENSURE TRUST
TRUTH.....	.....	CREDIBILITY
This first criterion is reflected by the human experience of the participants	• the practical engagement during data collection is too long • If participants were purposively invited to participate in the research • If the person conducting the focus group interview is not skilled this can lead to misinterpretation of the data	• Prolonged engagement in the setting. – 2 years of preparation and thereafter data collection by the researcher (Brink <i>et al.</i>, 2006:118; Polit & Beck, 2006:332) • Selection of participants – All the midwives of the one Level 1 hospital and two Level 2 hospitals in the North West province were invited to part to participate in the research (2.2.2.2.) • Interview technique – A pilot study (2.2.3.1) was conducted prior to the data collection (Brink, <i>et al.</i>, 2006:166). Field notes were made after the focus interview.

CRITERIA/STANDARDS	THREATS	STRATEGIES TO ENSURE TRUST
		• Peer group discussion – Consensus discussions were held with the co-coder, who also acted as the interviewer and who is skilled in conducting interviews. Conclusion: A qualitative research study can be considered credible if midwives are able to recognize the human experience through the dense description of the situation.
APPLICABILITY	.....	TRANSFERABILITY
To what degree can the findings be applied to other populations and contexts or settings?	The researcher can be biased	• Purposive sampling – A purposive sample is based on the judgement of the researcher regarding the suitability of participants based on knowledge about the topic to be studied (Brink <i>et al.</i>, 2006:134; Cresswell, 2008:145; Burns & Grove, 2005:352).

CRITERIA/STANDARDS	THREATS	STRATEGIES TO ENSURE TRUST
		• Dense description – A detailed description of the context, setting and methods of data collection in this study – Continue with data collection until data saturation occurs – All relevant data collection tools were kept for audit purposes
CONSISTENCY.....	.....	DEPENDABILITY
The third criterion refers to whether there would be consistency if the research was reproduced with the same participants over a period of time within a similar context	The researcher works alone on the research study and might become biased	• Indirect Measures of credibility – A dense description of the research setting and procedures of data collection and analysis • Direct – The pilot study resulted in maintaining the question as is.

CRITERIA/STANDARDS	THREATS	STRATEGIES TO ENSURE TRUST
NEUTRALITY.....		CONFIRMABILITY
The fourth criterion refers to the neutrality of this research study so that it is free from bias in procedure and results.		• Confirmability audit – Consensus meetings between researcher and co-coder (Krefting, 1991; de Vos, <i>et al.</i>, 2005:345; Brink <i>et al.</i>, 2006: 185) – Field notes and transcribed text are all kept in a safe place as required by the NWU guidelines for postgraduate studies (NWU, 2010:12)

Trustworthiness is regarded as the term for the evaluation of rigour in qualitative research (Klopper, 2008:70; Krefting, 1991:214-222; Lincoln & Guba, 1985:289-311; Brink *et al.*, 2006:118)

2.4 ETHICAL CONSIDERATION

This section provides an overview of the ethical considerations. Generally accepted international ethical principles in health research were applied, as outlined in the Helsinki Declaration and described in DENOSA (1998:1-8), Burns and Grove (2005:181-198) and Brink *et al.* (2006:30-43).

2.4.1 Code of ethics

The researcher made a conscious and deliberate decision to adhere to local, national and international ethical standards. Constant awareness of the ethical considerations was maintained throughout the research process.

2.4.2 International ethical governance

The study adhered to the international ethical guidelines of the International Council of Nurses (ICN) (2006,1-2), the Helsinki Ethical Declaration and the Nuremburg Code (Guidelines for postgraduate studies, North-West University, 2010:54) that stipulate the handling of human participants in medical research.

2.4.3 National ethical governance

At national level, the researcher adhered to the code of ethics as stipulated by the Medical Researcher Council (MRC) (Guidelines for post-graduate studies, North-West University, 2010:51) and the Democratic Nursing Association of South Africa (DENOSA, 1998).

2.4.4 The University's code of ethics

As a master's degree candidate of the North-West University (Potchefstroom campus) the researcher adhered to the ethics code of the University as stipulated by statute. A research proposal was submitted to the North-West University Ethics Committee, Potchefstroom campus, and ethics approval was granted with certificate number: NWU-00015-08-A1 [Appendix A].

2.4.5 North West Department of Health

The researcher requested ethical approval from the North West Department of Health, it was granted. [Appendix B]

2.4.6 Selected hospitals in the North West province

Having received ethical approval from the North West Department of Health, the researcher made appointments with the two Level 2 hospitals and one Level 1 hospital in the province to obtain permission to conduct the research in their institutions [Appendix C, D, and E].

2.4.7 The responsibility of the researcher to protect the rights of the participants

- **Informed consent:** The researcher provided the participants with clear and comprehensive information regarding the study both verbally and in writing. They were free to choose to participate or to withdraw from the process without harm (Brink *et al.*, 2006:31; Burns & Grove, 2005:194). Consent forms were given to request their consent to voluntary participation in the study (Brink *et al.*, 2006:35; Burns & Grove, 2005:196) [Appendix F]. Data was collected only once written consent had been obtained from the participant (Burns & Grove, 2005:197).
- **Right to privacy:** The participant had a right to determine the time, extent and general circumstances under which personal information would be shared. Confidentiality was assured through the fact that contact was directly with the researcher. The interviews were voice recorded. During the process of transcription, the participants' own names were not used. Transcripts, tapes and field notes were kept under lock and key and were not divulged to others (Brink *et al.*, 2006:33, Burns & Grove, 2005: 186).
- **Right to Anonymity and Confidentiality**

Anonymity was maintained because the names of the participants were not divulged. Codes were used to ensure that the identity of participants remain anonymous (Burns & Grove, 2005:188). The private information shared by participants was not shared with others without the authorization of the participant (Burns & Grove, 2005: 188).

- **Benefits**

The benefits derived from participating in the study were communicated to the participants (midwives) and authorities (North West Department of Health).

Right to protection from discomfort and harm: The right to protection from harm and discomfort is based on the ethical principle of beneficence, which dictate that one must do good and, most importantly, should do no harm (Burns & Grove, 2005: 190; Brink *et al.*, 2006:32). The researcher tried to conduct the study to protect the participants from any harm, be it physical, emotional, social or economic in nature. No harm is foreseen in this study.

- **Right to fair treatment**

The ethical principle of justice forms the basis of the right to fair treatment. The principle holds that each person should be treated fairly and receives what is due or owed. The population used in this study was selected fairly as they were directly involved to the research problem (Burns & Grove, 2005:189).

The participants will possibly benefit from this study as the benefits derived from participating in the study were communicated to the participants (midwives) and authorities (North West Department of Health) to implement continuous support during intrapartum period.

2.2.5.8 The responsibility of the researcher to do research of a high quality

- **High standards with regard to planning, implementing and reporting on research**

The proposal for the research was approved by the Ethics Committee of the North-West University (Potchefstroom campus) Ethics number: NWU-00015-08-A1. The planning, implementing and reporting on research were carefully conducted.

- **Displaying integrity by stating supporting and opposing views**

Various points of view found in the literature and during data collection were spelt out.

- **Acting honestly regarding results**

No results have been falsified and all participants and co-workers have been acknowledged.

2.4.9 The responsibility of the researcher to share the results

- **Distribution of information regarding this research**

This research results will be distributed to other scientists and service providers through publication in journals and workshops.

- **Giving feedback on the research**

After giving informed consent, each participant had the choice of whether they wanted to be informed individually regarding the results by the researcher. The results of the research were to be shared in the form of a report with all the participants who submitted their addresses, as well as with the management of the various hospitals and the North West Department of Health.

2.5 EMBEDDED LITERATURE

After data analysis, consensus between the researcher and co-coder was reached about the themes and sub-themes and a literature review was conducted to confirm the findings. The literature review formed a scientific basis from which the themes and sub-themes could be derived and interpretations made. The interpretations led to findings that were confirmed by the co-coder and the researcher. The conclusions of these findings led to the formulation of recommendations to promote continuous support during labour in public hospitals in the North West Province.

The literature control was conducted using the following databases: EBSCO HOST, Emerald, Medline, Academic Premier Research, CINAHL, Cochrane Library, Nexus, Theses and Dissertations (NWU), Sabinet, SACat and Science Direct.

2.6 SUMMARY

Chapter 2 presented the research design and research methods. In addition, the chapter discussed the process of data collection, the rigour and included the ethical considerations.

Chapter 3 presents the findings by revealing the descriptions of what the midwives of the three public hospitals regard as the challenges in implementing continuous support during the intrapartum period in public hospitals in the North West Province.

CHAPTER 3

RESEARCH FINDINGS AND EMBEDDED LITERATURE

3.1 INTRODUCTION

This chapter presents the research findings and description of the results of this study as aligned with direct quotation from the participants. Focus group interviews were performed in the two level 2 hospitals and one level 1 hospital in the North West province in order to investigate and explore midwives' views and experiences regarding the challenges related to implementing continuous intrapartum support in public hospitals in the North West Province.

3.2 DEMOGRAPHIC PROFILE

The bibliographic data pertaining gender, age, qualification (diploma or degree qualified) and experience in the unit of the participants were gathered and analysed in order to get a picture of the participants. The inclusion criterion was that participants had to have been working in a maternity obstetric unit for two years. The demographic data for the participants in the focus groups are illustrated in tables 3.1, 3.2 and 3.3 as follows:

Table 3.1 Demographic data of participants: focus group K1 and K2

Number of participants	Age	Gender F:female M:male	Diploma	Degree	Advanced Midwives	Experience in the unit
7	30- 57	F: 7	4	2	5	5-35yrs
5	30-55	F: 5	3	3	3	5-30yrs

Table 3.2 **Demographic data of participants: focus group P1 and P2**

Number of participants	Age	Gender F:female M:male	Diploma	Degree	Advanced Midwives	Experience in the unit
6	30-55	F: 6	5	1	2	5-35yrs
5	28-44	F: 5	4	1	1	3-20yrs

Table 3.3 **Demographic data of participants: focus group T1 and T2**

Number of participants	Age	Gender F:female M:male	Diploma	Degree	Advanced Midwives	Experience in the unit
5	35-58	F: 5	4	1	1	5-35yrs
5	30-50	F: 4; M: 1	5	Nil	1	3-25yrs

From the demographic data it is clear that most midwives in the participating hospitals in the North West province are mature with more than 5 years experience. The results reflect that there is a limited number of Advanced Midwife in practice in hospitals.

