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Understanding employee engagement among midwives in public health care facilities in a sub-district, North West Province

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DECLARATION

I, Valencia Laviky Thusanang Mothwane, MCur, Student No 16098005, solemnly declare that the following research with the title “Understanding employee engagement among midwives in public health care facilities in a sub-district, North West Province” is my own work. No plagiarism or intention to steal was committed knowingly, all literature was backed up by mentioning the authors of the specific source, as well as stating them in the references and in citations.

VL Mothwane

Valencia Laviky Thusanang Mothwane

Date: February 2020

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“I will give thanks to the Lord with my whole heart. I will tell of all your marvellous works. I will be glad and rejoice in you. I will sing praise to your name, O Most High.” (Psalm 9:1-2).

I thank God because He who began good work in me, has carried it on to completion.

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ABSTRACT

Key words: Employee engagement, Retention, Staff retention, Midwives, Public Health Facilities, Maternity Services

Background: Currently, South Africa experiences a high turnover of midwives. Midwives leave the South African public health facilities mainly due to reduced staff levels as there are many vacant posts not filled. The overall deterioration of the work environment e.g. broken equipment and shortage of necessary supplies, low image in the community they serve and legal issues such as disciplinary hearings about misconduct that is reported to the South African Nursing Council. The existing retention strategies used in public health facilities seems to be ineffective in addressing nurses' turnover. It is against this background that the researcher seeks to understand midwives' employee engagement in selected public health facilities in a sub-district of North West Province.

Research Aim: The aim of this research is to derive recommendations on how public health facilities could improve employee engagement amongst midwives, to enhance maternity service delivery and improve staff retention.

Research Design and method: In this study the researcher used a qualitative descriptive design and data were collected by means of semi-structured individual interviews and field notes. Content analysis is descriptive using inductive and deductive techniques in which the researcher revealed the experiences of midwives regarding their understanding of employee engagement.

Results: Different barriers were identified. The level of employee engagement of these midwives are low and it will not be easy to retain them. A few enhancers were identified. The barriers were much more than the enhancers and attention to recommendations can assist the sub-district-, district- and North West Department of Health management to take action to retain specialist and experienced midwives in deprived socioeconomic rural district public health facilities.

ABBREVIATIONS

ANC - Antenatal care.

BBA - Born before arrival

CD4 - Glycoprotein found in the surface of immune cell (T helper cell)

CPD - Continuing Professional Development.

CTG- Cardiotocograph.

DoH - Department of Health

FDC - Fixed dose combination

HAART - Highly active anti-retroviral treatment

Hb - Haemoglobin

HIV - Human Immune Deficiency Virus

HREC- Health Research Ethics Committee

MCH - Maternal and Child health

MDG - Millennium Development Goals

MMR - Maternal mortality rate

NaPeMMCo - National Perinatal Morbidity and Mortality committee

NMR - Neonatal mortality rate

NPC - National Planning Commission

NW - North West

NWDoH - North West Department of Health

PEP - Perinatal Education Programme

PHC - Primary Health Care

PMTCT - Prevention of Mother to Child Transmission

PN - Professional Nurse

RH - Rhesus factor

SANC - South African Nursing Council

SDG - Sustainable Development Guidelines

SOMSA - Society for Midwives of South Africa

SOWMY - State of World Midwifery

SSA - Statistic South Africa.

TAC - Treatment Action Campaign

WHO - World Health Organisation

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

This research study is designed to understand employee engagement among midwives in selected public health facilities in the Ngaka Modiri Molema sub-district of the North West Province.

Employees in health care services are pivotal for quality service delivery (Brandt *et al.*, 2016). This research argues that effective employee engagement is necessary to retain midwives in South African public health facilities (Tshitangano, 2013:1). In the study of public health facilities employee engagement refers to employees being dedicated to the success of the establishment trusting that being employed is seen as the best career opportunity for the employee (Iqbal *et al.*, 2015:1). Disengagement can lead to intentions to leave, and therewith increases staff turnover that causes direct and indirect costs for the public health facility.

The direct loss of costs is incurred by searching for new employees, time spends on job interviews, severance pay and administrative costs. Indirect costs resulting from factors like loss of health care user loyalty, loss of expertise, an increased rate of misconduct, and the necessity of re-training guidelines and standards of practice (Brandt *et al.*, 2016). According to the Department of Health (DoH) there is insufficient professional nursing staff, including midwives, in the public health services which hinder the delivery of quality health care services (DoH, 2011:67).

This research can provide direction on how public health facilities could improve employee engagement and midwife retention in public health facilities in the North West Province.

The background, as well as the problem statement, prompts the importance of the research. The research methodology explains the approaches to improve trustworthiness and ethical considerations of this study.

1.2 BACKGROUND

A functional health system provides safe and quality services to the population (Levesque *et al.*, 2013:2). The precise structure of these health systems differs from country to country. However, in all scenarios a functional health system requires a strong funding mechanism, skilled health and collaborating professionals, good remuneration to its employees, consistent policy

development, updating of guidelines, efficient decision-making structures, facilities that are well-maintained and the ability to provide quality care to health care users (World Health Organization (WHO), 2015a).

Public health facilities are complex and multifaceted. It includes various health care disciplines, inter-professional teams, the widespread use of resources, and a range of services that extend beyond health care comprising of engineering, cleaning, maintenance of buildings and water and electricity services to mention a few (Peltier *et al.*, 2013:3). In South Africa public health care are in a precarious state due to acute staff shortages and deteriorating infrastructure (Treatment Action Campaign (TAC), 2013:8). The DoH has repeatedly emphasised that their key challenge is to improve safety and quality care in the public health sector (Child, 2014:23) but South African Government fails to meet obligations for public health facilities (Mubangizi & Twinomugisha, 2010:107).

South African public health facilities should incorporate the same services like public health facilities globally. According to Mashigo & Mathibe (2016:2) and Mhlongo *et al.* (2016:172) some of the challenges South African public health facilities face are limited human resources, lack of equipment and supplies, limited funding and training resources. To provide optimal service delivery the management of a public health care facility should understand that these challenges may influence employee behaviour patterns, service delivery (Burton, 2010:17), maternal and neonatal mortality and retention (Gupta & Aileen, 2017:77).

The National Triennial Report of the Perinatal Mortality and Morbidity Committee [NaPemmCo], 2014:16, 38) indicates that the neonatal mortality rate (NMR) of North West Province is 14.1 deaths per 1000 live births of which 59.7% died in public health facilities. Maternal mortality rate (MMR) refers to the total of women that die since conception took place and 6 weeks (42 days) postpartum per 100 000 deliveries (Perinatal Education Programme [PEP], 2008:23). Globally, the MMR decreased by 45% from 1990 up to 2015, however there was only a decrease of 2.6% in the MMR annually between 1990 (269/100 000 live births) and 2013 (136/100 000 live births) from the required decrease of 5.5% MMR to successfully reach the Millennium Developmental Goal 5 (MDG) (WHO, 2015b:1).

South Africa experienced a substantial escalation in maternal deaths that resulted in the country not reaching the MDG 5 by 2015 of 138/100 000 live births. The probable MMR in South Africa was 311/100 000 live births in 2009. In 2010 South Africa experienced a decrease in MMR of 270/100 000 live births and the reduction continued in 2013 with a reported MMR of 141/100 000 live births (Statistics South Africa [SSA], 2015: xxv). These figures indicate that globally and nationally the health care services did not reach MDG 5 improving maternal health to reduced

MMR. Due to failure to reach the MDG 5 the WHO formulated guidelines for 2030 known as sustainable development goals (SDG). The global aim according to SDG for the maternal mortality rate is 80 per 100 000 live births.

Early neonatal deaths per 1000 deliveries refer to neonates that die during birth or within 7 days after birth (Perinatal Education Programme [PEP], 2008:36). A contributory factor related to (Neonatal Mortality Rate) NMR's is a high turnover of midwives. The high turnover of midwives is not exclusive to South Africa but globally an issue (Adegoke *et al.*, 2015:946; Brandt *et al.*, 2016; Christopher *et al.*, 2018:217 and De Gieter *et al.*, 2011:1562). With regards to employee engagement in public health services, it is pivotal to understand midwives' experiences of their work engagement which influences the high turnover of midwives (Gupta & Aileen, 2017:77 and Lowe, 2012:31).

The shortage of midwives also contributes to maternal and neonatal mortality (The State of the World's Midwifery [SoWmy], 2014). One major challenge experienced by public health facilities in South Africa is dealing with employee engagement. In this study, the focus will be on employee engagement of midwives working with women during the ante-natal and maternity period as the MMR and (NMR) is high during this period. Ali *et al.* (2018:41) refer to antenatal care as the care given to pregnant woman where risks are identified and addressed to ensure a safe pregnancy and healthy baby. This care includes physical and psychological preparation for childbirth and parenting. With maternity leave the Government Gazette (1997:26) it as leave which start four weeks before expected birth and last up to four months after delivery. The intrapartum phase includes first, second and third stage of labour including the delivery of new-born. (Bikitsha, 2014:18). According to Adegoke *et al.* (2014:947) adequate training, deployment, and retention of quality midwives could prevent more than 60% maternal and neonatal deaths.

In the following paragraphs, the challenges experienced by midwives are discussed as it influences employee engagement.

Midwives do not want to work in maternity wards for many different reasons. According to Ball *et al.* (2016:6) midwives in the United Kingdom experienced a lack of support and control over their working life. Other reasons behind midwives' intentions to leave were found to be their feeling of powerlessness to add value to midwifery and the lack of support from managers when midwives identified problems (Banonvcinova & Baskova, 2014:252; Makhubu, 2016:1). In addition to this, there is a feeling of worthlessness as midwives feel that their efforts do not matter, their inputs have little to no value and with regards to guidelines, there is no tolerance or open-mindedness to suggestions and discussions. There are limited opportunities for

professional development, followed by the low social image of midwives where there is a misunderstanding between patients and families resulting in degrading of midwives (Alilu *et al.*, 2017:4 and Tshitangano, 2013:1).

Another study that was conducted in sub-Saharan countries revealed more reasons for the high turnover of midwives. The authors highlighted different push and pull factors that are similar to those of other countries. Push factors include the lack of opportunity for further development, unavailability or broken equipment, shortage of necessary supplies, heavy workload, low wages, low job satisfaction and the threat of political instability and conflict. Pull factors indicate that midwives could be retained if there are better remuneration and working conditions which are favourable to ensure quality midwifery services, recognition and the provision of further professional development opportunities (Pope *et al.*, 2014:8-14).

A South African study on midwifery practices by Mhlongo *et al.* (2016:171-172) elicits the following challenges. There are a shortage of qualified midwives rendering maternity services; a difficulty in retaining health care workers in rural areas after completion of training (especially midwives, as every neonate or maternal mortality, are investigated by a multi-disciplinary team to determine what the actual problem was and how it could have been prevented); feelings of guilt under midwives (National Triennial report of Perinatal Mortality and Morbidity Committee, 2014:38); low salaries; lack of career incentives; an ageing workforce, a poor professional image, inadequate working conditions and a lack of quality local educational programmes (Mhlongo *et al.*, 2016: 171-172).

The statutory body of the nursing profession, the South African Nursing Council (SANC) concludes that increased incidence of disciplinary hearings is related to midwives due to complaints of negligence and misconduct. Staff shortages and working conditions make it difficult for midwives to continuously assess, monitor and evaluate women during the maternity stage (Mhlongo *et al.*, 2016:163). Tasks may be carried out but not recorded since they had to attend immediately to other maternity cases, leaving no time for essential recording of the previous patient's management during the maternity stage (Mashigo & Mathibe, 2016:2-3). South African midwives play a fundamental role in the care of women including prevention and fertility care, antenatal care (ANC), intrapartum care until the end of the postpartum period (Fraser *et al.*, 2010:5). Midwives are considered as skilled when the prescribed curricula and practical standards are being met and they are key role players in rendering maternal and child health (MCH) services. Quality maternity services can contribute to the reduction of mother and child morbidity and mortality (Adegoke *et al.*, 2015:947; Adolphson *et al.*, 2016:95). The burden, circumstances and unpredictable environment under which midwives work in South Africa results in great difficulty to continuously improve clinical skills through lifelong learning and to

simultaneously continue to maintain, reinforce and maximise the focus on interpersonal care for pregnant women until delivery (National Planning Commission, 2015:347).

1.3 PROBLEM STATEMENT

Currently, South Africa experiences a high turnover of midwives. Midwives leave the South African public health facilities mainly due to reduced staff levels (Pillinger, 2011:32). The overall deterioration of the work environment e.g. broken equipment and shortage of necessary supplies (Poppe *et al.*, 2014:8-14) low image in the community they serve (Alilu *et al.*, 2017:4) and legal issues such as disciplinary hearings about misconduct that is reported to the SANC (Mashigo & Mathibe, 2016:2-3). The main attraction for trading a South African public health system for a new working environment, was classified as improved working conditions abroad, career enhancement and development, as well as work environments that are less demanding (Pillinger, 2011:32).

The significance of midwives' engagement towards public health facilities in South Africa is recapped. The existing retention strategies used in public health facilities seems to be ineffective in addressing nurses' turnover. It is against this background that the researcher seeks to understand midwives' engagement in selected public health facilities in a sub-district of North West Province.

The study will determine how different drivers, such as work team, immediate supervisor or operational manager, job characteristics, training and development, and the public health facility influence midwives' engagement and the outcomes thereof (Gupta & Aileen, 2017:81). The researcher infers that assessing the 'employee engagement of midwives within the public health facilities' will be in the South African context, as there is limited literature in national research on this phenomenon.

1.4 RESEARCH QUESTION

What is the experience of midwives' regarding employee engagement within the public health facilities in a rural sub-district of the North West Province of South Africa?

1.5 RESEARCH AIM AND OBJECTIVE

The research aim and objective are outlined in the next two sections.

1.5.1 Research Aim

The aim of this research is to derive recommendations on how public health facilities could improve employee engagement amongst midwives, to enhance maternity service delivery and improve staff retention.

1.5.2 Research Objective

The objective of this study is to explore and describe the way in which midwives experience employee engagement in public health facilities in a rural sub-district of the North West Province of South Africa.

1.6 PARADIGMATIC PERSPECTIVE

A paradigm is defined as a framework, viewpoint or worldview based on people's philosophies and assumptions about the social world and the nature of knowledge and how the researcher views and interprets people, the social world and reality (De Vos *et al.*, 2012:513 and Polit & Beck, 2012:11). The researcher's assumptions are discussed in full detail in chapter 2. The meta-paradigmatic, the theoretical departure point as well as methodological assumption for this study follow in paragraphs below.

1.6.1 Meta-paradigmatic perspective

The researcher used the phenomenology as the underpinning philosophy (Brink, *et al.*, 2012:122) and looks at the experiences from the participant's viewpoint. A detailed discussion follows in chapter 2.

1.6.2 Scientific model of Gupta and Aileen underpinning the study

The employee engagement model developed by Gupta and Aileen (2017:82) will be the theoretical departure point of this study. According to the Gupta and Aileen model, employee engagement is influenced by five (5) different drivers and three (3) dimensions. The dimensions of job engagement can be low, medium or high and have a direct positive or negative impact on employee engagement and job satisfaction. The theoretical departure point is outlined in section 2.2.2 in Chapter 2. The conceptual definitions are outlined in 1.7 Conceptual Definitions.

1.6.3 Research methodology

The aim of research methods in a qualitative design is to obtain rich data until a point of data saturation is reached. Data saturation are reached when no new codes or sub-themes emerged

during data collection. In this study the researcher used a qualitative descriptive design and data were collected by means of semi-structured individual interviews and field notes.

1.7 CONCEPTUAL DEFINITIONS

- **Employee engagement**

The concept 'employee engagement' is wide, but mainly includes employees that believe they can make a positive contribution towards service delivery as well as employees who understand what is expected from them and therefore they can meet the needs of clients/patients (Bakker & Demerouti, 2007:324; Walsh & Martin, 2011). Furthermore, engaged employees are satisfied with their current jobs and find fulfilment in what they do. They have low levels of absenteeism and they are less likely to leave the service of an institution (Walsh & Martin, 2011).

- **Midwife**

A midwife is a person who is registered with the South African Nursing Council and who has completed a recognized education and training program to nurture, assist and treat the client. In this study the client/patient will be a woman receiving health care during the ante-natal and maternity period (SANC, 2005).

- **Maternal mortality rate** (MMR) refers to the total number of women from moment that conception takes place until 6 weeks (42 days) postpartum per 100 000 deliveries (Perinatal Education Programme [PEP], 2008:23).

- **Maternity Services**

For the purpose of this study, maternity service includes antenatal, intrapartum, postnatal and care of the newborn.

- **Neonatal mortality rate**

The neonatal mortality rate is the number of neonates that died within the first month after birth due to reasons that could be prohibited (Statistics South Africa [SSA], 2015:8).

- **Early Neonatal or neonatal mortality rate**

Early neonatal mortality is defined in terms of the Perinatal Education Programme (PEP) as the death of a neonate during birth or within 7 days after birth (early neonatal death), per 1000 total deliveries. (Perinatal Education Programme [PEP], 2008:36).

- **Retention**

Retention aims to retain those employees the employer wants to keep and not losing them from the organisation for any reason as a high turnover of staff is costly for an institution (Mohlala *et al.*, 2012:2)

- **Staff retention**

Staff retention can be viewed as a process where employees are encouraged to remain in the health care facility for at least 3 years since accepting an appointment (Gupta & Aileen, 2017:78).

- **Public health facilities**

Ataguba (2012:2-3) defines public health care services as facilities where the aim is to provide inclusive health care. For the purpose of this study, public health care refers to Primary Health Care (PHC) clinics/centres and level 1 hospitals that render maternity services. The aim of providing health services is to promote, restore, treat or maintain health in the best possible state it can be kept up (Ataguba,2012:2-3). These health care services are rendered to a target population that is residing close to the facility. Only level 1 public health facilities will be used for this study and the sub-district that was purposely selected is classified as a deprived socioeconomic rural district (National Triennial report of Perinatal Mortality and Morbidity Committee, 2014:149-150).

In the next section, the research design follows.

1.8 RESEARCH DESIGN

The aim of the research design is to align the research question to the execution of the research methods and ethical considerations (Botma *et al.*, 2010:289). The researcher will use a qualitative descriptive design, as the objective of this study is to understand employee engagement of midwives in selected public health facilities in a rural sub-district of the North West Province of South Africa (Sandelowski, 2000:336).

The main purpose of a qualitative description is to generate a transparent description of the participant's experience in words similar to what the participant said, in a truthful and accurate manner. Qualitative descriptive studies strive to capture as much data as possible in order to capture events as it unfolds (Sandelowski, 2000:336). See Chapter 2 for more detail.

1.9 RESEARCH METHOD

The research method includes all the steps taken when data was obtained and refer to the description of the population, sampling and sample size, data collection and data analysis as well as measures to ensure trustworthiness during the process, data management, dissemination of research results and ethical standards (Polit & Beck, 2008:765; Polit & Beck, 2012:12).

A detailed discussion of these aspects, as they relate to this research, is provided below.

1.10 STUDY CONTEXT

The North West Province is the platinum province of South Africa with a population of 3.4 million residents of which about a third are children under the age of 15 years. The North West Province has 318 PHC facilities, four health districts with 18 level 1 hospitals, four-level 2 hospitals and one level 3 hospital (National Triennial report of Perinatal Mortality and Morbidity Committee, 2014:149-150). The researcher is a midwife educator at various colleges and a clinical expert in the Gauteng Province and chose the North West Province to conduct the study in order to prevent bias and to obtain objective results.

1.11 POPULATION AND SAMPLING

In the following paragraphs, the population and sampling will be discussed.

1.11.1 Population

A population can be defined as a set of all members of a defined group (Gray *et al.*, 2017:53). This study consists of two populations namely public health facilities and midwives. To ensure the correct target population the researcher needs to have inclusion and exclusion criteria. Table 1.1 explain the inclusion and exclusion criteria for participation. A detailed discussion follows in chapter two.

Table 1.1 Inclusion and exclusion criteria

Inclusion Criteria	Rationale
Midwives working or rotating in maternity section of public health care facilities and involved in intrapartum care.	The selected sub-district has a specialised unit in the hospital and PHC facilities rendered intrapartum care. All professional nurses with midwifery qualification rotate to

Inclusion Criteria	Rationale
	midwifery and other departments e.g. casualty and medical ward and cannot be excluded as participants.
Midwives should have more than six (6) months of maternity experience.	Midwives with less than 6 months experience in a maternity section do not have enough exposure to provide rich data.
Should have midwifery qualifications (either diploma/degree/advanced diploma)	This studies focus is on midwives only.
Voluntary participation	It is unethical to conduct research if the participant did not provide informed consent and is willing to participate (DoH 2015:24)
Exclusion criteria	Rationale
Undergraduate students conducting clinical practice under the supervision of a midwife.	The student can be a professional nurse but not yet qualified in midwifery. Midwifery is an additional post graduate course.
Professional nurses without midwifery qualifications.	No midwifery services are rendered by professional nurses who do not have a qualification midwifery. It is not within their scope of practice.

1.11.2 Sampling

A sample of participants working at the midwifery unit or rotating for a certain period in the maternity section in the selected public health facilities was used. The researcher selected, in collaboration with an experienced midwife, the most suitable participants to obtain rich and relevant data for this study (Botma *et al.*, 2010:199). A detailed discussion follows in chapter 2.

1.12 RECRUITMENT OF PARTICIPANTS

The researcher obtained goodwill permission from the operational managers of the PHC facilities and the maternity unit of the hospital to conduct the study. The researcher requested the assistance of an independent administrative staff member at each public health care facility to assist with the recruitment of potential participants and the management of the informed consent (Chapter 2). A PowerPoint presentation was presented to all potential participants and they had the opportunity to clarify their questions with the researcher. The process of informed consent will be outlined in the following section.

1.13 PROCESS OF OBTAINING INFORMED CONSENT

After the PowerPoint presentation, the participants who were interested in being part of the research project was given two consent forms with a minimum of 24 hours to decide whether they would like to participate or not. Participants who wanted to take part in the research took their two informed consent forms to the independent person and signed both forms (See Chapter 2 for more details).

1.14 DATA COLLECTION

Ethics approval and permission to conduct the research were obtained from the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences of the North-West University (Addendum A), as well as from the North West Province Department of Health (NWDoH) (Addendum B). Permission from sub-district manager and goodwill permission from operational managers at selected public health facilities were obtained. All consent documents were submitted to the HREC. Both addendums of approval are required before the data collection and research could commence.

The researcher conducted semi-structured individual interviews using open-ended questions to inquire into the experience of midwives on employee engagement. A semi-structured interview is a carefully planned interview where the focus is on the collection of data and the use of communication techniques to obtain the best relevant information (Botma *et al.*, 2010:208; Gray *et al.*, 2017:259).

1.14.1 Data collection process

The data collection process consists of a discussion of the setting and setting of the interview schedule.

1.14.1.1 Setting for data collection

The manager was requested to provide a room with minimal disturbances. In this study, the operational manager's office was used for data collection. The private room was conducive for the interviews. On completion of the interview, the researcher expressed appreciation towards the participant for his/her time and valuable contribution. Refreshments were provided for the participant at the end of the session. The details are discussed in chapter 2.

1.14.1.2 Setting of the interview schedule

An interview schedule was developed based on the research question, the objective, and theoretical framework. The interview schedule was refined with the input of subject specialists. The interview schedule was approved by HREC and NWDoH. As 'employee engagement' may not be a well-known term, the researcher provided the participants with the following research definition of employee engagement before starting the interviews.

Employee engagement is an observable workplace phenomenon where employees stay at their employer for a long period of time, not intending to look for other jobs outside the public health facility. Employee engagement in this study focuses on the midwife's relation to the public health facility where he/she renders maternity services, as well as the relationship of the midwife with the operational manager, including the key persons of midwifery service.

On the other hand, employee disengagement may result in loss of trust, less productive work, high absenteeism and a high turnover of employees, as in this case, midwives (Poloski & Hernaus, 2015:5). The interview questions follow in chapter 2.

1.15 DATA ANALYSIS

Qualitative data analysis is not a once-off occurrence, it is a process that starts with the first interview and continues during data collection (Sandelowski, 2000:338). The researcher started with data analysis from the first interview until no new codes emerged, thus data saturation was reached. Descriptive qualitative data analysis utilises content analysis as the preferred method for data analysis. (Sandelowski, 2000:338). Content analysis is descriptive using inductive and deductive techniques in which the researcher looks for similarities and differences in the text that contribute to rich descriptions of, in this study, experiences of midwives regarding their understanding of employee engagement. Further discussion of data analysis follows in chapter 2.

1.16 TRUSTWORTHINESS

Trustworthiness refers to the strategies used to enhance quality (also referred to as rigour) in qualitative research (Botma *et al.*, 2010:218). There are epistemological standards related to trustworthiness with specific strategies and criteria to ensure rigour such as truth value, applicability, consistency, and neutrality (Chapter 2).

Although authenticity as criteria was included by Botma *et al.* (2010:233) the researcher prefers to stick to the criteria of trustworthiness set out in Lincoln and Guba (1985:290).

1.17 ETHICAL CONSIDERATIONS

The importance of adherence to ethical considerations when conducting a research study is outlined in the DoH research ethical guidelines (2015a:3). Ethical consideration is important to ensure that the research study is conducted in a responsible and ethical manner.

1.17.1 Risks and precautions

The researcher aims to align the research study with this principle which requires that the risk of harm posed by the research be reasonable in light of anticipated benefits; that research design must be sound and researchers must be competent to carry out the proposed research activities (DoH, 2015:14b). The above-mentioned aspects will be incorporated into this study (refer Research Design and Research Methods).