3.3 DATA ANALYSIS

The language used during data collection was English, therefore six voice recordings were transcribed verbatim (Cresswell, 2008:226). The audio tapes were listened to repetitively and the comments were typed word for word without altering the words spoken or the grammar. The researcher took field notes after the focus group interview as a validation of the audio recorded data; this is regarded as raw data.

The process of qualitative data analysis was:

- The researcher read through all the transcription to get a sense of the whole
- The researcher selected an interview and read through it and wrote down any thoughts that occurred in the margin
- After reading all interviews a list was made of the most relevant topics and similar topics were grouped together.
- The list was then taken back to the data, and codes were written next to parts of the text. Categories were assigned and codes emerged.
- The list of categories was reduced and grouped together to show inter-relationships.
- Final decisions were made regarding the abbreviations of categories and alphabetization of the codes
- Data belonging to each category were kept together and a preliminary analysis was conducted (Burns & Grove, 2008:548).
- Existing data were recorded if necessary by the researcher (Kruger & Casey, 2000:142).

3.4 EMBEDDED LITERATURE

Qualitative content analysis was undertaken with identification of themes and subthemes. The data collected from the participants during 6 focus group interviews were analyzed by the researcher and the independent co-coder. After a consensus discussion six (6) themes and eighteen (18) subthemes were identified (Figure 3.1). These findings are discussed with the relevant quotations from transcripts later on in the chapter. The literature review was conducted to confirm or negate the findings and was done after the focus group took place so that there was no preconceived framework on starting the focus groups (Klopper, 2008:67). Each theme was condensed into a conclusive statement. The conclusive statement in turn aids development of recommendations to promote continuous intrapartum support in public hospitals in the North West province (Burns &

Grove, 2005:116). The results of this study with the proposed recommendations will be presented to the Department of Health (North West province), the sampled hospitals and the midwives who participated in this research.

3.5 RESULTS AND FINDINGS

The results obtained from the data analysis process were integrated with findings from other studies and literature to formulate a conclusive statement regarding the objective of this study, which was:

- To explore and describe the challenges related to implementing continuous intrapartum support in public hospitals in the North West Province.

The findings reflect the midwives' views as to what they regard as challenges related to implementing continuous intrapartum support in public hospitals in the North West province. These findings are colour-coded for easy reference. In Figure 3.1 a summary flow chart of the results gives an indication of the main themes and subthemes.

Table 3.4: Summary flow chart of results

Data collection	
Data analysis	
Results and Findings	
Main Themes	Subthemes
Staff shortage	- Workload - Staff-patient-ratio - Staff experience - Burden of interns/student nurses/ agency nurses
Antenatal care	- Health education - Traditional medicine - Cultural and spiritual factors
Labour companion	- Family support - Doula programme
Policies and guidelines	- Hospital - Clinic referrals
Communication/relationship	- Rapport - Language - Attitude of staff - Attitude/expectations of patient/family
Resources	- Infrastructure - Medication - Stock and medical equipment

3.6 THEMES AND SUBTHEMES

Table 3.5 To explore and describe the challenges related to implementing continuous labour support in public hospitals in the North West Province

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
Sub-theme 1.1: Workload • High workload leads to burnout • Allocation of workload	Sub-theme 2.1: Health education • Birth plan • What to expect during labour	Sub-theme 3.1: Family support • A friend or relative to support the woman during labour	Sub-theme 4.1: Hospital • Orientation of agency nurses • Baby friendly hospital (International guidelines)	Sub-theme 5.1: Rapport • Trust/relationship	Sub-theme 6.1: Infrastructure • Rooms - privacy and labour companion
Sub-theme 1.2: Staff-patient ratio • Patient-nurse ratio • Patient-doctor ratio	Sub-theme 2.2: Traditional medicine • Kgaba	Sub-theme 3.2: Doulas program • only work limited hours/ not at night and weekends and public holidays	Sub-theme 4.2: Clinic referrals • referral criteria	Sub-theme 5.2: Language • medical language • emigrants	Sub-theme 6.2: Medication • drugs out of stock

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
Sub-theme 1.3: Staff experience • Different experience • Skills mix of midwives • Senior / junior ratio	Sub-theme 2.3: Cultural and spiritual factors • White/ Indian /black /Jewish			Sub-theme 5.3: Attitude of staff	Sub-theme 6.3: Stock and medical equipment • Shortage of linen • RH kit-rapid
Sub-theme 1.4: Burden of interns/ student nurses/ agency nurses • Orientation of new staff				Sub-theme 5.4: Attitude/Expectations of patient/family	

Table 3.6 Themes and sub-themes with quotes

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
Sub-theme 1.1: Workload High workload leads to burnout: “no it is definitely staff shortage, that uhm prevents us from giving continuous care. I mean we have got, we have a lot of patients we don’t have enough staff so we cannot stay with that patient the whole time progressing the patient, so I think that is definitely a challenge.” (P1) “I can add on the workload, the workload	Sub-theme 2.1: Health education - Birth plan - What to expect during labour “So the poor antenatal care also contributes because the woman do not attend antenatal clinic and then for delivery, risk factors were identified and you find that the person is a breech that is undiagnosed.” (P1) “...even if at the clinics the antenatal clinic they give proper health education to the patient	Subtheme 3.1 Family support A friend or relative to support the woman during labour “And then also the companionship is not there, the relative they also not there to support, because if you as a midwife you are alone and there is somebody or some relative who is supporting that woman through labour that can also help, but if there is no one then the woman	Sub-theme 4.1: Hospital - Orientation agency nurses - Baby friendly hospital “...maybe we can have some policies that are implemented in the hospital to say that certain people must be able to come with this patient or to stay with this person, maybe it will make the burden of the nurses a little bit lower you see.” (P1) “And also to add onto that one we initiated	Sub-theme 5.1: Rapport “I think the other thing is if maybe we can strengthen our co-operation and communication in the local clinics. If they can do the correct things and do everything correctly it would be just a walk over to us.” (P1) “...I think we have to have this relationship with the patient, continuous communication. And much as I am alone at the back let me let the	Sub-theme 6.1: Infrastructure Rooms – privacy and labour companion “I would say about the structure, it would be nice if like every, we would have only single rooms like for privacy for all the patients, like if maybe a patient is having a supporter so that they can have they own room you know. Like we are having a three bedded room here and then sometimes it is not

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
is high because currently in labour wards we are having about six sisters and, uhm, we are supposed to admit transfers from other hospitals and we get self-referrals from the local clinic." (K1) "Our workload is too much for us because there is much shortage of staff, we are ending up with burnout syndrome because of this shortage of staff, and really we really do need more staff in our hospital." (T1)	to the person to say if this person into labour you must support this person, maybe she can come along with this person..." (P1) "...they must also teach their patients on the true signs of labour how to, what to do if they are in labour because most of them, some of them they come already ruptured their membranes with meconium aspirations..." (T2) "...at antenatal clinic information guidelines issued to our clients as of a means of birth plans to say whom do I want	becomes anxious she pushes prematurely and all those things"(P1) " we have been doing that but the only thing is when our patients are in active labour we do accommodate the husband, maybe the family members are not here to come and accompany these patients they are here to <i>sommer</i> see what nurses doing..." (P1)	<i>mos</i> the baby friendly hospital initiatives. So for that also during the day the doulas are there to accompany them by the theatre and to remain with the mother, when she reach recovery room she help the other to breastfeed,..."(K2)	patient know I can't be with you all the time throughout..." (P1)	really nice to have one patient there with a supporter and then the other one on the other curtain with the supporter." (K1) "...hospital the space is not enough. We find that patients are overcrowded and I think a lot has to be done when coming to infrastructure..." (T2)

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
	to accompany me during labour..." (P1) "And it means the clinics should do their part whereby they should be able to give them a group session where they should be teaching them more about uhm maternity. I think most of our people they have this wrong impression about delivery probably because of a family member went through something that is not so well but, uhm, maybe if they can get education, proper education, proper counseling from the clinic, proper, uhm,				

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
	support from the clinic so that when they come here we don't struggle much, they just follow the instructions..." (T2)				
Sub-theme 1.2: Staff-patient ratio • Patient-nurse ratio • Patient-doctor ratio "If we are admitting many patients in labour rooms, we cannot just focus on that one as the others have to be helped also. So staffing, the one-to-one ratio." (K2) "..., our unit is a big unit which is being run by one of obstetric doctor now there is a	Sub-theme 2.2: Traditional medicine • Kgaba "...is the use of "kgaba" the people in South Africa they like using <i>muti</i> to curb, eh, curses that are brought about by their ancestor or witchcraft or whatever so they are using this "kgaba" and these patients they have intense pain throughout labour even if we give pain relief it doesn't	Sub-theme 3.2: Doula's program • only work limited hours/ not at night and weekends and public holidays "...still on the doula system, I think maybe if our patients can be taught during antenatal care, be encouraged about the doula system at least that also will help us for the doula to be able to monitor and she will be keeping an eye on the pregnant	Sub-theme 4.2: Clinic referrals • referral criteria "...when the woman comes unbooked and not, uhm, not attending the clinic. When she comes here maybe she is in a very serious condition and she never attended the clinic, isn't it that we should start from down there where they must give blood and take all the gynae obstetrical history." (P1)	Sub-theme 5.2: Language • medical language • emigrants "Sometimes, I think it is also the, uhm, patients who can't understand our language." "We had this specific one last week here, a Shangaan, and we were not able, but so lucky we were able to get an interpreter from another ward that could come and help us. And that is why	Sub-theme 6.2: Medication • drugs out of stock "And the other factor I think that also hampers continuous care, the medical, the medicine is out of stock sometimes we find that there is no..." (P2) "The other challenge I will say also is we find that most of our drugs that we are using is out of stock and it is sometimes it is the

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
great challenge in the intrapartum care by the doctor sometimes the doctor becomes exhausted by examining the patient because sometime she has been running the unit which contains five different categories of different units, he fails to meet all the needs of the patients..." (T1) "It is the main thing that we are having at the moment if the department of health will find a way of balancing ratio between patients and doctors and nurses in	have pain release because they have taken an overdose of "kgaba" drank it and instead they must wash with this "kgaba"..." (T1) "...the patient really need to be educated on the dangers of the traditional medication that they have, the medication that they are using, because most of the time when they come, they have taken <i>muti</i> at home, eh, ingestion of "kgaba" which will result in a strong contraction and when we give pain relief it does not really assist	woman." (P2) "At the moment they are of big help, but they are only working during the day, that is our problem they are not really working Sundays or public holidays and also night duty, because they don't get night duty allowance, they don't get the extra money for public holidays or for Sundays, so that is why they are only working from Monday till Saturday and not after hours and night duty." (K1) "The other one is labour companions, sometimes	"And the intake, increase in intake because I think the patient from Carletonville now they just come, it is self-referral." (P2) "To just get rid of the patient to send the patient away from the clinic." "Then that is the reason for referring." (P2) "..., to add on that one we had a meeting with the district and they make a standard operational procedure for the referral. That the patient, all the clinics will first contact the doctor,	sometimes it is better to get one of the family members who can also stay behind and support the patient." (K1) "Eh, language barrier of lot of clients come from Korea, China and Pakistan there is a difficult in communication..." (T1) "...yes like the deaf and dumb patients there is a poor communication between the nurse and such patients now the management becomes disturbed yes." (T1)	drugs that we really we need to use that during intrapartum and then you will find is for long times out of stock." (K2) "There is not enough stock or the medication used for patients or no dry stores in the hospital to provide." (T1)

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
each hospital especially the district ones whereby most of the patients come to deliver.” (T2)	us anymore...” (T2)	we don’t have for the night as well as weekends and public holidays so that they can give patients support throughout the labour.” (K2) “...we have no doulas available for provide continuous support...” (T1)	the obstetric doctor, before they send the patient.” (K1) “...give us a lot of problems because this clinics some of this clinics they just refer some of cold cases that they were supposed to be nursed and taken care at the clinics, so we are having a lot of problems at this clinics.” (T1)		

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
Sub-theme 1.3: Staff experience • Different experience • Skills mix of midwives • Senior/junior ratio “Because sometime you find that they will, uhm, they will send an inexperienced doctor and you have to make the decision for the doctor...” (P2) “You get the experienced sisters alone working with the new sisters is a burden to her because she must be responsible for all those patients and it	Sub-theme 2.3: Cultural and spiritual factors • White/Indian/black/Jewish “Cultural factors also are a challenge because we experience when the white patients come they usually bring a lot of people following them, even the Indian people..., ...where you find the black people, sometimes the black person comes alone and is rare if she is accompanied by a relative then she just left them here...” (K2) “The one is the spiritual			Sub-theme 5.3: Attitude of staff “We also need to change our attitude towards our patients, the way you talk to them I mean if you tell them nicely to say “I am going to go off at seven o’clock somebody is coming to relief me”, you know she becomes at ease...” (P1) “...and this shortage result in midwives attitude they are being overworked so they become so irritable, so you know we are tired, so tired we are irritable with our attitude with our	Sub-theme 6.3: Stock and medical equipment • Shortage of linen • RH kit “...there is no medical equipment we can’t just like the RH kit we don’t have, it has been for a year now since we don’t have RH kit so it is very difficult for us to nurse this woman...” (P2) “Sometimes we are encountering the problem of linen the shortage of linen sometimes, especially during the weekend.” (T1)

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
is really heavy for her.” (K2) “...lie all the old registered nurse who have got experience, most of them who are here are in high care, you go to labour room all the new ones with no experience they are allocated in the labour rooms, we should mix.” (K2)	belief, especially the Jehovah witness, sometimes they come with the abruption, they are bleeding heavily and you cannot give blood.” (K2)			patients. They are not, eh, convinced with the care that we are giving is not it gives a problem.” (T1)	
Sub-theme 1.4: Burden of interns/ student nurses/ agency nurses Orientation of new staff “...most of our doctors, they are interns, they are doing their				Sub-theme 5.4: Attitude/Expectations of patient/family “And problematic patients or problematic families you know sometimes patients eh patients from the	

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
internships, they are working also in our department and the nurses are the ones helping guiding them..." "...and sometimes you will find the students also you know there is not always that they will have accompaniment from the college side or even from university." (K2) "...make use of moonlight staff midwives, they come in and they are still inexperienced or they don't know the environment so the				community they come with what we call a negative attitude you know like eh they come here thinking that they are going to be shouted at, yelled at and already when they come in here they speak to us like we are nothing..." (K1)	

Theme 1: Staff shortage	Theme 2: Ante-natal care	Theme 3: Labour companion	Theme 4: Policies and guidelines	Theme 5: Communication/ Relationship	Theme 6: Resources
care of the patient is also still at risk..." (K2)					

3.6.1 **THEME 1: Staff shortage**

According to Buchan and Aiken (2008:3264) staff shortage is the gap between the reality of current availability of nurses and the aspiration for some higher level of provision. The respondents commented as follows on this matter:

“And then I must say this has been a continuous ongoing thing of shortage of staff because we have been working like that throughout the years”(P1)

“no it is definitely staff shortage, that, uhm, prevents us from giving continuous care. I mean we have got, we have a lot of patients we don’t have enough staff so we cannot stay with that patient the whole time progressing the patient, so I think that is definitely a challenge.” (P1)

“..... in the case of shortage of staff we are doing our utmost best, but if our facility can just try to see the situation we are in then they try to add some staff....” (T2)

The main challenge identified by the focus group interviews was the shortage of staff. The participants in this research felt that it hinders the implementation of continuous intrapartum support.

The International Confederation of Midwives Triennial report (ICM, 2011:19) published figures highlighting the global shortage of health workers. This report estimates that over 4 million additional health workers were required and at least 57 countries around the world were suffering from an acute shortage. The world’s missing midwives are clearly part of a bigger picture of gaps in global health.

Buchan and Aiken (2008:3262) maintain that the scarcity of health personnel is one of the biggest obstacles to achieve health system effectiveness. McLachlan *et al.* (2011:173) and Tracy *et al.* (2000:109) demonstrate that maternity services worldwide are under significant strain due to increased numbers of women giving birth and critical workforce shortages, especially of practicing midwives. As a result, maternity services are under threat or have closed due to the workforce shortages. Ashcroft *et al.* (2003: 2) conclude that midwives are fundamental components in the system of intrapartum care and the system cannot operate safely and effectively when the number of midwives is inadequate.

The “*Saving mothers report 2008-2010*” states the recommendation that staffing and equipment norms must be adequately established for each level and for every health institution concerned with the care of pregnant women (SA, 2011:47).

Blaauw and Penn-Kekana (2010:24) report that there is a critical shortage of human resources in the public health system - particularly midwives, advanced midwives, doctors and obstetricians - but no clear plan for tackling the issue. The Department of Health and Human services in the USA, quoted by McHugh *et al.* (2008:7) predicted that by 2010 the national shortage of nurses will more than double to 275,000, a shortfall of 12%, and if remedial actions are not taken, these shortage are expected to balloon by 11% to 24% by 2020.

In the North West province the staff shortage leads to an excessive workload and remains a key labour issue and this result in difficulty in the implementation of continuous intrapartum support.

3.6.1.1 Sub-theme 1.1: Workload

“Our workload is too much for us because there is much shortage of staff, we are ending up with burnout syndrome because of this shortage of staff, and really we really do need more staff in our hospital.” (T1)

“..... I mean we have got, we have a lot of patients. We don’t have enough staff so we cannot stay with that patient the whole time progressing the patient, so I think that is definitely a challenge.” (P1)

Box 3.1 Workload

A number of researchers report that the increase in responsibility and accountability that the midwives are faced with seems to be a common experience (Gilliland, 2011:529; Green & Hotelling, 2010:35; Mottl-Santiago *et al.*, 2008:375).

This results in burnout, which is the psychological term for a person's negative response to chronic job-related emotional stress.

Wiegers (2007:427) reports on an international study that found a shortage of midwives and widespread complaints about excessive workloads. Midwives felt they could not spend enough time with their clients, because the next client would already be waiting. Aiken *et al.* (2013:144) report that previous studies done in Europe documented high workloads, nurse burnout and work environments not supportive of professional nursing practice. Nurses in hospitals across Europe are rationing care because of high workloads and have concerns about eroding quality of care and insufficient priority of management of patient safety. Internationally, Ashcroft *et al.* (2003:5) have found that there are no contingency plan in any units to cope with the surges in demand for care that occur frequently in labour wards.

In Sub-Sahara Africa, Igboanugo and Martin (2011:64) reported that shortage of personell can affect the workload of existing staff and pose a potential threat to continuity and safety of childbearing women. Thorsen's (2011:1) study done in Malawi reflects that burnout among healthcare workers contributes to poor patient outcomes or impaired performance, which results because of shortage of staff which hinders continuous intrapartum support.

The findings of the above studies endorse the perceptions of the participants' in T1 and P1 that too high workloads impede the implementation of continuous intrapartum support.

The work load relates strongly to staff-patient ratio, which is discussed next.

3.6.1.2 Sub-theme 1.2: Staff-patient ratio

In countries with staff shortages there is often a poor distribution of the available nurses (midwives), which exacerbates the impact of staff shortage. Rural areas in developing countries (such as South African, specifically the North West Province) tend to be the most underserved areas (Beksinka *et al.*, 2006:308).

“If we are admitting many patients in labour rooms, we cannot just focus on that one as the others have to be helped also. So staffing, the one-to-one ratio.” (K2)

“It is the main thing that we are having at the moment if the department of health will find a way of balancing ratio between patients and doctors and nurses in each hospital, especially the district ones whereby most of the patients come to deliver.” (T2)

Box 3.2 Staff : patient ratio

Baral *et al.* (2010:327) report that there is an international chronic shortage of skilled resources e.g. the physician and nurse ratios are 5 and 26 per 100,000 people respectively. In view of above statement the shortage of physicians also have an implication on the midwives providing continuous intrapartum support. According to Temmar (2006:85) there is currently a worldwide shortage of midwives to attend to the large number of births, the ratio being 1 midwife to 289 births. In

Igboanugo and Martin (2011: 70) comment on Sub-Sahara African staff related problems by saying that improper staff-patient ratios create long delays in treatment, thus increasing the risk of continuous support which may also influence the MMR. Thorsen *et al.* (2011:1) state that in a study done in Malawi the physician-patient ratio is one physician per 62 000, compared to WHO’s recommendation of 1 per 5000. This results in impaired performance like burnout among health care workers, which detracts from the inability to provide intrapartum continuous support. This in turn contributes to poor patient outcomes and concurs with the statement from focus group T1:

“..., our unit is a big unit which is being run by one of obstetric doctor. Now there is a great challenge in the intrapartum care by the doctor. Sometimes the doctor becomes exhausted by examining the patient because sometime she has been running the unit which contains five different categories of different units, he fails to meet all the needs of the patients...” (T1)

According to Gaunt, (2010:101) district hospitals in South Africa are historically under-resourced. Gilliland (2011:529) supports the statement in focus group K2 by saying that midwives in hospitals have more than one mother to attend to at a time which depend on the staff:patient ratio on the given time and it also influence the quality of continuous intrapartum support rendered.