The physical, psychological, social, legal, economic, dignitary and community risks and precautions that ease the identified risks are specified in Table 1.1

Table 1.1 Risks and precautions (DoH, 2015a:14)

RISKS	PRECAUTIONS
Physical risk: No physical harm is anticipated.	The individual interview will take place in a properly ventilated room, a comfortable chair will be provided and throughout the interview, the researcher will ensure that the participant is comfortable. Water will be available during the interview and refreshments will be provided after the completion of the interview.
Social and patient risk: It can happen that when an individual interview is scheduled the midwife provides maternity care.	Maternity care cannot be assigned to another midwife. If the researcher experienced such a situation, the interview time would have been rescheduled for another time in order to ensure that care to the patient is not interrupted. At no time patients will be left without care.
Psychological risks:	A psychiatric nurse will be available for debriefing purposes after

RISKS	PRECAUTIONS
Questions may stir up emotions e.g. if the participant does experience negativity in the work environment.	conducting the interview.
Economic risk: No economic risks present as the researcher visits the public health facility at a time that suits the participant and facility. Costs are incurred by the researcher.	Refreshments will be available after the interview.
Risk of loss of confidentiality and privacy	The interview will be conducted in a suitable private room at the public health facility. The researcher will post a note indicating to not disturb, on the door. The researcher will ensure the participant that the personal details or information discussed will not be revealed in any way. At the end of each day, all individual interviews will be loaded on the researcher's laptop and will be password protected (field notes are digitally recorded). The diary which outlines the activities of each day in the field will be kept in a locked cupboard. The moment the audio recording is loaded on the researcher's laptop; the audio recording will be deleted from the digital audio recorder. The participant will be informed that feedback will be given as a summary report to the operational manager and that the researcher will provide a research report to the North West Province DOH and an article will be published without reference to any individual participant's detail.

1.17.2 Anticipated benefits

The anticipated benefits will be divided into direct - and indirect benefits and discussed under the headings that follow:

Direct benefits

There are no direct benefits for the participants.

Indirect benefits

The indirect benefits for society at large or for the research institution are provided in Table 1.2.

Table 1.2 Direct and indirect benefits

DIRECT BENEFITS	INDIRECT BENEFITS
There are no direct benefits.	Recommendations can be derived to align with current retention strategies in order to prevent “brain drain” of our midwives. According to Docquier (2014:2) the term “brain drain” refers to recruitment of human capital resources and it applies to migration of highly qualified individuals from developing to developed countries. The high turnover of our midwives can be reduced if policy developers and human resources give attention to recommendations. The more the experienced midwives can be retained, the more the MMR and NMR can decline as research has identified that experienced midwives are key role players in preventing these death rates (Adegoke <i>et al.</i>, 2015:947; Adolphson <i>et al.</i>, 2016:95; National Triennial report of Perinatal Mortality and Morbidity Committee 2014:16,38). The larger community, as well as future mothers and babies, will benefit due to a better quality of caretaking.

1.17.3 Experience, skills, and competency of researcher

The researcher did research ethics training in 2017. The study is supervised by an experienced supervisor who has been part of a larger international research program dealing with quantitative and qualitative methods for three years. The supervisor has attended a research internship in Kenya offered by the Canadian Institute for Health Research in 2009 and a qualitative workshop provided by professor Greeff in 2018. The supervisor specialised in PHC and is current regarding the maternity guidelines in South Africa. The co-coder is an experienced qualitative researcher.

1.17.4 Permission and goodwill permission

Permission to conduct the research will be obtained from the North West Department of Health, HREC committee, of the North-West University, and the manager of the sub-district office.

Goodwill permission will be obtained from the PHC facilities manager and the operational manager of the maternity unit of the public hospital.

1.17.5 Participant recruitment and informed consent

A cover letter detailing an informed consent document is formulated (see Addendum C). Informed consent documents (2) will be given to interested participants directly after the

PowerPoint presentation. They will also be informed about their voluntary participation, as well as their right to withdraw at any stage of the research process without any consequences whatsoever. The participants will be informed that they have a minimum of 24 hours to decide whether they would like to participate in the research as the researcher will do rounds at all the public health facilities on the day of recruitment. The details are discussed in chapter 2.

1.17.6 Respect, privacy, confidentiality, and anonymity

South Africa is a democratic country in which human dignity, equality and the advancement of human rights are respected, promoted, and protected in terms of the Constitution of the Republic of South Africa (1996) (DoH, 2015a:6). Section 12(2) of the Bill of Rights in the SA Constitution protects against research abuse by providing that: 'everyone has the right to bodily and psychological integrity which includes not to be subjected to medical or scientific experiments without their informed consent' (DoH, 2015a:6).

This principle of respect for individuals strengthens the requirement that a person must choose voluntarily whether to participate in research or not, based on the information given to him/her allowing them to make informed choices (DoH, 2015a:24).

The respect, privacy, anonymity, and confidentiality (DoH, 2015a:17) applied in this study are discussed throughout. The researcher will ensure privacy, confidentiality, and anonymity of the participants' information.

The transcriber and co-coder, will sign a confidentiality agreement as they require access to data (DoH, 2015a:14).

Collected data will be managed that only the researcher, transcriber, supervisor and the independent co-coder of the study have access (DoH, 2015a:14). The details are discussed in chapter 2.

1.17.7 Data management

In this section the researcher discuss the implementation of password protected documents and final data management. This step ensures further anonymity as the audio recordings are password protected. The supervisor, researcher, and transcriber need to use a code to open and listen to the audio recordings (DoH, 2015a:17). As soon as the transcriber completes the transcription, she will send it password protected to the researcher.

After the research study all audio recordings, transcripts, and password protected name lists will be removed from the researcher's laptop and will be available on the supervisor's laptop for a

period of five (5) years. All hard copies (informed consent, diary, and proof of data analysis) will be locked in a cupboard in the supervisor's office for a period of five (5) years. This will be kept for audit purposes only. After 5 years all electronic data will be removed from the supervisor's computer in such a way that it cannot be retrieved in any manner. All hard copies will be shredded.

1.17.8 Dissemination of research results

The researcher will disseminate the findings of the research (DoH, 2015a:14) honestly and truthfully, in order not to deny anyone information or benefits that the findings of the study may hold. Dissemination of findings to participants will be conducted by means of a research report to all the participants in each public health facility.

Analysed data will be presented in such a way that all participants and even negative feelings about the operational manager will not identify any specific participant or operational manager. The North West Provincial DoH, HREC and sub-district management will be informed regarding the research results through a research report.

Peer researchers will be informed through the publication of an article in a peer-reviewed journal. The researcher will submit abstracts to the Society for Midwives of South Africa (SOMSA) and North West Health Research day for an opportunity to present the outcome of the study at a conference. If the abstract is accepted by the North West Province research day, all participants will be informed about the opportunity to get verbal feedback as the sub-district is near the venue where the research day presentations are held.

1.17.9 Conflict of interest

There was no conflict of interest relevant to this study.

1.18 RESEARCH CHAPTER'S STRUCTURE

CHAPTER 1: Overview of the study

CHAPTER 2: Research Methodology

CHAPTER 3: Discussion of results: data collection imbedded in literature findings

CHAPTER 4: Conclusion, limitations, and recommendations

1.19 SUMMARY

Chapter one provides an overview of the study. In chapter two the research methodology will be discussed in detail.

CHAPTER 2

RESEARCH METHODOLOGY

2.1.1 INTRODUCTION

In the previous chapter, an overview of the study was given. In this chapter, the researcher examined the methodology that assisted to obtain high-quality data and ensured rigorous research. The researcher ensured that the research process was valid and reliable and that ethical considerations were maintained. The research paradigm, theoretical departure point, and the design are discussed in the paragraphs below.

2.2 RESEARCHER'S ASSUMPTIONS

The following meta-theoretical, theoretical and methodological assumptions define the framework of this study.

2.2.1 Meta-theoretical assumption

Meta-theoretical assumptions are non-epistemic statements that are not intended to be tested. These are general assumptions that reflect the researcher's worldview. It also includes the researcher's thoughts, ideas, decisions and actions taken with every step of the research study. The researcher used phenomenology as meta-theoretical assumption. Studies with phenomenology as meta-theoretical assumption explain human experience through the description that is provided by the participants in a study (Brink *et al.*, 2012:122).

In this research, the objective was to explore and describe the experiences of midwives with reference to which factors keep them engaged and practice midwifery in public health facilities. A Meta-paradigmatic perspective refers to the researcher's beliefs about the person as a human being, health, the purpose of and the nursing discipline of midwives rendering antenatal, intrapartum care, postpartum as well as care for the newborn. It includes the general orientation about the world and the nature of research that a researcher holds (Botma *et al.*, 2010:187).

The researcher's meta-theoretical assumptions are:

- **Human being**

In this research, a human being refers to a pregnant woman in a rural sub-district receiving ante-natal, intrapartum care and postpartum care in public health facilities. The researcher views a woman during the ante-natal and intrapartum period as a unique human being, with

specific needs that must be addressed by the midwife in order to assist her with care during pregnancy, delivery of a baby or babies and care of the newborn.

Another group of human beings involved in this study is midwives. Midwifery is a profession with the abilities to care for women during pregnancy and childbirth as well as with reproductive health issues, in order to avoid complications during a woman's reproductive age, antenatal-, intrapartum- and postpartum period, and to support and preserve health in pregnant women and neonates (Fraser *et al.*, 2010:5). In this research midwifery refers to the employee engagement of midwives when rendering antenatal and intrapartum care to pregnant women in labour within public health facilities. Passionate midwives are essential to provide quality antenatal and intrapartum care to the woman.

- **Health**

Health, according to the WHO (1946:100) is viewed as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Health in this study refers to efficient antenatal and intrapartum care during delivery of a newborn baby and care to the mother postnatal in order to reduce maternal and neonatal deaths and to ensure a healthy mother and newborn. Maternal and neonatal mortality statistics are key indicators of a country's health status and are used globally to assess a country's health service delivery (Dennill & Rendall-Mkosi, 2012:35)

- **Environment**

The environment is viewed by the researcher as the surroundings that have an emotional impact on the activities and growth of something or a person. The environment may consist of physical-, psychological-, social-, and technological mechanisms (Bandura & Bussey, 1999:679). The environment in this study is the maternity unit in public health facilities. Within this physical environment, health during pregnancy is promoted as well as the prevention of complications during birth through the engagement of midwives working in these public health facilities.

The theoretical departure point states the framework for this study and will be discussed in the following paragraphs.

2.2.2 Theoretical framework

Employee engagement is essential to ensure quality healthcare service delivery and it is essential for public health facilities to foster employee engagement. Currently there is a great focus on improving support in the work environment for employees to deliver quality healthcare

services. Recent studies indicate that employees with high levels of engagement deliver high-quality patient care and staff turnover is low (Lowe, 2012:29-30). The employee engagement model developed by Gupta and Aileen (2017:82) will be the theoretical departure point of this study.

According to Gupta & Aileen (2017:82), the drivers that influence employee engagement includes:

- Job characteristics: What is expected from a midwife rendering quality intrapartum care;
- Training and development: The availability of opportunities to align with new guidelines and policies;
- The work team: The role of the midwife in the multi-disciplinary team;
- The role of the operational manager of the public health facility; and
- Public health facility support that is available for the midwife.

The abovementioned drivers have an influence on the three dimensions of engagement. The three dimensions of engagement are:

- Dimension 1: Emotional dimension: The employees are proud to work in their specific facility or on the other hand, they do not want to tell others about their work. The emotional dimension is supported or depleted if colleagues agree or arguing with each other.
- Dimension 2: Rational dimension: Expression of the overall job satisfaction of the employee in the workplace which can range between poor and excellent. The rational dimension is supported or depleted if the job experiencers is satisfied/dissatisfied.
- Dimension 3: Behavioural dimension: The employee looks forward to going to work or not. The behavioural dimension is explained by the heart in figure 2.1. The behavioural dimension indicate the intrinsic feelings of the employee e.g. does the employee wants to go to work or not.

The drivers and dimensions determine the level of engagement which can be high, medium or low (Lowe, 2012:33). The level of engagement has a direct influence on the turnover of staff. The aim of employee engagement is to keep hold of competent staff because a high turnover of staff can be very costly (Lowe, 2012: 35). According to Gupta and Aileen (2017:80), there is a

positive correlation between engagement and staff turnover. The employee engagement model is displayed below in figure 2.1.

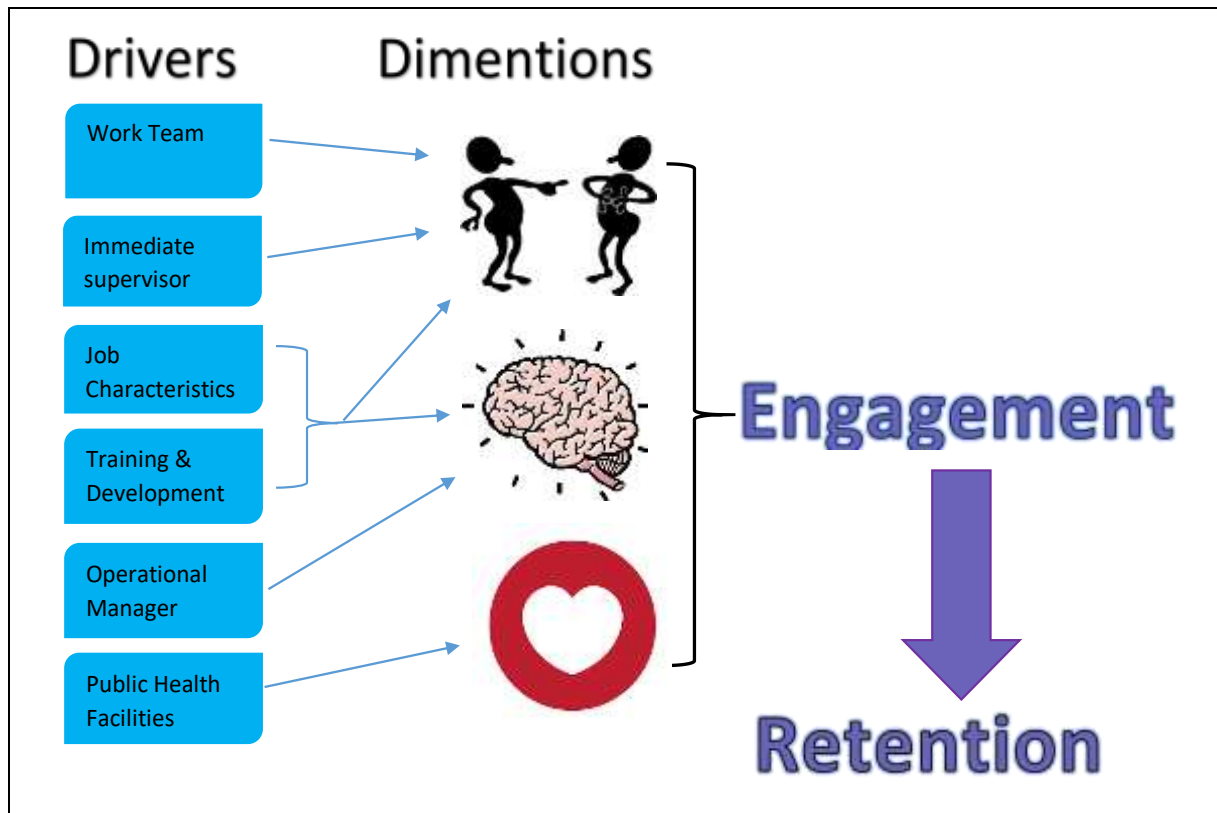


Figure 2.1 Employee Engagement model (adapted from Gupta & Aileen, 2017:81).

2.2.3 Methodological assumption

This research followed a qualitative descriptive design. According to Sandelowski (2000:80) a qualitative descriptive design a factual perspective of interview data that is almost an accurate and honest track of reality.

In the paragraphs below the research design and method followed are outlined.

2.3 RESEARCH DESIGN

The aim of the research design is to align the research question with the execution of the research methods and ethical considerations (Botma *et al.*, 2010:289). Creswell (2013:49) explained that the research design guides the researcher in the planning and implementation of the study in such a way that the proposed objective will be achieved. According to Burns and Grove (2009:218), a research design guides the researcher in the planning and implementation of a study in such a way that it is most likely to achieve the intended goal. Botma *et al.* (2010:6)

emphasized the importance of being knowledgeable about the research design and adhering to its guidelines in order to ensure rigorous research.

This research followed a qualitative descriptive design. According to Sandelowski (2000:80) a qualitative descriptive design provides a factual perspective of interview data that is almost an accurate and honest track of reality. The results displayed perspectives and events that conveyed the truth regarding the research on the aspect of employee engagement under midwives. The main purpose of a qualitative design is to generate a transparent description of the participants' perceptions in words similar to what the participants said in a truthful and accurate manner (Sandelowski, 2000:336; Wood & Ross-Kerr, 2011:115). Qualitative descriptive studies strive to capture as much data as possible in order to develop new codes and sub-themes as it unfolds. Sandelowski (2000:336) also indicated that in medical research, a qualitative descriptive design is a useful qualitative method as it requires that the researcher needs to be open to different perspectives and not commit to any one particular viewpoint.

A Qualitative research design was followed as little is known (Brink *et al.*, 2012:120) about midwives' perceptions on employee engagement in public health facilities in a rural sub-district of the North West Province of South Africa. As mentioned above, data from this design is considered to be documentary traces of perspectives, behaviours, and events that communicate the truth about the experience of midwives regarding employee engagement (Sandelowski, 2000:80). This design produces codes, sub-themes and themes composed from the interpretation of data, not much transformed during data analysis.

The following section outlines the research methods that were used.

2.4 RESEARCH METHOD

The research method includes all the steps taken when data was obtained and refer to the description of the population, sampling and sample size, data collection and data analysis as well as measures to ensure trustworthiness during the process, data management, dissemination of research results and ethical standards (Polit & Beck, 2008:765; Polit & Beck, 2012:12).

2.4.1 Study Setting

The researcher identified the area for the research as a sub-district of the North West Province in South Africa. South Africa has 9 provinces of which the North West Province is one. The North West Province is bordered by Botswana and the Limpopo Province on the northern side. The Northern Cape Province and the Kalahari Desert is on the western side, Gauteng Province

to the east and the Free State Province to the south. The North West Province has a geographical area of approximately 104 882km² and a population of 3.4 million people. The economy of the North West Province is dominated by mining, manufacturing, agriculture and construction projects (Tibane, 2017:6).

The North West Province was chosen due to its large rural areas where limited public health services are available and these public health facilities are often far and widespread. The North West Province was chosen as the region of study as it is deprived socioeconomic rural district with severe staff shortages and hampered resources (National Triennial report of Perinatal Mortality and Morbidity Committee, 2014:149-150) of South Africa and therefore the retaining of midwives is of utmost importance as maternity services are rendered in health facilities such as Community Health Centres (CHC), Primary Health Care (PHC) facilities and level 1 hospitals. The public health facilities are often far from the communities and difficult to reach.

This province consists of four districts namely Dr Kenneth Kaunda District, Ngaka Modiri Molema District, Dr Ruth Segomotsi Mompati District, and Bojanala Platinum District (Rural development and land reform, 2016:25) & (Massyn, et al., 2017:576). The X district was chosen for this research and consists of 5 sub-districts. The research was conducted in the X sub-district as the public health facilities that render maternity services are rural and widely spread from each other.

Figure 2.2 below provides a map of all the Health Districts in the North West province as well as the location of the Ngaka Modiri Molema District. The area where the research was conducted is indicated as the Ditsobotla sub-district.

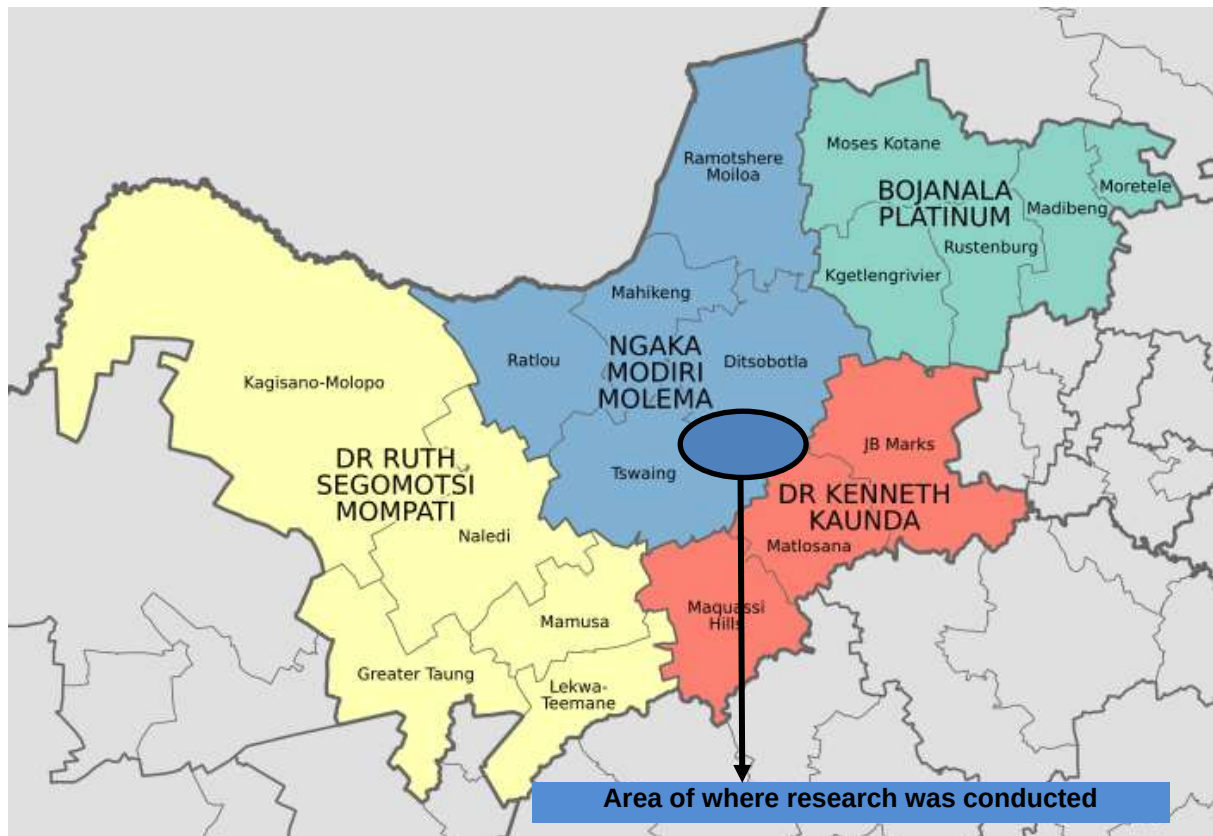


Figure 2-2: Map of Districts of North-West Province (www.municipalities.co.za)

2.4.2 Population

A population can be defined as a set of all members of a defined group (Gray *et al.*, 2017:53; Brink *et al.*, 2012:131 and Polit & Beck, 2012:59). This study consisted of two populations namely public health facilities and midwives working at PHC facilities.

The study was conducted in a rural sub-district where only 4 facilities qualified to be included, namely three PHC facilities and one level one hospital (N=4; n=4). These were the only public health facilities which rendered intrapartum services that are part of maternity services as focus of this study and therefore they are included. The target population for this study included all the midwives rendering maternity services (N=66) in these facilities.

From the target population the researcher used a sample to represent the population. A sample refers to a sub-set of the accessible population (Gray *et al.*, 2017:53), in this case the midwives that signed the informed consent as indication that they would like to participate voluntarily in the study. It is essential to provide information about the target population because it determines the feasibility of the study (Botma *et al.*, 2010:124)

2.4.3 Sampling

A non-probability purposive sample was used for participants working at the midwifery unit or rotating for a certain period in the maternity section in the selected public health facilities. Non-probability means that the participants who are selected are more knowledgeable about the research topic than others (Brink *et al.*, 2012:139).

Purposive sampling was used to identify and select participants who could make a substantial contribution. The researcher arranged a suitable time and venue with the operational manager and visited each public health facility to present a PowerPoint presentation about the planned research. Emphasis was placed on the inclusion and exclusion criteria as well as everything that informed consent entails. Potential participants were given time to ask questions that were clarified by the researcher. After the session, two informed consent forms were handed to potential participants and they had 24 hours to decide whether they would like to participate in the research. An independent person was arranged at each public health facility to assist with the receiving of the informed consent forms and training was provided.

2.4.4 Sample size

The sample size was determined by data saturation which can be seen at the point in research where no new or relevant information is emerging (Botma *et al.*, 2010:200). During this study data saturation was reached with 23 semi-structured individual interviews. Inclusion and exclusion criteria were formulated beforehand to ensure that selected participants contributed towards rich data. A detailed discussion follows in chapter two. The sample size was determined by two guiding principles: appropriateness and adequacy (Botma *et al.*, 2010:199; De Langen, 2009:3 and Burns & Grove, 2009:343). Appropriateness was ensured by the identification of the best-suited participants from whom to obtain information for the research. The appropriateness of the participants was discussed in abovementioned paragraphs and in Chapter 1, the inclusion and exclusion criteria to participate in this study were outlined (See Table 1.1). Adequacy was ensured by having enough data to reach data saturation.

It was foreseen that a minimum of twenty ($n=15$) interviews should be conducted depending on data saturation. Data saturation was seen at the point in research where no new or relevant information was emerging. In this study, 23 semi-structured individual interviews were conducted (Botma *et al.*, 2010:200) whereby data saturation was reached. The data obtained from the interviews can be seen as part of a study, in reality, the reality about the way in which midwives understand employee engagement. Language can be viewed as the way in which

midwives express themselves about their experiences on employee engagement (Sandelwoski, 2000:79 and Grove *et al.*, 2013:57).

The skill of the interviewer is fundamental in the data collection process in order to be able to answer the research question.

2.5 INFORMED CONSENT

The researcher provided a PowerPoint presentation to midwives about the research and what would be expected from them. During the presentation, time was allocated to clarify uncertainties. Every interested potential participant received two informed consent forms. They had 24 hours to decide whether they would like to participate in the research or not. The informed consent forms were signed in the presence of the independent person who co-signed with them. One form was given back to the potential participant for their perusal and the other informed consent form was kept in a non-transparent container.