Beksinska *et al.* (2006:305) stipulate that the number of staff required for rendering quality intrapartum care at their various Levels of service. This does not take into consideration the number of patients seen or type of care a woman requires. This can be a gap in achieving implementation of continuous intrapartum support if the intake/ type of care changes, as mentioned in focus group T2.

The staff-patient ratio is important and it can be alleviated if skilled birth attendants were available as it would impact on the quality of intrapartum care rendered. It is crucial that the midwives have the necessary skills and experience to enhance continuous intrapartum support.

3.6.1.3 Sub-theme 1.3: Staff experience

King and Mhlanga, (2006: 113) define a skilled attendant as an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to the level of proficiency in the skills needed to manage normal pregnancy, childbirth and the immediate postpartum period and in the identification, management and referral of complications in women and newborns.

“...lie all the old registered nurse who have got experience, most of them who are here are in high care, you go to labour room all the new ones with no experience they are allocated in the labour rooms, we should mix.” (K2)

“Because sometime you find that they will uhm they will send an inexperienced doctor and you have to make the decision for the doctor...” (P2)

You get the experienced sisters alone working with the new sisters is a burden to her because she must be responsible for all those patients and it is really heavy for her.” (K2)

Box 3.3 Staff experience

Internationally studies confirm the experiences related by the participants in focus group K2, P2. Ashcroft *et al.* (2003:5) found that during intensely busy periods when shortfalls were most acute, senior midwives in charge of the shifts were unable to provide support for inexperienced midwives. Latent failures therefore increased when combinations of inexperienced midwives and inexperienced medical staff were left unsupervised with complicated cases. Ashcroft *et al.* (2003:1) report that a poor skills mix of midwives erodes labour ward skills and confidence, because midwives spend time in performing clerical duties, which hinders continuous intrapartum support.

In the *Saving mothers report 2008-2010* (SA, 2011:48), one of the recommendations is the importance of labour with skilled birth attendants and early attendance to labour to prevent prolonged labour.

Carlough and McCall, (2005:200) state that the presence of a skilled birth attendant at the delivery is important in averting maternal and neonatal mortality and morbidity because they are able to treat complications and to refer, resulting in the promotion of continuous intrapartum support by attending to the emergencies promptly.

Beksinska *et al.* (2006:307) indicates that any facility that carries out deliveries should have at least one advanced midwife as this will aid in the proper management of complicated intrapartum care and prompt referral to the next level.

Maclean (2007:26) concludes by saying that it must be acknowledged that skills alone cannot save lives if there are insufficient drugs, inadequate equipment or desperate staff shortages contributing to the inappropriateness of the place of care. In view of the above mentioned reasons continuous intrapartum support is not commonly practiced due to limited resources and exposure.

According to the researcher's observation of the three hospitals, most of the midwives are highly experienced midwives, as illustrated in tables 3.1, 3.2 and 3.3 of the demographic data for the participants in the focus groups, but the implementation of continuous intrapartum support can be influenced by other responsibilities such as the burden of interns/student nurses/agency nurses.

3.6.1.4 Sub-theme 1.4: Burden of interns/student nurses/agency nurses

"...most of our doctors, they are interns they are doing their internships they are working also in our department and the nurses are the ones helping guiding them..." "...and sometimes you will find the students also you know there is not always that they will have accompaniment from the college side or even from university." (K2)

"...make use of moonlight staff midwives, they come in and they are still inexperienced or they don't know the environment so the care of the patient is also still at risk..." (K2)

Box 3.4 Burden of interns/student/agency nurses

Ashcroft *et al.* (2003:4) state that the national shortfalls of labour ward midwifery staff result in reliance on bank midwives to maintain minimum staffing levels and this impacts negatively on continuous intrapartum support as the bank midwives are not as experienced as labour ward staff. Ashcroft *et al.* (2003:4) also relate that during intensely

busy periods, when shortfalls are most acute, senior midwives were unable to provide support to inexperienced midwives. As a result latent failures increased when combinations of inexperienced midwife and inexperienced medical staff were left unsupervised with complicated cases.

According to the Nursing Act no 50 of 1990 (SA,1990) one of the roles of a professional nurse is to develop other nurses, hence in the clinical setting student nurses should be guided and supervised in rendering care to the patient i.e. antenatal, intrapartum and postnatal. The focus starts during antenatal care in order to establish continuous maternity care.

3.6.2 THEME 2: Antenatal care

According to Beksinska *et al.*, (2006:305) antenatal care programmes are the responsibility of the Woman's Health and Genetics Directorate. Routine antenatal care for low risk women is supposed to be provided at any primary health care centre. The *Guidelines for Maternity Care in South Africa* (2007:28) stipulates the content and procedures that should be undertaken in the first and subsequent antenatal visits. One of the components of antenatal care is health education, which informs the women regarding their choices to bring a companion during childbirth for continuous labour support to facilitate a positive birth experience (Beksinska *et al.*, 2006:305).

3.6.2.1 Sub-theme 2.1: Health education

“...even if at the clinics the antenatal clinic they give proper health education to the patient to the person to say if this person into labour you must support this person, maybe she can come along with this person...” (P1)

Box 3.5 Health educations

The Batho Pele Principles state that patients need to be informed to make the right decisions about their health. The information that labouring women can be obtained from health workers during the antenatal period Lowe (2004) refer to the importance of the

mother being provided with as much information as possible during the antenatal period, especially about what to expect in the labour ward in order to be sensitive to continuous intrapartum support.

Beksinska *et al.* (2006:306) quotes from the detailed context in which guidelines were developed for KwaZulu-Natal:

- Limited health education and planning for the birth takes place at the antenatal visits.
- There has been no concerted effort to bring community, family and partner participation into the holistic care of pregnant women and new mothers.

Beksinska *et al.* (2006:298) state that national pregnancy education week (PEW) is held annually to raise community awareness and promote safe pregnancy through quality information and education. Factors that can be included in health education during the antenatal period include topics like traditional practices. Such information can aid in safeguarding a healthy mother and baby throughout labouring process.

Health promotion is important as it addressed cultural / traditional practices that may influence the health of mother and baby and the outcome of labour.

3.6.2.2 Sub-theme 2.2: Traditional medicine

The use of traditional medicine during pregnancy amongst black South Africans is a common practice, but what it comprises varies from culture to culture. In the North West province, for example, “*kgaba*” is used more by the Batswana (Van der Kooi & Theoland, 2006:11).

Kgaba is the name used to refer to traditional remedies, which might be herbs, other substances believed to get rid of ancestral spirits cast by a relative who is in disharmony with a pregnant mother (Van der Kooi & Theoland, 2006:11).

“...the patient really need to be educated on the dangers of the traditional medication that they have the medication that they are using, because most of the time when they come, they have taken muti at home eh ingestion of “kgaba” which will result in a strong contraction and when we give pain relief it does not really assist us anymore...” (T2)

Box 3.6 Traditional medicine

Igboanugo and Martin (2011:69) support the provision of antenatal education that encourages the avoidance of harmful traditional practices. Teaching communities to identify problems that require immediate professional attention would work towards improving maternal and neonatal outcomes.

The *Saving Mothers report 2008-2010* (SA, 2011:48) recommends that the health care information should warn against self-medication with oxytocic agents to encourage labour.

The fact that alternative means of healing still prevail and draw a large patronage means that it becomes a challenge to provide continuous intrapartum support to a client who used medicine that had an influence on labour progress not known to the health worker. Noble *et al.* (2009:544) emphasize that healthcare providers need to respect the cultural / spiritual beliefs of the clients, which can influence the provision of continuous intrapartum support.

3.6.2.3 Sub-theme 2.3: Cultural/spiritual factors

Culture refers to the way of living, distinctive knowledge, habits, ideas, norms, values and language shared by a group of people and it differs from one society to another (Berman *et al.*, 2008:312). According to Berman *et al.* (2008:313), professional nursing care should be culturally sensitive, culturally appropriate and culturally competent. Nursing care should be provided across cultural boundaries and should take into account the context in which the client lives. In the absence of blood products a disruption of continuous intrapartum

support occurs which influence the quality of intrapartum care and thus may influence the MMR.

“The other one is the spiritual belief, especially the Jehovah witness sometimes they come with the abruption, they are bleeding heavily and you cannot give blood.” (K2)

“Cultural factors also are a challenge because we experience when the white patients come they usually bring a lot of people following them, even the Indian people..., ...where you find the black people, sometimes the black person comes alone and is rare if she is accompanied by a relative then she just left them here...” (K2)

Box 3.7 Cultural/spiritual factors

Taniguchi and Baruffi (2007:94) and Noble *et al.* (2009:544) agree that child birth is influenced uniquely and sensitively by each culture; hence culturally sensitive approaches prevent perinatal mental dysfunction and facilitate good birth outcomes and positive childbirth experiences. Noble *et al.* (2009:544) further state that caring for labouring couples necessitates that culturally competent midwife recognize culturally related responses in order to appropriately care for women and their families.

Hoang and Kilpatrick (2009:1) state that cultural differences in maternity care may result in conflict between migrants and health care providers, especially when migrants have minimal English knowledge and this fact affects the quality and efficacy of the care provided. If for instance an Asian migrant retain traditional views and practices for maternity care, confusion and conflicting expectations may occur. The findings from the above authors concur with the experiences from focus group T1:

“And sorry those cultural beliefs which we have in maternity ward, we have to explain something like placenta incineration or how to how to discard the placenta should you want to ask the permission to discard the placenta you don’t know how to explain yourself to such patient...”(T1)

Being culturally sensitive will benefit the implementation of continuous intrapartum support. The use of a labour companion can enhance this.

3.6.3 THEME 3: Labour companion

A labour companion is a person who provides the woman and her husband or partner both emotional and physical support throughout the entire labour and delivery process and to some extent afterwards (Klaus *et al.*, 2002:4).