The role of the independent person was to receive informed consent forms, to ensure that potential participants understood the informed consent and to answer any questions they might have had. If the independent person could not answer the question, the potential participant was referred to the researcher. When there were no further questions to clarify, the independent person co-signed both forms with the potential participant in a private room. The independent person kept one consent form in a non-transparent box in his or her office in a locked cupboard until the researcher came to collect the forms. Participants were asked to sign two copies of the informed consent documents in order to also have a copy with the contact details of the researcher. Upon receiving the informed consent forms the researcher compiled a list of names of all interested potential participants according to their public health facility.

An experienced midwife was asked to assist with the selection of participants who could provide rich relevant information in order to reach the objective of the study. The experienced midwife acted as a mediator for the purpose of this study. The operational managers were not asked to assist in the selection of possible suitable participants as they are in a position of authority over the midwives and it could have altered the findings and outcome of the study. If the experienced midwife was interested, he/she could also participate in the study.

In the next section sample size and data collection will be discussed.

2.6 THE DATA COLLECTION SETTING

The researcher ensured that the semi-structured face to face individual interviews was held in a private and comfortable area, free from interruption. For this study the operational manager's

office was booked as it was private, convenient, well ventilated, clean and adequately lit to create a conducive environment. To ensure privacy, a “Do not disturb” sign was posted on the outside of the door to inform others that an individual interview session was in progress (DoH, 2015a:17). The researcher preferred no central obstruction, e.g. a table, in order to be able to observe a participant’s nonverbal or postural responses more easily. The researcher told the participants that she needed to jot down a note from time to time as the researcher was unable to remember everything, the participants could, however, continue talking (Burns & Grove, 2009:403).

Before every interview, permission was obtained to audio record the session. The researcher ensured that the participant was relaxed during the interview. The room allowed for a comfortable seating arrangement to maintain eye contact. Participants were requested to switch off the sound of their cell phones for the duration of the interview, but were allowed to answer should the call be work-related. During the whole data collection undertaking, it was not once necessary for any participant to answer their phones during interviews, thus no disturbances were experienced (Burns & Grove, 2009:403).

2.7 DATA COLLECTION

The data collection method for this study involved semi-structured individual face to face interviews and open-ended questions were used to explore the perceptions of midwives about employee engagement. The interview is defined as the exchange of information between the participant and the researcher in building a social relationship, the exchange of information must be understandable and manageable depending on the quality and quantity of the information received (Botma *et al.*, 2010:208).

A semi-structured interview can be viewed as a carefully planned interview where the focus is on the collection of data and the use of communication techniques to obtain the best relevant information. Semi-structured individual interviews involve a collaborative activity between the researcher and the participant to discuss a phenomenon, in this study the midwives’ understanding of employee engagement, to gain understanding through active listening (Botma *et al.*, 2010:208, 210). The semi-structured interview was the best method of data collection for this study because it provided a broad range of information and reveal new perspectives (Botma *et al.*, 2010:210), as most previous employee engagement studies were quantitative studies.

Other data that are gathered with semi-structured face to face individual interviews includes extensive field notes which the researcher will audio record directly after the interview (Gray *et al.*, 2017:269). The questions formulated were open to allow participants to express their

understanding thereof and probing and paraphrasing were used in case a question was not understood (Cresswell, 2014:190-191).

2.7.1 Data collection tool and process of interview

The interview schedule was developed based on literature, the opinion of experts in the field and with the objective in mind. Questions were also carefully structured to prevent the participants from any emotionally harmful exposures when answering these questions.

The interview schedule was made up out of the following steps:

- Confirmation of informed consent and confirmation that participation is voluntary and that a participant may withdraw at any stage.
- Formulation of ground rules e.g. a kind request to the participant to put the cell phone on silent and only answer the phone in case of an urgent work-related matter. During this research, no participant had a need to answer their phones during the interviews.
- Introduction to the semi-structured interview: As a midwife involved in maternity care, the interest is in the participant's experience regarding employee engagement. Employee engagement describes how satisfied the participant is in practicing maternity services in the current facility and the factors that assist or hinder to stay at this facility. The questions will mainly focus on the participant's engagement and relationship with the operational manager.

2.7.2 Interview questions asked:

1. How do you experience working at the clinic?

Prompt: How does this have an impact on your engagement?

2. How does your experience with the mothers during the antenatal and intrapartum phases have an impact on your engagement?

3. How do you experience your relationship with your operational manager?

Prompt: How does this relationship impact your experience of engagement at your workplace?

4. What is your experience of the implementation of new maternity guidelines in reference to your engagement at work?

5. What other aspects have you experienced that have had an impact on your work engagement?

Field notes are important data to audio record or jot down and a discussion follow in paragraphs below

2.7.3 Field notes

Field notes were used as part of data collection and were used during data analysis. The field notes are the written proof of the things the researcher heard, saw and felt in the process of the individual interview. It is much broader, more analytical and more interpretive than merely a listing of occurrences (Botma *et al.*, 2010:217). Field notes are thus a description of what the interviewer observed such as a gut feeling, gestures, facial expressions, noises, and reaction after a question were asked during the interview process (Botma *et al.*, 2010:218).

- **Descriptive notes** include the physical setting (details were already outlined), dialogue and activities during the process (Botma *et al.*, 2010:218).
- **Methodological notes** refer to deviation from the research method e.g. a reminder to rephrase a question after the question is asked, to ensure a clear understanding. It could also express a critique of the research process on what could be done in another way to make the research process easier e.g. considering the afternoon for interviews because the public health facility is busier in the morning (Botma *et al.*, 2010:218).
- **Reflective notes** are a researcher's personal thoughts, feelings, ideas, impressions and judgments the researcher observed during data collection (Botma *et al.*, 2010:218).

According to Babbie (2010:204) analytical memos are the end of a field day summary or progress review the researcher wrote after the day's data collection. A diary was kept during the research to provide an overview of the day's research. An example of such a reflective note was that the researcher realized that one participant out of all the other participants expressed firmly and visible his or her negative opinion regarding the operational manager's leadership skills at the same public health facility where all the other participants felt quite satisfied with the operational manager's leadership methods. The researcher observed a bit of jealousy towards the operational manager as the interviewee was much younger and immature than the operational manager.

2.7.4 Recording of data

A digital audio recorder was used to record the semi-structured individual face to face interviews for comprehensive record keeping. Prior to the use of a digital audio recorder to capture the conversation of the individual interview, the researcher first obtained permission from the participants.

The digital audio recorder was placed in such a way that it did not distract participants. Soon after the individual interview was over the researcher listened to the audio-recorded interview to check for audibility and completeness and to allow for self-evaluation of the researcher's own interviewing style and any need for follow-up (Botma *et al.*, 2010:214).

2.8 TRANSCRIBING OF DATA

After each day of fieldwork, the researcher uploaded the digital audio recordings onto the researcher's laptop and password protected the audio recordings as trained by the supervisor. The researcher e-mailed the audio recordings to the supervisor and transcriber. The transcriber also had to sign a confidentiality agreement. The audio recordings of the day were removed from the digital recorder to ensure anonymity and privacy. This procedure was followed at the end of each day in the field as the researcher devoted all her time to this study during the days of data collection.

A qualified transcriber transcribed the data verbatim from the audio recorder because a verbatim transcription is a critical aspect when preparing for data analysis. After transcribing, the transcriber sent the transcripts that were password-protected, back to the researcher and supervisor. The researcher ensured that transcriptions were accurate and that it reflected the totality of the interview by repeatedly listening to the audio recordings, making corrections where needed and notes to ensure a true portrayal of the data (Botma *et al.*, 2010:214). In the transcripts, the researcher left enough space in both left and right margins to allow for notes during analysis. Additional data in the transcription such as silence, sigh, laugh and crying were typed in brackets to enrich the depth and the context of the transcription (Botma *et al.*, 2010:215).

2.9 DATA ANALYSIS

With qualitative descriptive studies, data analysis takes place at the same time as the data collection. (Sandelowski, 2000:338). The researcher started with data analysis from the first interview until no new codes emerged, thus data saturation was reached. Descriptive qualitative

data analysis utilises content analysis as the preferred method of data analysis (Sandelowski, 2000:338).

During data analysis, codes were developed from the data and used as a template to analyse the remaining data. As the researcher analysed each new transcript, the codes were refined and modified. The occurrence of each code was summarised into sub-themes and themes (Sandelowski, 2000:338). It is expected that the data analysis will yield a straight descriptive summary of the informational content of the data (Sandelowski, 2000:338), as is needed in this research.

The specific data analysis steps were as follows:

- Initially, the researcher listened to the audio recordings after each field day and made notes of wording (initial ongoing coding and reflected on the actual data collection of the day).
- After receiving the verbatim transcripts, the researcher read and re-read the transcripts and field notes, recalling the information given by the participants.
- The researcher noted her own impressions of the transcripts.
- The researcher coded the first transcript by using important words and phrases. A set of codes was generated.
- The set of codes was used to analyse further transcripts.
- New codes were added as data analysis progressed.
- The identified codes were refined and modified during the analysis process and were clustered into, sub-themes and themes of meaning that contained related codes.

Both the researcher and an independent, experienced co-coder conducted data analysis according to the above-mentioned principles and steps and held consensus meetings to finalise the codes, sub-themes, and themes. After the consensus discussions, the findings were presented as a rich descriptive summary. The data analysis was supported with quotes from the transcripts and was embedded with the findings of scientific literature.

2.10 DATA MANAGEMENT

According to Creswell (2013:175), there are certain principles to be followed for data storage. This includes the following:

- Any identifying information must be removed from the transcripts and participants are referred to using code names, e.g. 'Participant 1.' Names of public health facilities were removed and an A, B, C or D was used to indicate where the data was collected.
- The recordings were removed from the digital recorder after each field day.
- Electronic copies of the transcripts were removed from the researcher's computer and stored password-protected on the supervisor's laptop.
- These electronic copies will be destroyed after a period of 5 years by deleting all copies from the supervisor's laptop. Additional electronic password protected prove are kept by the supervisor including password-protected audio records, typed password-protected transcripts received from the transcriber and password-protected transcripts corrected by the researcher on an external drive and locked away in a cupboard in the supervisor's office and will be deleted after 5 years.
- Hard copies of the transcripts, proof of all field notes, and analysis of data will be stored in a locked cupboard in the supervisor's office for a period of 5 years, after which it will be destroyed through shredding.

2.11 TRUSTWORTHINESS

Trustworthiness refers to the strategies used to enhance research quality. In order to ensure trustworthiness, Lincoln and Guba (1985:290-294) outlined four epistemological standards, strategies, and criteria by which the quality or worth of a qualitative study can be evaluated, namely, truth value, applicability, consistency, and neutrality.

Table 2.1 Strategies to enhance trustworthiness in qualitative research based on Lincoln and Guba (Lincoln & Guba, 1985:290).

CRITERIA	STRATEGIES	APPLIED STRATEGIES
Truth value: The confidence of the researcher in the accuracy of the findings reported on.	Credibility: Conducting the research in such a way that the credibility of the findings was enhanced.	The researcher engaged with each participant for at least 20-45 minutes during the semi-structured individual interview and different communication techniques e.g. para-phrasing, clarifying and probing were used to obtain more in-depth data. The researcher did adhere to the research plan as approved by ethical committees. With no deviation needed, it was not necessary for any further approval from HREC for amendment.
Applicability: The extent to which research findings can be generalized.	Transferability: The focus of data collection will be on the quality of information obtained from the participant. The rich and dense information allows for inductive generalization from the sample to the target population in the sub-district where data was collected.	A minimum of 23 individual interviews was conducted and data analysis started after the first interview. Data collection was done until no new information emerged. A thorough and in-depth description of the research context was provided and the process followed during data collection by the researcher was to provide another researcher with enough information to evaluate contextual similarity.
Consistency: Ensures that the research method can be applied to the same population in a similar context and will yield similar results.	Dependability: Refers to the stability of data over time and conditions, therefore, the strategies of credibility and dependability are interdependent of each other.	Descriptive validity: Raw data includes the list of names of interested participants, purposively selected participants, process notes, transcriptions and data analysis documents will be available for inquiry audit by HREC. Transcriptions were transcribed verbatim by a transcriber and sent back, password protected, to the researcher who made corrections according to audio recordings, because the transcriber is not a trained health professional and was not present. Process notes included the methodology followed, the interview, as well as descriptive-, methodological- and reflective field notes. A clear methodology will be published.
Neutrality: Refers to the researcher being objective throughout the research process.	Confirmability: In qualitative research, the focus is on the characteristics of the data with the researcher remaining objective and unbiased.	The researcher portrayed the views of the participants with honesty and integrity. This was enhanced using an experienced independent co-coder during data analysis.

2.12 ETHICAL CONSIDERATIONS

The researcher ensured that the research was conducted in an ethical manner by applying the ethics principles prescribed by the Department of Health. (DoH, 2015a:14-17). The three broad principles that guide ethical conduct in research are respect for persons, beneficence, and justice (Polit & Beck, 2010:152). The application of these principles in this research was outlined in detail in chapter 1 and therefore the researcher didn't discuss it again in this chapter.

2.13 SUMMARY

In this chapter, a summary of the research design and methods that were followed are comprehensively discussed. The trustworthiness of the research was established using steps to ensure that the research was done according to the methodology. Establishing trustworthiness ensured that the research can be conducted in a similar environment and that it will produce reliable results.

In the next chapter, the data analysis is outlined.

CHAPTER 3

DATA ANALYSIS EMBEDDING WITH LITERATURE AND INTEGRATION WITH THEORETICAL MODEL

3.1 INTRODUCTION

In the previous chapter, the research methodology was discussed. This chapter analyse and reports on the data. In the first section, the data are analysed according to research questions and leads the formulation of codes, sub-themes and themes. The findings were embedded with scientific literature. In the second section, the theoretical framework used for this research is integrated with scientific result and a conclusion is derived regarding midwife employee engagement.

3.2 DATA ANALYSIS FINDINGS

The biographical information obtained during the research indicates that 1 out of the 4 public health facilities function without an advanced midwife in the human resource structure. The average midwife experience is eight years and 62% of participants have more than 8 years of midwife experience. It is, however important to consider that maternity services are provided at a level 1 public health care service. Table 3.1 outlines the biographic information which was obtained during the research.

Table 3.1 BIOGRAPHIC INFORMATION OBTAINED WITH RESEARCH

Average years of experience as a midwife	8 years
Minimum years' experience as a midwife	1 year
Maximum years' experience as a midwife	22 years
Total midwives with specialist midwifery qualification in the 4 public health facilities	5
Total public health facilities without a specialist midwife	1

In the table below the themes and sub-themes are outlined. A discussion of each sub-theme follows under Table 3.2

Table 3.2 Themes and Sub-themes derived after data analysis

THEMES	SUB-THEMES
1. Organisational matters influencing midwife engagement	1.1 Opportunity for further professional development.
	1.2 Shortages of midwives.
	1.3 Environment not conducive for maternity services.
	1.4 Unavailability of equipment/health care resources.
2. Challenges experienced by midwives	2.1 Guidelines are difficult to implement at the grass-root level.
	2.2 Difficult patient/disrespectful patient.
	2.3 Midwife having to account for complicated patients.
3. Managerial actions influence midwife engagement when rendering maternity services	3.1 Leadership skills.
	3.2 Favouritism within an organisation.
	3.3 Support from management to midwives to render quality maternity services.

3.3 THEME 1: ORGANISATIONAL MATTERS INFLUENCING MIDWIFE ENGAGEMENT

The first main category derived was organisational matters that influenced midwife engagement in this category negatively. The following codes were identified during data analysis and clustered under the theme organisational matters.

3.3.1 Sub-theme 1.1: Lack of opportunity for development

The sub-district office and public health facilities do not co-ordinate further professional development as a priority. Further specialised training is part of a midwives' development plan and should be a priority especially in a rural area where facilities are situated far away from the next level of service delivery. National Strategic Plan for nurse education training and practice (2012/13-2016/17-31) revealed that there are limited number of nurses with advanced midwifery in the public sector. In the case of midwifery professional nurses (PN), they should be sent to specialise in midwifery to ensure safe and effective service delivery and to deal with difficult intrapartum care e.g. a breech delivery or previous caesarean section which just arrive at the level one public health care facility. By ensuring that at least 2 professional nurses are trained

as specialist midwives the facilities rendering maternity services can be covered during shifts. Specialist midwives contribute to lower maternal and neonatal mortalities (Mhlongo *et al.*, 2016:171-172; Adolphson *et al.*, 2016:95). It is an expectation and part of the career path planning for midwives to receive training and clinical accompaniment and to be promoted to higher levels when there is proof of essential skills, leadership, and managerial skills (National Planning Commission, 2015:347). The following quotes support the insufficient promotion opportunities where managers were rotated for years without the permanent appointment of a supervising facility manager.

“...She applied for advanced midwifery study leave but professional nurses are sent for PHC training. This is an institution mostly utilises for midwifery services You know what they told her? Advanced midwifery is not a priority...”

“This facility has not been with an advanced midwife, now, for almost, emm, six years. The only advance midwife that we had, it was the manager who got relocated to the sub-district office. Since then, we have not had an advanced midwifery...”

“...Here only managers are doing short courses....”

“...its for the first time I hear that institution doesn't take their personnel to college or....which mean that you can be PN for 20 years”

“...im' very young, I want to see myself being a specialised before 30.....in this side they say there is no money”

South Africa needs well trained competent midwives to reduce mortality rates as it is evidenced that poorly trained midwives will increase both neonatal and mortality rate (Maree *et al.*, 2018:2). It is very important to allocate an experienced advanced midwife to mentor and support student nurses and conduct clinical practical to stimulate their critical thinking skills. A competent midwife experience job satisfaction while rendering maternity services (Joubert & Villiers 2015:1).

According to Rizwan *et al.* (2012:30), trained workers are more satisfied with their job compared to the untrained. Trained employees become self-reliant and are problem solvers with positive thoughts and attitudes which benefits their institutions. Mashigo (2016:20) believes that midwives have to develop themselves so that they are on par with the current competencies and evidence-based practices. Adegoke *et al.* (2015:947) added that adequate investment in training, deployment and retaining quality midwives could save mothers and babies by 60%. It is an expectation and part of the career path planning for midwives to receive training and clinical

accompaniment and to be promoted to higher levels when there is proof of essential skills, leadership, and managerial skills (National Planning Commission, 2015:347). The following quotes support the insufficient promotion opportunities where managers were rotated for years without the permanent appointment of a supervising facility manager.

3.3.2 Sub-Theme 1.2: Shortage of midwives

Shortage of midwives rendering maternity services seems to be challenging in the public health facilities selected for this research. It is evident that in the sub-district where the research was done, the management does not consider the nurse-patient ratio. One could expect serious adverse events, difficult unaided intrapartum services and a risk of losing one's professional registration at the professional regulating body, in this case, the South African Nursing Council (SANC) (Mhlongo *et al.*, 2016:163). This research confirmed a shortage of midwives as indicated by the following quotes.

"...it's only one professional nurse and one ENA so I couldn't leave the clinic....."

"...because here you'll be... maybe like for instance working alone at night..."

"....so the workload is too much for us because there is also people from X, .. X is a big village"

"...the children are sick... And then, I am alone here, I must do all the routine when the doctor is here.... From there, I must attend to maternity cases at the same time...."

"...was soo, working alone, in the ward of the labour rooms... and then, I was just asking myself, is, is it okay for a, a person to work alone because I was working with the babies as well who are ... came from, who were delivered at the labour rooms...(They were kept in the baby room for observation)"

"...And I was wondering, how is this institution (stammering) working on... because I know if (stammer) in the ward, there must be two nurses. That was my experience... when I was working there....."

"So it's a problem, that one and you are alone. And assistant is just there to help clean the baby... bla-bla.."

".....you'll find that em, only one midwife work, during the day at maternity, doing ANC, post-natal deliveries and whatever....."

"...they can't even take their nurses to go to workshops, because of shortage of staff..."

Midwife shortages is still a global problem (Alilu *et al.*, 2017:2; Adegoke *et al.*, 2015:947). Apteker *et al.* (2009:106) ascertain that lower nurse staffing levels lead to greater patient mortality and inability to rescue complication rates resulting in the ability to save patients once complications arise. Patterson *et al.* (2019:22) confirms that the shortage of staff is an ongoing issue resulting in bullying and undermining thus causing turnover in early years' post-qualification. Stone *et al.* (2011:804) reported that some nurses and midwives work alone and are expected to make difficult decisions but at the same time denied the opportunity for professional development and face criticism from their colleagues.

3.3.3 Sub-Theme 1.3: Environment not conducive for maternity services

The environment where maternity services are rendered should be safe and baby-friendly. The following quotes indicate that the maternity service delivery environment is not conducive for maternity services.

"...there's a signal problem and, also, the infrastructure of the clinic". We are supposed to have a curtain between (intrapartum women) but that curtain doesn't serve any purpose because the beds are so close..."

"...the passage is so small (between beds). The patients always close to each other, you know that cross-infection."

"...their partners can not accompany them while they are in labour because of the space..."

"...and the ideal clinic we are not complying again because of that small rooms. Even our medicine cab... room, the... you will see them...."

"... labour room we only have two beds...."

"We have to work in labour rooms, and they expect us to come again, to work in neonatal room as well..."

"There's no cleaning material. We don't have paper towels, we can't wash hands because all the consulting rooms don't have water....."; "... you know, the only thing that is, but, that is not eh, (pause), yes, it is a problem ... shortage of water".

Organisational factors such as workload, role stress, poor communication within the institution may negatively affect the employee (midwife in this study). The feeling of being undervalued, lack of status, no support or understanding of midwifery service delivery challenges and nature of work e.g. working with newly qualified staff itself may predispose to stress which are barriers

to provide quality midwifery care and force the experienced midwife to quit working at a public health facility (Bremmes *et al.*, 2018:2; Hughes, 2017:2).

Furthermore, research findings confirmed that stress and burnout under midwives have been reported and lead to turnover. Therefore, it is vital to identify these stressors in order to retain experienced midwives (Geraghty *et al.*, 2019: e2097; Elmir *et al.*, 2017:4185). Midwifery services suffer due to structural health system deficiencies such as insufficient space, no running water and periods without electricity supply. Though it is expected from public health care services to render quality maternity services which are cost-effective. Cost-effective interventions are only possible when infrastructure is developed (Miller *et al.*, 2016:2177).

3.3.4 Sub-Theme 1.4: Unavailability of equipment and healthcare resources

Maternity services cannot be delivered without the necessary equipment and healthcare resources. According to Massyn *et al.*, (2017:587) appropriate resources must be available to render quality services. Vital ideal clinic requirements for maternity services includes restocking of emergency trolley before and after use, readily equipped resuscitation trolley with basic equipment that are fully functional, daily recording of temperature of medicine room, maintenance of cold chain and maintenance of medication store room temperature (Massyn *et al.*, 2017:587). The following quotes express the unavailability of healthcare resources:

“...Especially when we come to shortage of medications; that is something that is actually sometimes giving us a tough time in terms of how can, how should we manage our patients....”

“Shortage of medication at times. Um, for times, for instance, we didn’t had Chloromax eye ointment”

“there was even a time that they said, because there’s no Syntocinon, we just refer all our patients to X.”

“...sometimes the equipment are not working like the... the... the... the warmer. So I need the warmer (clicking sound) to prevent hypothermia...”

“...the shortage of equipment, we don’t have a steriliser, we must make our packs, send them to X for sterilisation. The next week, we must go and collect them”

“lack of equipment, you know...When you admit the patient, you use a foetal scope – the old model, we don’t have CTGs”

“...the only thing that I realise is CTG, we don’t have CTG..“

“CTG, we don’t have it.”

Gauteng Department of Health Annual Report (2016/2017) revealed that “access to healthcare is a fundamental human right and medicine availability is a key indicator of access to services”. Health care facilities are still inaccessible and unavailable to provide maternity care to pregnant mothers. The lack of Cardiotocography (CTG’s) in public health facilities rendering intrapartum care leads to a lack of foetal monitoring to detect foetal distress (Mianda & Voce, 2018:88). These facilities are unable to respond to abnormalities and delay the referral system which are the preventable factors leading to mother and neonatal mortality (Mianda & Voce, 2018:88). Additionally, the lack of equipment and stock supplies within the health system has been the most important reason for poor working conditions (Pope *et al.*, 2014:2; Sibiyi *et al.*, 2018:1; Thopola & Lekhuleni, 2016:4; WHO, 2016:28).

In essence, this research reveals that the practice environment faces a critical shortage of human, environmental, equipment, medication and material resources. These findings are confirmed by Miller *et al.* (2016:2177) that declares that the rendering of midwifery services are crippled by structural health system deficiencies such as insufficient equipment and drug supplies. Nevertheless, it is expected that maternity care professionals have to deliver cost-effective evidence-based care interventions.

The following quotes support the insufficient promotion opportunities where managers were rotated for years without the permanent appointment of a supervising facility manager.

“We don’t have a facility manager. We just have a team facilities managers that works six months and then we change, and then we change. The... We don’t have posts currently for facility managers. The facility manager which was... which was permanent was... she left in 2015.”

“Yes. And then it was from 2015. And then 2016 I went for operation so I couldn’t manage to continue, so they chose the other one. Relationship, excellent. I... I work as a mentor”.

“The first one was a, advanced midwife as well as an acting operational manager, and the current one is a PhD trained operational manager”

“...so we have an acting operational manger since last year....”

“...you are not operational manager....I’m acting sometimes as operational manager but never appointed.”