3.6.3.1 Sub-theme 3.1: Family support

“And then also the companionship is not there, the relatives they are also not there to support, because if you as a midwife your are alone and there is somebody or some relative who is supporting that woman through labour that can also help but if there is no one then the woman becomes anxious, she pushes prematurely and all those things. (P1)

Box 3.8 Family support

International studies indicate that traditionally women in labour were surrounded by other women from their family (generally woman who had already given birth). A friend or family member experienced with childbirth may be able to provide continuous support, this serves as a re-assurance to a woman (Page & McCandlish, 2007:337). The advantage is that they know the woman intimately and have already built the relationship. These women do not need formal training; they only need to be willing (Green *et al.*, 2007:28).

Ali *et al.* (2008:3) found in a study done in Pakistan that when women are unable to go to a health facility unaccompanied, male family members must accompany them. Van Bussel *et al.* (2010:143) concur that childbirth is considered a safe event for both mother and child and developed countries have progressed to a patient centered focus aimed to increase maternal comfort during labour and delivery, i.e. (partner / husband / family).

Murray *et al.* (2010:463) highlight in Australia that some women described the use of husbands or interpreters as helpful and said that it made them they feel much more in control, relaxed and comfortable. Van der Westhuizen (2011:18) highlights that in modern society it has become an expectation (although not in all cultures) e.g.African culture for the father to be in the labour room. The expectation is that he should be a companion, provide emotional support and be the labour coach who takes charge of the birth.

According to Beksinska *et al.* (2006:311) the poor quality of care extends into delivery where a woman will often deliver without the support of a partner or family member.

3.6.3.2 Sub-theme 3.2: Doula programme

According to Van der Westhuizen (2011:16) and BIA (2009) doula means 'supportive companion' in labour. Green *et al.* (2007:27) and Medforth *et al.* (2009:26) both define a doula as an experienced labour companion who provides the woman and her husband or partner with emotional, informational and physical support throughout the entire labour and delivery.

“...we have no doulas available for provide continuous support...” (T1)

Box 3.9 Doula Program

Walker (2009:41) supports the use of doulas by describing the doula as able to take control over the birthing process and if done with compassion, it can help the mother to remember to trust what she already knows and help her to learn to be flexible when faced with the unknown.

Gilliland (2011:525) reports that doulas utilize intricate and complex emotional support skills when providing continuous support for women in labour. Doula care has been shown to have a positive influence on labour and birth outcomes with no negative side effects. In this research a lack of opportunities for doulas seems to be a challenge as it influence the implementation of continuous intrapartum support.

Mottl-Santiago *et al.* (2008:372) state that women with doula support had significantly higher rates of breastfeeding intent and early initiation.

In South Africa, according to Sr Kaibe in Van der Westhuizen (2011:16), the presence of the doula lightens the load of the midwife and is a valuable resource in obtaining better birth and post-partum outcomes.

The utilization of a doula programme is influenced by hospital policies, which have to provide for such a programme to be available to labouring women for the provision of continuous intrapartum support. Because lack of hospital policies the implementation of doulas to render continuous intrapartum support is a challenge.

3.6.4 THEME 4: Policies and guidelines

According to Beksinska *et al.* (2006:305) policies and guidelines deal with the management of pregnant patients and also specify where or what management should be provided by each level of care. It defines the level of care, the referral systems, as well as staff required at a specific level of care, together with what services they should be rendering. A number of important guidelines and policies have been produced by the Department of Health (DoH). If the necessary intrapartum support is not given it also influence the quality of intrapartum care rendered.

3.6.4.1 Sub-theme 4.1: Hospital

“...maybe we can have some policies that are implemented in the hospital to say that certain people must be able to come with this patient or to stay with this person maybe it will make the burden of the nurses a little bit lower you see.” (P1)

Box 3.10 Hospital

The maternal health policy outlines a minimum set of national requirements for management of patients in maternal health care services. Each province is autonomous in being able to adapt or develop its own guidelines (Beksinska *et al.*, 2006:305). The

Guidelines for Maternity Care in South Africa (SA, 2007) laid the foundation for how maternity services should be rendered. Other issues of relevance are not yet included, e.g. the involvement of men/ companions during the maternity period (Beksinska *et al.*, 2006: 306).

Beksinska *et al.* (2006: 306) sketch in detail the context of integrated and evidence based antenatal and postnatal policy and guidelines for KwaZulu-Natal, in particular with issues related to Box 3.10:

- Antenatal visits offer limited health education and planning for the birth
- There has been no concerted effort to bring the community, family and partner participation into the holistic care of pregnant women and the new mother. This reveals that there is possibly a gap or challenge surrounding the formulation of policies and guidelines to inform clients of the use of labour companions in order to facilitate the implementation of continuous support.

This information is supposed to be disseminated during antenatal care in the clinics.

3.6.4.2 Sub-theme 4.2: Clinic

“...give us a lot of problems because this clinics some of this clinics they just refer some of cold cases that they were supposed to be nursed and taken care at the clinics, so we are having a lot of problems at this clinics.” (T1)

Box 3.11 Clinic

The *Saving Mothers report 2008-2010* (SA, 2011:47) recommends that criteria for referral routes for maternity patients must be established and utilized appropriately in all the provinces. All facilities providing maternity services must have functional referral routes and referral criteria to appropriate Level 1 or Level 2 or Level 3 hospitals. According to Beksinska *et al.* (2006:312) and the *Guidelines for Maternity care in South Africa* (SA, 2007) classifies facilities into clinics, community health centres and three different levels of

hospitals, hence the referral route should follow the sequence of first clinic or community health centre to the hospital. The criteria for referral should be communicated between the facilities in order not to overburden the next level of service with an unnecessary workload.

3.6.5 THEME 5: Communication / relationship

Communication means an interchange of information between two or more people to exchange thoughts or ideas. It can be a transmission of feelings or a more personal and social interaction between people (Berman *et al.*, 2008:460)

3.6.5.1 Sub-theme 5.1: Rapport

An international study done in England by Beake *et al.* (2010:1) states that staff should be aware that how they interact with woman could make the difference between a positive or a negative experience of care.

Lewis (2012:310) cites that the vast majority of midwives work hard to establish rapport with women in order to ensure that their experience of care during the continuum of childbirth is a positive one. Lundgren and Berg (2007:220) support that the relationship between the midwife and the woman is essential for a positive experience for the woman during the childbearing period.

Beksinska *et al.* (2006:344) relate to the fact that the type of quality care received is influenced also by issues of communication and interaction between patient and provider. Language forms an integral part of enhancing good communication during continuous intrapartum support.

3.6.5.2 Sub-theme 5.2: Language

“Eh, language barrier of lot of who can’t understand our language.”(K1) clients come from Korea, China and Pakistan there is a difficult in communication...” (T1)

Box 3.13 Language

International research done in Australia, re-African woman, by Murray *et al.* (2010:458) reported that the English language skills of the refugees and the ability of health providers to use interpreters have greatly impacted on the effectiveness of communication. According to Cross-Sudworth *et al.* (2011:460) language is commonly cited as a hindrance for Pakistans in Brittain in accessing health care in the destination countries and these results in a lack of information and hinders the woman's choices throughout the process of intrapartum care. Mottl-Santiago *et al.* (2008:376) state that in a multicultural environment, the provider may not always be able to provide culturally competent support in the language of the labouring woman.

Taniguchi and Baruffi (2007:92) present similar results in that Japanese women living in Hawaii cited the language barrier as the most difficult factor during pregnancy and child birth, closely followed by the attitude of the health caregiver, the difference in culture, especially for those women who are in intercultural relationships with non-Japanese partners. Much as the language can be identified as a hindrance in continuous intrapartum support, if a health care provider displays a caring attitude it will bring re-assurance to the birthing woman and enhance intrapartum support.

3.6.5.3 Sub-theme 5.3: Attitude of staff

"...and this shortage result in midwives attitude they are being overworked so they become so irritable so you know we are tired so tired we are irritable with our attitude with our patients they are not eh convinced with the care that we are giving is not it gives a problem." (T1)

Box 3.14 Attitude of staff

Igboanugo and Martin (2011:66) comment on the unwelcoming attitudes of staff towards pregnant women that can create social and psychological barriers that limit the willingness of consumers to attend care. Igboanugo and Martin (2011:66) further elaborate on poor staff attitude by saying that it can cause women to decline orthodox care and instead labour at home or in spiritual houses. The researchers also highlight that the inhospitable attitude may also be attributed to substantially high caseloads, which can result in high

stress levels and a feeling of insufficient support from the employing trust as stated by participants in the current study.

Vedam *et al.* (2009:274) raise the issue that a health care provider's attitude toward maternity care options influences the nature of informed decision making discussions and patient choice. In order for continuous intrapartum support to be effective the provider should have a positive intent to meet the expectations of a client.

3.6.5.4 Sub-theme 5.4: Attitude / expectations of patient/family

And problematic patients or problematic families you know sometimes patients eh patients from the community they come with what we call a negative attitude you know like eh ..." (K1)

Box 3.15 Attitude / expectation of patient/family

Lumadi and Buch (2011:4) state that patient satisfaction with the health care service is a measure of the quality of care received and of the responsiveness of health care systems to patients expectations. There are several factors that influence patients' expectations of service, including a woman's past delivery experiences, media reports and cultural and religious beliefs (Lumadi & Buch, 2011:5). Unmet expectations can result in dissatisfaction. Bussel *et al.* (2010:145) state that by providing information about the biological process and the care available, a woman is enabled to have realistic expectations about the childbirth. These maternal childbirth expectations have been found to be an important predictor of woman's actual child birth experiences.

Mbye *et al.* (2011:59) relate that labour support plays an important role because it influences the woman's classification of the birth experience as positive or negative. Fulfilling the woman's expectations about childbirth can increase her satisfaction with the birth experience.

Lumadi and Buch (2011:15) quotes that according to Smith and Engelbrecht (2001:5) "client satisfaction is regarded as the level of satisfaction that clients experience having used the service which reflects the gap between the expected service and the experience

of the service.” These authors mention that there are five broad areas to be measured in expected service namely: tangibles like equipment and physical surroundings, reliability or the ability to accurately perform the service, responsiveness, implying the willingness to assist clients, assurance or the ability to be knowledgeable and to inspire confidence and trust, including the ability to display compassion. The next theme discusses one of the broad aspects that is measured in expected service, namely equipment and physical surroundings.