Jones *et al.* (2016:117) detected that continuing professional development (CPD) is widely recognised as an essential part in developing skilled maternity workforce so as to achieve positive birth outcomes, however, the challenge with CPD is unavailability of funding for the skilled educators. To reduce mortality rate, midwives must receive training and CPD to improve professional competency (Jones *et al.*, 2016:117). One of the manager's key functions is to assist employees with career planning and to prepare them for when promotion opportunities become available within institutions (Grobler *et al.*, 2011:276). Management should provide opportunities for employees, for instance, to act as an operational manager while they are on leave, develop their skills, and provide training, such as short courses. Performance criteria should be applied to motivate employees to grow and develop (Grobler *et al.*, 2011:276). The geographical imbalance is a major challenge in rural areas as the ratio of health workers is even less than in urban areas. Employees in rural areas receive fewer opportunities than their urban counterparts with regard to training, opportunity to specialize in advance midwifery and promotion to higher positions (Safi *et al.*, 2018:952). Rewards that can be used by sub-district managers and operational managers as a form of incentives to midwives are praise, recognition, increased income and promotion (Nieman & Bennet, 2013:100; Crowther *et al.* 2016). Rouleau *et al.* (2012:3) states further that working conditions, remuneration, the nature of work itself, promotion, professional development, recognition, job security revealed to be the causes of midwife disengagement as experienced midwives are aware that they have special global needed skills.

Andrejiova *et al.* (2019: 14-15) signify that there is a link between worsening state of health and inappropriate or uncondusive environment. Quality maternity care requires adequate technological equipment, efficient and stable service delivery processes and skilled midwives. Work satisfied midwives are more willing to render quality maternity services (Wu *et al.*, 2017:79). Work overload, long working hours, rapid changes in maternity policies and guidelines are considered to be work stressors and impacts neonatal and maternal mortalities (Cazan *et al.*, 2019:3-4). The ideal public health care facility consistent with Reyes & Norona (2019:243) has a work environment where the employees (midwives) are satisfied and conduct safe maternity practices. They further declare that a healthy work environment is characterized by work-life integration, opportunities to progress, to take on leadership roles, training programs for professional development, a dynamic work environment which makes use of latest technology and an effective leadership working strategically to reach target performance indicators.

3.4 THEME 2: CHALLENGES EXPERIENCED BY MIDWIVES

The second theme that affects work engagement was derived from the challenges experienced by midwives in rendering maternity services at selected public health facilities. After combining the different sub-themes, the following challenges presented:

3.4.1 Sub-Theme 2.1: Maternity guidelines difficult to implement

The Guideline for maternity care outlines the steps which are used by midwives in giving appropriate care for specific problems. The main challenge of the guidelines is it is difficult to implement as most of the maternity patients present themselves at the facility without an appointment and already in the advanced stage of labour. These high-risk patients are HIV positive, defaulted treatment and poses further risks to their unborn child. Jinga *et al.* (2019:2) discovered that women presented late because of the following reasons, intention for abortion, feared the ANC HIV test outcome, jealousy and bewitchment. The subsequent quotes indicate how difficult it is to comply with certain guidelines:

"...here are also that women who present at delivery and they are unbooked. Some of them, you even find that when you test them in labour, they are positive so that really impacts a lot in the government strategy of eliminating HIV in transmission to, from mother to baby."

"....they don't attend antenatal correctly, and as a cultural issue...most pregnant women are going to their mothers to deliver at home. You see. So, and then the, and then the, most of them give us problem because, most of them, their babies are infected. They give statistic of PCR..."

"....they stay far. So, we have, um, eh, BBA's (baby born on arrival's), mothers who are defaulting on HIV treatment."

The Treatment Action Campaign (TAC) is an organisation that drives the provision of ante-retroviral treatment for persons living with HIV/AIDS. In 2015 TAC forced the government to redress the inequitable access to healthcare for under-privileged persons living with HIV/AIDS. At the same time the government was forced to acknowledge lesbian, gay, bisexual and transgender activist groups to gain wider leverage in South Africa and internationally. The court also ruled in favour of TAC by expanding implementation of ante-retroviral treatment for pregnant mothers to prevent HIV transmission to unborn and breastfeeding children and prisoners. More than 200 treatment literacy practitioners at the time provided information to over 100 000 people every month. The more media attention increased the more practitioners were recruited at grassroots-level that led to the success of the Treatment Action Campaign (Huang

et al., 2015:2424). The guidelines for maternity cases are outlined in the subsequent paragraphs.

Clinical guidelines: PMTCT (Prevention of mother to child transmission) (2010:16) affirms that all women attending Antenatal Care (ANC) first visit and those who follow up should be offered information on HIV testing and PMTCT including how HIV is transmitted.

- Women who have never been tested previously as well as those who require repeat testing should meet with a counsellor, nurse or midwife in a one-on-one information session.
- Each woman needs to be informed about routine HIV testing procedure and must be free to ask any question.
- HIV testing should then be offered by verbal consent.
- Women refusing HIV testing should be offered post-refusal counselling by an experienced counsellor without forcing her to explore the reason for the decision or choice.
- Post-test counselling has to be offered to all women no matter the status. HIV positive woman needs to be confirmed by using a second rapid HIV test of another company.

According to Guidelines for maternity care in South Africa (2015:138) a midwife should check the HIV status of a woman and determine if the treatment that was provided was used. In the case of unknown status and the woman is in the first stage of labour, HIV counselling and treatment should be offered.

3.4.2 Sub-theme 2.2: Difficult and disrespectful patients

The patient in intrapartum phase does not only need physical support but understanding, respect, alliance, trust, care, warmth as well as encouragement from the midwives (Ezeuduji & Mdivasi 2017:128). A midwife should have an understanding and caring attitude and the ability to get on well with people from a wide range of background. The midwife should remain calm during stressful situations. There are instances where patients can elicit strong negative emotions from the midwife. Hunter (2010:255) revealed that as midwives attend to women, they engage in the intrapartum in the women most challenging and intimate events and ultimately develop high level of emotions. The intense sensation and pain observed by midwives may cause withdrawal or distancing themselves from labouring women as part of their coping mechanism.

Labour pain, on the other hand, is painful and unpleasant (James, 2018:2), causes exhaustion and frustration, it may be debilitating and drain women of vital energy which will be needed during the birth process. This leads to a lack of cooperation by the patient during labour and may cause complications such as laceration of the perineum, an atonic uterus, foetal distress, maternal or newborn death. The following statements demonstrate that the midwives are faced with difficult- and disrespectful patients:

“..... the attitude of the community towards us nurses. They have this mentality that nurses are rude, so, even if we are nice to the patient, they will come with their rudeness to you and it makes it difficult for you to do, to be nice to them”

“.....some, they are having an attitu..., attitude towards the midwives, and even if, when you talk to them so né, kindly, eh-eh, they become irritated.”

“...some they come at the very early age of ... 14 years...so, they give us some problems... they don't cooperates well, um...”

“....during delivery, the problem is that, women, when they are in pain, they don't cooperate. Sometimes, you find yourself screaming at them because you are thinking I have to save this baby....”

“... they would treat you as if... you don't know anything because you are a professional nurse. They think, ... okay, this one is young... Sometimes, um, I'm being criticised for being slow by the patients...”

The abovementioned indicate that maternity clients do not have respect for midwives rendering maternity services. Public health care services are blamed by maternity patients with complaints and bad reports (Girmay et al., 2018:2). Maternity patients visiting public health facilities are affected by feelings of anxiety, fear, pain, and illness. They do not know what the intrapartum phase entails, and they may become frustrated and violent. Frustration and negative feelings lead to dissatisfaction and complaints about maternity service delivery (Beattie *et al.*, 2018:117).

Patient feedback is indispensable to assist public health facilities to evaluate maternity service delivery, to take remedial actions in case of complaints and enhance quality maternity service delivery. Health care facility teams can use identify gaps and use such measures to improve quality of care. It also provides praise to effective and efficient midwives that walk the extra mile. (WHO, 2016:2)

Patients may complain when they are unhappy with services rendered; when the professional conduct is perceived not up to standard; when they feel that the patient-midwife communication

is inadequate or when they identify medical treatment errors and feel that incorrect health care was rendered (Ha *et al.*, 2015:1).

Another research study in Kolkata public hospitals indicated that when maternity patient complaints are ignored, corrective actions are not implemented nor feedback provided to the complainant. Saha and Daw (2016:406) further indicates that when unsatisfied maternity patients report small issues due to negligence direct to the hospitals' authority patient complaints are acknowledged, addressed via the applicable hospital and lead to a reduction of maternity patient complaints and improvement in maternity service delivery.

3.4.3 Sub-Theme 2.3: Midwives forced to account for complicated cases

A midwife should be able to render maternity services under pressure as two lives are involved, the life of the mother and the unborn or newborn. Midwives working at public health facilities should always be prepared for the unexpected as well as for high-risk maternity patients. The extracts below show how complicated maternity care can be:

"...one day, I had a severe eclampsia patient coming with fits. I tried to call eh, other nurses at acute... I called, called, called for a long period ... until one of the securities hear me... Until the securities come and assist me to put the patient on the bed....."

"....those that are delivering they do... there are those who will come to the facility even if they know that it's a high risk.....".

"Pregnant woman, who are actually, not booking in time.... Some are coming here with condition of pre-eclampsia's, her blood being higher, because of such patients, are patients who are not actually doing what is right."

" I took was taking over from the day shift. I found they had delivered a premature baby, was weighing 900 grams... because we don't have incubators in our ambulances. So they had to contact X ambulance services because they have the incubator. The incubator was in X (another district) so, by the time it arrived, it was, I think it was three hours later, the baby had already died now,....."

"The high-risk patient, they come here during labour and sometimes the ambulance delay...even if the patient is aware that she is not supposed to deliver at the clinic, she has to deliver at the hospital"

In case of complicated case it is expected from midwives to write a report after a maternal, stillbirth or neonatal death. The chart and reports are scrutinised at sub-district and district level

to identify if every clinical step was clearly recorded, was there a misconduct and which remedial action will be taken to prevent such a case in future. The midwife has a right to defend her action at the investigating committee (National Triennial report of Perinatal Mortality and Morbidity Committee, 2014).

A confidential inquiry into causes of maternal death indicates that a delay in seeking early maternity care is one of the leading causes of maternal deaths (Sibiya *et al.*, 2017:2). The guidelines for maternal care (2015b:120) state that if a patient report preterm labour i.e. between 28 and 33 weeks she should be urgently referred to a level 2 or 3 hospital.

The nearest level 2 or 3 hospital is 80 - 145 km from the public health facilities where the research was conducted. If the delivery is imminent, the mother must be transferred to hospital before delivery as mothers' uterus is the best incubator and steps need to be taken to suppress labour to allow the maternity patient to reach a level 2 or 3 hospital (Guidelines for maternity care, 2015:102).

After the neonate's birth, he or she must be admitted to the neonatal intensive care unit. Public health facilities need to ensure that all high-risk patients are aware of the referral system to ensure that pregnant women will be treated at the appropriate level of care through proper communication. Saving mothers (2014-2016:10-11) revealed that the referral system should be improved by ensuring that the guidelines outlines are adhered to.

In case of severe, pre-eclampsia, imminent eclampsia and eclampsia, the initial treatment to manage the pregnant mother is outlined in the guidelines (Guidelines for maternity care, 2015b:87; Health Professions Council of South Africa, 2018:23). It is important that midwives rendering maternity care at public health facilities know which emergencies can arrive at their facilities, implement the appropriate guidelines and refer the patient as soon as possible to the next level of care.

3.5 THEME 3: MANAGERIAL INFLUENCE ON PERINATAL DELIVERIES

The third main theme was the managerial influence and how it affects midwife engagement. Operational management at public health facilities was identified as a theme that has an influence on the rendering of maternity services. This theme was defined after categorising the different codes together and formulating the themes and subthemes. The following sub-themes were identified.

3.5.1 Sub-theme 3.1: Leadership skills

Leadership skills are key for public health facilities to render quality health care services and succeed in the key performance indicators as set in the Health Information System. The operational manager is responsible to ensure that both long- and short term goals for the public health care service are met. Maphumulo & Bhengu (2019:8) indicated that failure in public health care delivery is caused by poor leadership skills and inadequate management. Participants use both he and she in their interviews and the researcher is of opinion that they do that to protect themselves if the research results need to be disseminated to the North West Province DoH, sub-district manager, the operational managers and participants. The following leadership skills were quoted by the participants:

“...the current one is X trained operational manager so, they are very helpful... They don’t act as if they are above being human. They are human and they are also professional, so, that also, yes, they instill the ubuntu.”

“My manager is very good. She’s an objective leader, eh, he’s assertive. He’s not biased and also approachable.”

“...we have an acting operational manager since last year. She is supportive.”

“...she’s good, like, she’s very supportive, she’s understanding, like, she’s trying her level best. Even if we are running short of the suction machine, she will try and get hold of other facilities so that they can assist us”

“She’s not an ideal operational manager. I don’t understand why she’s an operational manager. An operational manager is supposed to take care of his staff sake, supposed to make sure that the staff is not suffering, including the patient.”

“When we engage our problem to her, she doesn’t have answers, she’ll be saying that the sub-district office are the one’s to answer...”

“...there’s no good relationship. Because we are not free to talk to them”

“She...doesn’t make things easy for others but now she’s...I... I and her, we are not in good speaking conditions sorry. So it does not bother me anymore. Because his doing his things there and I do my things there”.

“ I was newly-qualified... and then I was delivering a patient, and that patient was so uncooperative. And I was alone in the labour room. And I came and called her, ‘could you

please come and talk to this lady because she's so uncooperative?' Then he said to me, 'when she's not listening to you, now... how I am going to tell her?'