3.6.6 THEME 6 : Resources

3.6.6.1 Sub-theme 6.1: Infrastructure

“I would say about the structure, it would be nice if like every, we would have only single rooms like for privacy for all the patients like if maybe a patient is having a supporter so that they can have they own room you know.” (K1)

Box 3.17 Infrastructure

Igboanugo and Martin (2011:67) state that well-designed hospital environments can have a real impact on patient welfare, the size and scale of hospital building, its layout, lighting and landscape impact on the experience of a childbearing woman. During delivery women require comfortable rest and privacy in rooms equipped with the essential amenities.

Gaunt (2010:101) reflects that the maternity ward involved in the study had poor infrastructure, i.e. the labour ward was too small with only two beds. Poor equipment had two delivery packs, the hospital had one laryngoscope and the other resuscitative equipment was very inadequate which had an impact on the continuous intrapartum care.

According to Beksinska *et al.* (2006:311) the delivery setting often does not give the woman privacy, making it difficult for partners to attend delivery. Oyerinde *et al.* (2012) concur that poor facility infrastructure and perceptions that facilities are poorly stocked impact on continuum of care services and these were the barriers to facility utilization for maternity and newborn care (see Box 3.17). One of the under stocked items that was

identified to have an impact on the quality care rendered for continuous intrapartum support is lack of medication.

3.6.6.2 Sub-theme 6.2: Medication

“And the other factor I think that also hampers continuous care, the medical, the medicine is out of stock sometimes we find that there is no...” (P2)

Box 3.18 Medication

Baral *et al.* (2010:325) state that a lack of medicine is common in hospitals. Pearson and Shoo (2005:209) also support that essential supplies and medicine are often inadequate e.g. (oxytocin) in community health centers, which also have an impact on the quality of continuous intrapartum support that is rendered. According to *Saving Mothers' report 2008-2010* all community health centers must ensure provision of basic emergency care namely oxytocic drugs (SA, 2011:50). The recommendations further state that there must be an adequate supply chain of essential drugs namely ergometrine and oxytocin and these must never be in short supply (SA, 2011:51). An essential part of quality care is to have sufficient stock supply.

3.6.6.3 Sub-theme 6.3: Stock and medical equipment

“...there is no medical equipment we can't just like the RH kit we don't have, it has been for a year now since we don't have RH kit so it is very difficult for us to nurse this woman...” (P2)

“Sometimes we are encountering the problem of linen the shortage of linen sometimes especially during the weekend.” (T1)

Box 3.19 Stock and medical equipment

The *Saving Mothers' report 2008-2010* recommendations state that all pregnant women should be offered information on screening for and management of non- pregnancy related infections and common medical disorders (SA, 2011:51) and institutions should ensure that basic monitoring equipment such as pulse oxymeters, on site HIV testing kits are available in order to influence on the quality of intrapartum support and care rendered (SA, 2011:51).

Igboanugo and Martin (2011:67) argue that a health center with skilled workers cannot prevent maternal or child death without adequate supply of specialized equipment. The *Saving Mothers' report 2008-2010* recommends that equipment norms must be established for each level and for every health institution concerned with the care of pregnant women (SA, 2011:47). Woods (2009:78) states that a lack of essential equipment has a major impact on rendering quality intrapartum care and continuous intrapartum support rendered.

3.7 SUMMARY

This chapter offered a discussion of the findings of the study with direct quotations from the participants and confirmation from other studies. Findings were embedded with other scientific published articles, journals and electronic databases to support or confirm the findings and expand the new insight gained. The research findings of this study indicate reasonable challenges experienced by the midwives related to the implementation of continuous intrapartum support.

Chapter four deals with the conclusions, limitations and recommendations to promote continuous intrapartum support to the labouring women.

CHAPTER 4

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

This chapter offers some conclusions that arise from research findings. In addition, it touches on the limitations of the study and offer recommendations regarding the challenges related to implementing continuous intrapartum support in public hospitals in the North West province.

Six focus group interviews involving 33 registered midwives were conducted to answer the research question of challenges related to the implementation of continuous intrapartum support.

4.2 CONCLUSIONS

Childbirth constitutes a life changing event during which a woman experiences physical, emotional and psychological changes in the process of taking a positive motherhood role. The changes that the woman undergo may result from many factors, but nevertheless, the implementation of continuous intrapartum support can relieve some of these changes for the optimum facilitation of good birth outcomes and a positive childbirth experience.

Childbirth is a universal biological event and is seemingly similar for everyone, but the birth experience is in fact not the same for any two women. Since every woman has a unique experience, continuous intrapartum support can instill positive personal meaning of the birth experience of immense depth. The woman can remember this throughout her life. Continuous intrapartum support can uplift the quality of her birth experience. If a woman has a positive birth experience during the intrapartum period, it has a significant impact on a range of clinical outcomes (Ross-Davie *et al.*, 2013:163).

4.3 LIMITATIONS OF THE STUDY

- The study was conducted in the public sector in the North West province, thus limiting the findings only to the public context within the NWP. However, continuous intrapartum support is also applicable in private context.
- Some of the midwives who form the target group in this study were working shifts. The result is that some of the midwives were working night duty during the data collection period and could not meet their appointments due to their nights off.
- One of the limitations of this study is that the midwives who have less than two years' experience in labour room were excluded. Their perceptions of what constitutes challenges related to the implementation of continuous intrapartum support could have added value.
- Focus group interviews with patients could have revealed evidence of client satisfaction or dissatisfaction together with experience of quality intrapartum care, although this was not the focus of the study.

Despite the limitations of this study the objective of the research was achieved, namely to explore and describe the challenges related to implementing continuous intrapartum support in public hospitals in the North West Province.

4.4 RECOMMENDATIONS

Recommendations for practice, education, policy and research are stated below:

4.4.1 Nursing practice

4.4.1.1 Community involvement

- Health care providers during antenatal visits should empower the pregnant woman by informing her of the benefits and advantages of continuous intrapartum support and the choice of the preferred labour companion. This should be done through

educating them in the language that they understand. Partners should be included during the antenatal period to enable them to understand their expected role in birth support.

- All hospitals must become accredited to the Better Birth Initiative in order to enhance continuous intrapartum support. Strategies to work toward BBI accreditation are in planning.
- Identify interested community members to become doulas and to promote doula in-service training to support continuous intrapartum care.
- A patient satisfaction survey should be developed to improve the quality of continuous intrapartum support to be used by patients in maternity wards.

4.4.1.2 Educational material and equipment

- Midwives should make use of educational materials to explain continuous intrapartum support to pregnant women.
- Information should be provided in a range of languages. This information should be readily available in the form of pamphlets, booklets and audio visual tapes.
- There should be adequate supply of the materials and equipment needed during the intrapartum period to enhance continuous intrapartum support.

4.4.1.3 Human resources

- In order to alleviate the staff shortage, more staff with a passion for work in maternity units should be contracted and retained.
- **Staff compliment should be increased to balance midwife: patient ratio to a safe level and to improve the quality of intrapartum care.**
- The agency staff should not be the first solution for the human resource shortage, but if used should be orientated regarding continuous support to women during the intrapartum period.

- Support and mentor the newly qualified/appointed midwives in order to prevent burnout and to provide better intrapartum care, which includes continuous intrapartum support.
- There should be an adequate skills mix of trained midwives, including advanced midwives, to prepare for managing unforeseen complications and to enhance continuous intrapartum support.
- Midwives need to respect cultural beliefs and explore cultural congruent interventions that allow women to feel comfortable to become mothers in foreign countries. Midwives should become culturally competent so that they can respond appropriately to care for a woman and their family while rendering continuous intrapartum support.
- Clinicians should not only to be culturally competent, but also communicatively competent. This goal can be achieved with cross-cultural training or the use of interpreting services to enhance continuous intrapartum support.
- Contingency plans should exist in maternity units to cope with the unexpected surges in the demand for care that occur frequently on labour ward, since such surges may lead to an interruption in continuous labour support.
- Provide a friendly, welcoming and enabling environment in labour rooms where the patient can be surrounded by her choice of preferred companion for continuous intrapartum support.
- Occupational specific dispensations should be offered to advanced midwives in order to recruit and retain the best skilled midwives for continuous intrapartum support.

4.4.2 Nursing education

- Emphasis on inclusion of the importance regarding skills to encourage continuous intrapartum support in both the undergraduate and post-graduate midwifery curricula.

- Midwives should be trained to provide culturally sensitive intrapartum care, which includes views regarding continuous intrapartum support.
- Lifelong learning, which leads to capacity building of midwives, is important to improve the quality of intrapartum care.
- A midwife educator must have more than basic midwifery knowledge in order to teach midwifery to undergraduate and post-graduate students and to enhance the implementation of continuous intrapartum support.
- The nursing education institutions must have additional clinical preceptors to relieve the burden of student nurse accompaniment for midwives so that the midwife may focus on promoting continuous intrapartum support.
- Mentorship and clinical role modeling from nursing education institutions may be as important as knowledge transfer regarding continuous intrapartum support.
- Student midwives should be taught the similarities and differences between indigenous and western practices when taking care of patients so that all nurses become familiar with these practices so as to enhance continuous intrapartum support.
- Include a comprehensive module in cultural competence into nursing and midwifery education since there is valuable knowledge among traditional birth attendants regarding indigenous practices such as "kgaba" and oxytocin.
- Establish role models for students through the appointment and recognition of exceptional clinical staff.

4.4.3 Policy

- Develop recruiting and retaining policies for midwives to enhance the quality of intrapartum care.
- Develop a policy about the presence of support person of the labouring woman own preferred choice.

- Formulation of guidelines to promote continuous labour support objectives, for instance:
 - Community upliftment and involvement through educating the community
 - Identification of people with interest in becoming a doula
 - Offering in-service training and development to become a successful doula
- Proposed curriculum content for being a successful doula can include the following:
 - Non-pharmacological management of pain e.g. massage technique, use of positions and hydrotherapy.
 - Signs of onset of labour
 - Exercises
 - Nutrition of a pregnant woman
 - Physical and emotional support
 - Cultural sensitivity
- Culturally sensitive and language policies should be made available within the working context to ensure that the midwives are capable of working in a cross-cultural situation with back-up interpreters to improve the continuous intrapartum support. A list of interpreters be made available in the maternity unit.

4.4.4 Nursing research

The following topics could contribute to continuous support during intrapartum:

- Exploring the effect of “kgaba” during labour in the context of rendering continuous intrapartum support and care.
- Exploring the experience of mothers regarding the effect of continuous intrapartum support

- Conducting a survey of patient perceptions of what they regard as continuous intrapartum support
- Exploring whether the perceptions of patients in private hospitals differ from patients in public hospitals?
- To investigate what is the actual time a midwife spends on different aspects of client care during the intrapartum period.
- To establish a model of continuous intrapartum support that would fit the South African context.
- To establish a model for patient-midwife ratio to determine how many midwives are needed in maternity units to render continuous intrapartum support.
- Establishing the possibility of transferring culturally sensitive midwifery from one culture to another in order to understand the need of the labouring women to promote continuous intrapartum support.

4.5 PERSONAL REFLECTION

During this long process I learned to do or die.... Various situations come to mind with obstacles that I did not foresee. In one instance I was invited to sleep over at a participant's house after data collection, just to find a bed without linen. I also realized that a cake can open to the hearts of unwilling participants. As Midwifery lecturer I truly believe that the implementation of continuous intrapartum support will improve the quality of intrapartum care, leading to a reduction of MMR and a positive birth experience for the mother and the community.

4.6 SUMMARY

This research study, conducted within the North West province public hospitals, sought to explore and describe the challenges related to implementing continuous intrapartum labour support. The research study revealed that the midwives have an understanding of the benefits of continuous intrapartum labour support, but its implementation is hindered by challenges, as identified during the data collection process.

Chapter 4 of this research reflected on the conclusions, limitations and recommendations for practice, education, policy and research, and includes the researcher's reflections on the research process.

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SANC **see** South African Nursing Council (SANC)

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Stats SA **see** Statistics South Africa

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APPENDIX A

ETHICAL APPROVAL: NWU-00051-08-A1 (PROF HC KLOPPER)



NORTH-WEST UNIVERSITY
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ETHICS APPROVAL OF PROJECT

Ethics Committee
Tel: +27 18 299 4850
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Email: Ethics@nwu.ac.za

This is to certify that the next project was approved by the NWU Ethics Committee:

Project title : Challenges in implementing continuous support during intrapartum in public hospitals in the North West Province	
Student : Sylvia N. Spencer	
Project leader: Prof H Klopper	Sub project leader: Dr A du Preez
Ethics number: NWU -00015-08 -A1	
<u>Status:</u> S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation	
Expiry date: 10 July 2013	

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

The formal Ethics approval certificate will be sent to you as soon as possible.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Me. Marietjie Halgryn'.

Me. Marietjie Halgryn
NWU Ethics Secretariate

APPENDIX B

ETHICAL APPROVAL: NORTH WEST DEPARTMENT OF HEALTH



health

Department of
Health
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POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

To : Ms N Spencer

From : Policy, Planning, Research, Monitoring & Evaluation

Subject: Research Approval – Challenges in implementing continuous support during intrapartum in public hospitals in North West Province.

Purpose

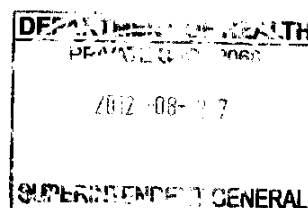
To inform Ms N. Spencer that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter as prove that the Department has granted approval to the districts or health facilities that form part of the study.

Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher and the department expects to receive the final research report upon completion.

Kindest regards

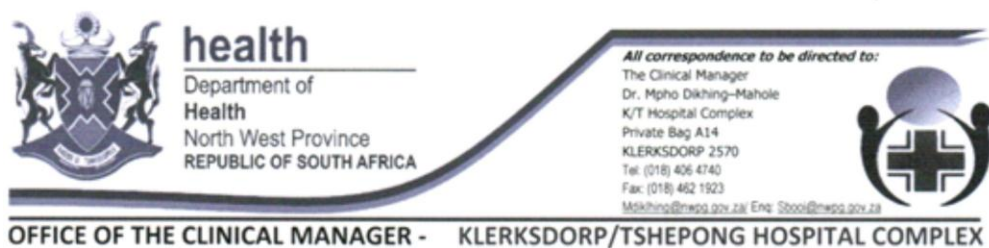
Director: Policy, Planning, Research, Monitoring & Evaluation
Mr B Redlinghys

24/08/2012
Date



Healthy Living for All

APPENDIX C
PERMISSION TO CONDUCT RESEARCH AT
KLERKSDORP HOSPITAL



25th November 2013

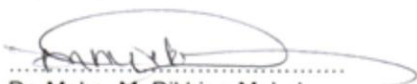
To: Whom it may concern

RE: Ms. Sylvia Spencer's Research Study /To conduct Data Collection in Challenges in Implementation of Continuous Support during Intrapartum in Public Hospital in North West in Klerksdorp/Tshepong Hospital Complex

This letter serves as a provisional approval to continue with the above mentioned study. This complex will give recommendations to the head office to give the final approval about this study.

The researcher can continue with the study in the K/T complex as per agreement with the Patient Safety Group.

Regards,


Dr. Mpho M. Dikhang-Mahole
Clinical Manager
PSG Chairperson
K/T Complex

APPENDIX D
PERMISSION TO CONDUCT RESEARCH AT
POTCHEFSTROOM HOSPITAL



health

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POTCHEFSTROOM HOSPITAL OFFICE OF THE CEO

To: MS N.S SPENCER
MASTERS DEGREE CANDIDATE & RESEACHER
NWU (POTCHEFSTROOM CAMPUS)

From: MS G.T. TLHAPI
CHIEF EXECUTIVE OFFICER
POTCHEFSTROOM HOSPITAL

Date: 01 OCTOBER 2012

RE: PERMISSION TO CONDUCT RESEARCH AT POTCH HOSPITAL

Permission is hereby granted to conduct research titled, "Challenges in implementing continuous support during the intrapartum period in public hospitals in the North West Province."

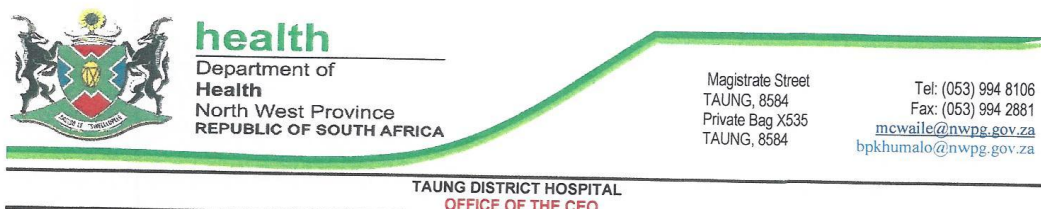
Sincerely,

MS G.T. TLHAPI
CHIEF EXECUTIVE OFFICER
POTCHEFSTROOM HOSPITAL

POTCHEFSTROOM
HOSPITAL
2012 -10- 01
PRIVATE BAG X938
POTCHEFSTROOM 2520

PERMISSION TO CONDUCT RESEARCH AT POTCH HOSPITAL

APPENDIX E
PERMISSION TO CONDUCT RESEARCH AT
TAUNG DISTRICT HOSPITAL



To: Dr. A. du Preez
Study Supervisor

28/11/2012

Att: Ms. N.S. Spenser
Master Degree Candidate and Researcher

RE: ACKNOWLEDGEMENT AND APPROVAL OF YOUR REQUEST

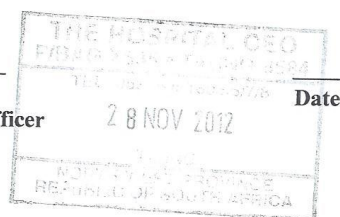
The management of the Hospital wishes to register acknowledgement of receipt of the letter and approval on permission to conduct research at our institution.

We really thank you for choosing Taung District Hospital, this is helping us to take to logical conclusion the good intention of our institution. Truly so, you have added positive impetus to our institution for better life.

We thank you very much, and hope that you will be assisted during your stay in Taung.

Regards,


Ms. M. C. Modisane
Acting Chief Executive Officer
Taung District Hospital



APPENDIX F

INFORMATION LEAFLET AND CONSENT FOR NON-CLINICAL RESEARCH



Dear Participant

INFORMATION LEAFLET AND CONSENT FOR NON-CLINICAL RESEARCH

TITLE OF STUDY: Challenges in implementing continuous support during intrapartum in public hospitals in the North West Province.

INTRODUCTION

I am a Master's degree candidate of the North-West University (Potchefstroom campus). You are invited to participate in a research study regarding challenges in implementing continuous support during intrapartum period in public hospitals in the North West Province. This leaflet will help you to decide if you want to participate. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the researcher.

ETHICAL APPROVAL

This study has received written approval from the Research Ethics Committee of the Faculty of Health Science at the North West University (Potchefstroom Campus), Department of Health North West Province, and Hospital Management of this institution.

THE NATURE AND PURPOSE OF 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 labour in public hospitals, in the North West Province. The findings of this study will contribute to guidelines to promote continuous support during the intrapartum period in public hospital in the North West Province. As a midwife you are a very important source of information on impeding and facilitating factors influencing continuous labour support.

EXPLANATION OF PROCEDURES TO BE FOLLOWED

This study involves the conduct a qualitative research, descriptive and explorative to determine the current practice regarding continuous labour support. Focus group interviews with midwives will be conducted to determine the perceptions among the staff relating to challenges in implementing continuous support during the intrapartum period at Level 1 and 2 hospitals in the North West Province.

RISK AND DISCOMFORT INVOLVED

There are no risks foreseen in this study. The interview and focus group will take some of your time. The interview and focus group will be conducted at a time and venue that is most suited for you. It can be conducted in the hospital in teatime or when it suits you. The interview will take approximately 30 minutes. You will be asked to tell me about the challenges in implementing continuous support during the intrapartum period in public hospital. Your permission is also asked to record the interview to be transcribed and analyzed

afterwards. The recordings will be locked away in a safe place and the final report it will not be traceable back to any participant.

POSSIBLE BENEFITS OF THIS STUDY

Although the participant will not benefit directly from participating in the study, the results of this study will contribute to guidelines to promote continuous support during the intrapartum period in public hospitals in North West Province). The aim will be to promote continuous support during labour in public hospitals in the North West Province improving the quality of intrapartum care.

RIGHTS AS A PARTICIPANT

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the focus group interview. Your withdrawal will not affect you in any way.

CONFIDENTIALITY

All information that you give will be strictly confidential. Once the information is analyzed 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 hospital.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of this study. I have also received, read and understand the above mention information (INFORMATION LEAFLET FOR INFORMED CONSENT) regarding this study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I voluntarily participate in this research.

INFORMATION AND CONTACT PERSON

If you have any questions about the study please contact the researcher, Ms N.S.Spencer at cell 083 683 3896. You are welcome to indicate on the document if you wish to receive a report of the study after it has been completed.

Yours sincerely

Ms. N.S. Spencer
Master's degree candidate and researcher

PARTICIPANTS NAME : _____ (Please print)

PARTICIPANTS SIGNATURE: _____ DATE: _____

RESEARCHERS NAME : _____ (Please print)

RESEARCHERS SIGNATURE: _____ DATE: _____

WITNESS'S NAME : _____ (Please print)

WITNESS'S SIGNATURE: _____ DATE: _____

APPENDIX G

TRANSCRIPTION OF FOCUS GROUP INTERVIEW

I – Interviewer
R – Respondent
K2

- I Good afternoon ladies I am Sylvia Spencer, Masters degree student from Potch university I am doing a research study pertaining the labour patients the title of the study is challenges in implementing continuous intrapartum support in public hospital, the aim of this study is to promote continuous care whilst a woman is delivering and at the end of this study I am going to be able to formulate some recommendations whereby they are going to assist us in promoting continuous intrapartum care to these clients. The questions which I want to raise is from registered midwives with nursing council which are two years or more in labour room so I will be able to gain an in depth data in order to have some perception in this question which says what are the challenges in implementing continuous intrapartum support in labour room?
- R If we are admitting many patients in labour rooms, we cannot just focus on that one as the others have to be helped also.
- R So staffing, the one to one ratio.
- I Okay so it says the nurse ratio does not balance as you are admitting many patients at a time.
- R Yeah.
- I Thank you mam.
- R The other one is labour companions, sometimes we don't have for the night as well as weekends and public holidays so that they can give patients support throughout the labour.
- I Labour companions are not available at night duty, public holidays and Sundays for them to be able to support us in continuous intrapartum care.
- R Hmm.
- R And also to add onto that one we initiated most the best baby friendly hospital. So for that also during the day the doulas are there to accompany them by the theatre and to remain with the mother, when she reach recovery room she help them to breast feed at night still it is a challenge because at night we

I – Interviewer
R – Respondent
K2

don't have doulas allocated to do that for us and when sister has to go to theatre and then two is remaining in labour rooms and if the ward is full that sister cannot remain there with the patient to continue with breast feeding as we said is one of the facts that we must breast feed within the first thirty minutes after delivery so that one is a very big challenge for us because we still lack with that one.

I Okay with the implementation of baby friendly initiative the doula also task to play a role with the mother who is going for caesarean section in implementing the breastfeeding within the first thirty minutes. Whereby it causes a problem for the remainder of the patients in the labour room to be taken care off as the doula is with the sister and two sisters remaining in labour room. Thank you so much and another factor mam.

R Cultural factors also are a challenge because we experience when the white patients come in they usually brought a lot of people following them, even the Indian people. They are always there they are always on your feet and the structure of labour rooms is not so adequate and good to keep them all there and this people especially the whites and the Indians they are always nagging and demanding and you know wanting answers, wanting this and wanting that to be done fast and it is only three people being allocated per shift per day, night or day, but they are always in demands where you find the black people, sometimes the black person came alone is rare and if she is accompanied by a relative then she just left them here if she is going to deliver or not and then they left.

I Okay then it means the point which is coming our here is cultural factor saying that with the other culture they just bring a lot of people around which they are are really putting a burden a pressure towards the care role players being raised at midwives because the expectation is to take care according to what they expect of which the burden is on the midwives. Thank you so much mam.

I – Interviewer
R – Respondent
K2

R The other one is the spiritual belief, especially the Jehovah witness sometimes they come with the abruption, they are bleeding heavily and you cannot give blood.

I Spiritual belief is another factor, it is impeding in continuous care because if a patient is coming with abruption blood administration has to be commenced but because we respect their beliefs it impedes on continuous care to the clients.

R Hmm.

R The other challenge I would say is most of our doctors, they are interns they are doing their internships they are working also in our department and the nurses are the ones helping guiding them so it is another burden on us because all responsibility will be left on the sisters and sometimes you will find the students also you know there is not always that they will have companionship from the college side or even from university. So most of the time you know development, it is only the sisters so it is an extra responsibility also on the sisters also.

I Okay is Klerksdorp hospital qualifies as a level three hospital and in the same breath it is a training hospital whereby training medical doctors is as interns are supposed to be guided and developed by the experienced midwife in maternity ward the same as training learners from the university and colleges is putting more burden on development and training by the registered midwife whereby the accompanist are not seen in the ward. Not always then the burden is allotted on the registered midwife than the care or continuous care to the client won't be achievable. What else?

R The other one, I don't know but this new change over which is pertaining to Klerksdorp hospital is really a burden you get that. You get the experienced sisters alone working with the new sisters is a burden to here because she must be responsible for all those patients and it is really heavy for here.

R The internal amendment of changing over of shifts you will get that there is a registered midwife who is supposed to take lead to take as a head of shift

I – Interviewer
R – Respondent
K2

developing others who are new in the department then it really burdens the one professional nurse who needs to take leave.

R Can I give an example like all the old registered nurse who have got experience, most of them who are here in high care you go to labour room all the new ones with no experience they are allocated in the labour rooms, we should mix.

I So the mixture of experienced registered midwife with those who are not experienced for the continuity of care towards clients which is of quality.

R Hmm.

R For quality person.

R Quality of care.

R Hmm is going down.

R Is not so?

I It is questionable.

R But the one with two that is why I say we must mix.

R Because they took all the experienced people away.

R Hmm.

R You see in ward seven, experience are in ward seven in high care, the ratio is not all right.

R Balance. It is not balancing.

I Thank you for that because in this continuous we are deeming as well quality care, quality must not be compromised as we hear that only the minimal experience,

R Juniors.

I – Interviewer
R – Respondent
K2

- I Juniors registered midwives are placed there then one who is there being experienced will be burdened by she will be always a source of referral for the others and the patient then will be impeded who should be given care at that time.
- R And to add on that one because of the shortage of staff we make care of moonlight staff midwives, they come in and they are still inexperienced or they don't know the environment so the care of the patient is also still at risk and then the person who is there working with them, the experienced person had also to help this people because you be there for all the patients, you have to cover for all the patients, so at the end you work the whole night. For instance if I can make an example one night I was working with two agency sister and the ward was full, at one stage I had seven patients, just one for myself the others were quing there in the chairs and they just disappear. So what can you do you maar just be there you just continue at one stage I said I cannot take this anymore and then still you had to confirm PV's you had to reject. You help with the surgery you help if there is a resuscitation with the baby you help when the patient is about to deliver it is really sometimes it is very hectic.
- I Irrespective goes back to the shortage of staff because because with that they are using moonlight sisters which needs really actually orientation and showing around and at some stage support in applying the skills which are required by the clients because the sister which is there is the permanent staff has to take over in each and every patient for confirmatory care which is being given. That is another challenge in continuous care. Thank you.
- R The other challenge I will say also is we find that most of our drugs that we are using is out of stock and it is sometimes it is the drugs that we really we need to use that in the labour room intrapartum and then you will find is for long times out of stock.
- I Out of stock.
- R So I mean how is that still it is a challenge for us because then if we don't you know be after the doctors after the in charges and to and even the in charge

I – Interviewer
R – Respondent
K2

in the pharmacy to really understand the importance of that drugs we will never have it. So it is still a burden for us also because they are supposed to control at pharmacy when stock is going to get less and then make means before it run out of stock to have always stock available for us.

I To cap this it says the backlog of drugs which are used in labour they are really causing an interruption in providing continuous care to the clients because if the stock is not checked by the pharmacist and doctors are not there to pursue in the demand of the drugs then it puts a delay or an interruption in the care that is provided to the inpatient women. Any other factors?

R Burn out, burn out from the staff as a result of moonlighting cause there is a shortage of staff.

I So staff burn out it can impede continuous care because they are trying to cap the shortage by moonlighting.

R It can have an effect also on the attitude of the staff.

R But then again if you see the sister is going to be alone with the agent sister even if you are tired you sacrifice not exactly moaning but you sacrifice cause you see that one is now is going to be in trouble.

R And you feel sorry because tomorrow it might be you.

I okay and the burnout influencing to the attitude but it is not a deliberate attitude which is coming up forth it is out of availing yourself for capping up the shortage which is occurring in the ward.

R Hmm.

I Thank you so much I think we have reached the time that we say we have exhausted all factors again ladies I would just like to thank you again for all the contributions which you have done they were fruitful and precious. I think I out of this contribution we will be able to formulate the guidelines as soon as the study is finished I would be in a point of coming back to give you to give

I – Interviewer
R – Respondent
K2

the feedback out of what did we implement out of this comments that you have made because the study is going over aboard in the North West selected hospitals and these hospitals which were selected are all hospitals which are involved with training so that we can impact on more people who were affected in there and then as we come out with the guidelines feedback will be escalated towards you, thank you for you contribution once again. Bye.

R Thank you and salute all the midwives.

I Viva midwives.

APPENDIX H

FIELD NOTES

FIELD NOTES

Focus Group

Descriptive Notes:

The midwives signed the consent form to participate voluntarily in the focus group interview. The aim of the study and the reason for the focus group was explained to the participants. They were seven (7) in number, and all of them have been registered with the South African Nursing Council and have been working in the intrapartum unit for more than two years. The Age group ranged from 20 to 55 years. They all appeared professional in their uniform which displayed a good image of the nursing profession. They all looked ready for the interview and appeared calm .I picked up that they show signs of willingness to partake in the focus group interview. They were very attentive and engaging in all aspect of communication.

Reflective notes:

The participants were looking forward to this interview; they appeared as if the remedy will be accomplished immediately after the interview. Throughout the interview there was a sign of respect displayed as they gave each other a chance to talk. In all the instances there were ready answers to be given and all of them valuable. The tone of their voices were audible enough for all of others to can hear. In all the midwives' perceptions cited most of the challenges in implementation of continuous intrapartum support were mentioned.

Demographic Notes:

The interview was conducted on the 09 October 2012 in the duty office in labour rooms. The office was relative big enough to accommodate all participating midwives, although there were two of them standing. The office was relatively quiet and the door closed to keep the noise from the labouring patients low. The office was well ventilated as the windows were opened. The researcher was offered a chair behind a table where she

could gain sight of all participants as they were around and alongside the table. The researcher had in possession of a tape recorder which was fully charged and placed on the table to record. The researcher took field notes. The demographic conditions were conducive for an interview to take place effectively.