"I was in the meeting with most of my managements and it was my fault, even though it wasn't my fault. Because, I am new. That person is older."

There are requirements for an effective leader which includes setting priorities, critical thinking skills, problem solvers, respecting people, communicate skilfully, be able to visualise the bigger picture, developing of subordinates in management skills to enable them to function as leaders when the operational manager is not available (Weiss *et al.*, 2019:65). Salleh *et al.* (2017:65) add that leader personality influence employee satisfaction, good interpersonal relationship with subordinates by just being transparent, fair and open, trustworthy and be presentable. According to Ding *et al.* (2012:1B) and Iqbal *et al.* (2015:5) staff orientated style of leadership leads to higher employee satisfaction. Furthermore, the operations manager needs to assist and respect employees, shows quality and personal charm to increase trust, display a positive attitude to employees and this staff oriented style of leadership enhance employees' willingness to stay.

3.5.2 Subtheme 3.2: Favouritism within the organisation

A manager should, by all means, have boundaries within the workplace so that friendship should be separated from work schedule thus avoiding favouritism. Makhubela *et al.* (2016:4) revealed that unfairness can have negative impact towards the organisation i.e. the employees will not be productive and negative attitude towards the organisation. Unfairness in evaluation of work performance may also affect the employee attitude towards the organisation. The following excerpts display fairness and favouritism.

"he's having a good relationship and same quality of leadership... Equality.

"She's an objective leader, eh, he's assertive. He's not biased"

"If he doesn't like your attitude to other... towards your colleagues. He will call you and say: No, let's talk about this"

"She's doing it for the loved ones, I guess; if, can we call them that? The special people... "The special ones, the ones she likes. She doesn't hide it"

"They don't listen to us because the other, they've got favourites. Well, if you got problems, they can, others they listen, others they don't listen to us."

“ No favouritism. Ja, if you are wrong, she will tell you straight in your face that you are wrong and I’m not here to build a friendship with you.”

Favouritism refers to special preferences or treatment by a manager towards certain employees (Arasli *et al.*, 2019:198). According to Nel *et al.* (2012:383) favouritism have a negative impact on teamwork as well as productivity and the focus should rather be on approaches dealing with issues such as equal opportunities and fair treatment which is crucial for all employees in an organisation.

Managers who are ethical, fair and predicable are mostly trusted by employees thus promoting a high level of employee engagement (McCabe & Sambrook 2013:817). Furthermore, employees who are unfairly treated are more likely to develop divergent thinking behaviour as a result of mal- and abusive treatment by managers (Caroline, 2015:76). Altwerthan (2016:2) revealed that previous studies on job stress and favouritism have shown that favouritism was regarded as a stressor leading employees to resign. This research identifies that some managers tend towards favouritism. It has a negative influence on midwife engagement and retention.

3.5.3 Subtheme 3.3: Support from management to midwives to render quality maternity services

Midwives support by operational managers is crucial to render quality maternity service. Operational managers can support midwives with for instance complicated maternity cases or attend to staff requests within fair circumstances. Midwives may have personal problems and sometimes only listening can be valuable. Midwives supported by operational managers tend to be more engaged in their work than staff who are not being supported. Mashigo & Mathibe-Neke (2016:71) discovered that staff needed management support as a way of creating positive work environment to midwives, giving them praise and recognition not only to wait for incidents or mistakes by staff. The following quotes shows that support from management plays a vital role in the organisation:

“acting facility manager here is very good because whenever we have challenges we go and address them, then he will come back to us and then we address the whole issue”

“Even if you have maybe a problem at the maternity. Because the... the office is nearby he can go there and help.”

“he’s approachable. He is a male. He doesn’t have problem of delivering ... all that stuff.”

“I mean, when we are, when we are operational manager... I think when you see this shortage of staff, we have to, to help your staff where we can... they'll be just sitting there, they can't say, no, no, no, that one is, or they even don't care. Have you had your lunch time or tea time? They'll just... take their bags at 16 hours and went home”

“Very supportive. And, even if you get a problem and complications, she was always with, with us”

“ But, the present one, I'm telling you, yoh, this child, she's so supportive, ko re you feel ... ko re you feel free, that is why people they are not”

“she's very supportive ... very understanding person..... if you have a problem as a worker, I'm not afraid to go to her and tell her that ...”

This research revealed that operational managers can support midwives if they are willing to assist with a complicated maternity case, while others are not available or sensitive to the needs of the midwife in the clinical environment rendering antenatal, intrapartum and postpartum services. According to Munir *et al.* (2016:1389) supportive or performance-oriented recognition is vital to the organisation and has a positive effect on employee engagement.

The National strategic plan for nurse education (2012/13-2016-/17:23) highlighted that midwives encounter challenges such as inadequate support from their operational managers, poor relations with doctors and staff absenteeism. Orgambidez-Ramos and de Almeida (2017:38) believes that when work engagement and job satisfaction is positively moderated by managers physical and emotional support, it will reduce the negative effects of burnout.

3.6 THEORETICAL AND EMPIRICAL INTEGRATION OF RESEARCH FINDINGS

The employee engagement model from Gupta and Aileen (2017:1) was adapted and used as the theoretical departure point for this study and was described in chapter 2. The research findings incorporated in this study derives a conclusion of the current level of midwife engagement in public health facilities in a rural sub-district of the North West Province.

The drivers and the three dimensions which influence the drivers were discussed. The dimensions determine the level of engagement.

Dimension	Drivers	Themes	Sub-themes
		skills.	and community health workers. *No fulltime doctors, physiotherapist, radiology or laboratory services. *Only one midwife and one assistant nurse to run maternity section.
Rational Dimension	*Operational manager. *Job characteristics. *Training and development.	*Favouritism. *Limited specialised midwives. *Lack of CPD.	*Preferential treatment on midwives. *Professional nurse /midwife expected to manage difficult deliveries. *rural areas with scares resources. *No opportunities
Behavioural dimension	*Operational manager. *PHC facility.	*Operational manager's role. *Environment not conducive for maternity care.	*Lack of leadership and supportive schools. *Cannot address clinical problems. *Building and equipment challenges, not up to standard. *Shortage of equipment and support services. *Shortage of ambulance services.

3.6.1 Drivers and dimensions which act as enhancers or barriers to midwife employee engagement

The five drivers (work team, operational manager, job characteristics, training and development, and public health facilities) and the dimensions integrated with the findings will be outlined in the paragraphs below.

3.6.1.1 Work Team

No public health care facility can deliver services without the services of the multidisciplinary team and inter-sectoral collaboration e.g. public works who act as a maintenance team for facilities. The midwife has an important role in the multidisciplinary team. According to Crisp et al. (2018:12), a midwife contributes to the health and wellbeing of patients which she attends to. Referred to in this study as the antenatal-, intrapartum- and postnatal patients as well as the newborn baby. The midwife should respect the culture and values of patients and maternity

services rendered should be patient-centred as each patient is unique. The midwife serves as a gateway to other health services and she should prepare the patient for delivery at a level 1 public health facility or refer the at risk patient to deliver at a hospital where a doctor, laboratory and theatre services are within reach.

The public health facilities where the research was done do not have a full-time doctor, physiotherapist, radiology or laboratory services. Obtained blood specimens are sent by courier to laboratory and results are available via smartphones.

The midwife is also responsible for promoting the four central domains of public health:

- Reducing negative effects on health and wellbeing e.g. encourage hygienic environment at home which will prevent a newborn from getting sick.
- Assist maternity patients to make healthy choices e.g. choose seasonal vegetables and fruits as it is then cheaper and more available. A healthy diet should be encouraged during consultations.
- Health protection by protecting the population from major incidents of threats e.g. if the antenatal patient should avoid contact with people suffering from rubella.
- Health care, public health and preventing premature mortality by reducing the number of people living with preventable ill-health and people dying prematurely. A competent clinical experienced midwife renders quality maternity services with the aim to reduce maternal and neonatal deaths (Sauders, 2016:254).

This study reveals that only one midwife and an assistant nurse are allocated for maternity services during the night. The midwife needs to deal with emergency cases as well. As North West Province is known for the largely rural area the public health facilities render services to a large catchment area and the unbooked cases aggravate the situation, especially if they are HIV positive. The un-availability of a doctor in complicated situations worsens clinical practice. As a result, the emotional, rational and behavioural dimensions will be negative and has a negative impact on midwife-employee engagement. Midwives can be searching for other jobs. Employee retention can be difficult.

3.6.2 Operational Managers

The operational managers are responsible to oversee all aspects of the facility e.g. coordinate patient care activities, ensure safety and quality care, supervising of employees as well as the monitoring of the quality of patient care (Armstrong *et al.*, 2015:2; Naidoo & Matlakala 2017:4-5). To be an effective operational manager extensive clinical practice is required as well as

leadership, communication, and administrative skills. The list outlines some of the operational managers' duties. This is not a comprehensive list of functions of a public health care operations manager but provides an overview (Naidoo & Matlakala 2017:4-5).

- Operational managers handle all supervisory duties of the public health care facility, overseeing PHC nurses, midwives, assistant nurses and support staff (clerks, pharmacy assistant, data capturers, cleaners and security officers).
- They set work schedules, delegate assignments, assign tasks and evaluate employee job performance as well as conduct disciplinary hearings for employee's who do not fulfil their job requirements or provide inadequate care.
- The operational manager is responsible to orientate new employee's and allocate a mentor if needed, sometimes they mentor less experienced nurses as well by offering clinical and career advice.
- They set goals and standards for the public health facilities according to key indicators that are used to evaluate health service delivery in a sub-district.
- The operational manager holds regular staff meetings where they give feedback about new health legislation or changes in guidelines, budgetary issues and discuss areas for improvement.
- With reference to maternity services, operational managers are responsible for ensuring clinical leadership, and to equip midwives with skills to make effective clinical decisions regarding maternity care.
- Operational managers need to contribute to effective teamwork, create a conducive environment for optimal maternity care (Mianda & Voce 2019:1).

With regard to this study, leadership skill and favouritism was sub-themes identified with regard to operational managers' role. The enhancers identified with regard to leadership skills were being helpful, don't act if they are better as the midwife, enhance Ubuntu, are objective, assertive and not biased. Some operational managers were approachable, supportive, assisted with obtaining equipment and addressed challenges of midwives satisfactorily.

However, 50% of the participants of 2 public health facilities identify barriers with regard to leadership skills, favouritism, and nepotism. According to these midwives their operational managers' are not supportive, approachable, be unable to address clinical challenges in the sense that they cannot provide answers. They tend to negate these challenges as instructions from district office and shun their responsibility. Some midwives stated that they do not have a good relationship with their operational managers. When they try to talk to them, they handle

the issue at hand in such a way that the midwife ends-up being wrong. According to these group midwives these operational managers in two of the public health facilities support favouritism and nepotism.

The findings consider that 50% of midwives identify enhancers which relate to the emotional, relational and behavioural dimensions and has a positive effect on midwife employee engagement. This means that 50% of midwives are proud and satisfied with their allocated operational managers while the other 50% of midwives dissatisfied with the behaviour of their allocated operational manager. The conclusion can be made that 50% of midwives can be difficult to retain.

3.6.3 Job characteristics

To render quality maternity services a midwife should have the required training and specialties. A midwife in South Africa should have completed the training as stipulated in Regulation 174 of the South African Nursing Council [SANC] at a Higher Education Institution. The duration of the course is 4 years' full-time study and lead to registration as professional nurse and midwife (Nursing Act No 33 of 2005: Regulation 174). After completion of the required training, the midwife should be competent to render quality maternity services including antenatal, intrapartum, postpartum, reproductive services as well as to care for the newborn.

Nevertheless, it is important that the midwife attend midwifery educational programs which are recognised in South Africa and pay the applicable registration annual fee to the South African Nursing Council in order to continue to practice (Fraser *et al.*, 2010:5). The midwife is recognised as a responsible and accountable professional who works in partnership with women and multi-disciplinary team members to give the necessary support, care and advice during antenatal and intrapartum period, to conduct birth on the midwife's own responsibility and to provide care for the new-born. This care includes preventive measures, promotion of normal birth, detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures (Fraser *et al.*, 2010:5; Wisanskoonwong, 2012:16). The midwife has an important task in health counselling and education, not only for the woman but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare. A midwife may practice in any setting including home, community, hospitals, clinics or health units. Furthermore, the experienced professional midwife in the clinical setting is responsible for mentoring newly trained midwives to support them at the beginning of their professional careers (Malwela *et al.*, 2015:1).

In South Africa, it is possible to specialize in midwifery. The previous terminology used was advanced midwives. In this study the term advance midwife and specialist midwife were used interchangeably. However, the Minister of Health withdrew the reference “advance midwifery” to the specialist midwife with Regulation 368 of the (Nursing Act 33 of 2005). The Minister state in Regulation 368: “I, Aaron Motsoaledi, Minister of Health, hereby, in terms of section 31(2) of the Nursing Act, 2005, and after consultation with the South African Nursing Council, create the following category of practitioners—

- a. Nurse Specialist.
- b. Advance Midwife will onwards be referred to as Midwife Specialist.

These categories of practitioners hold an additional qualification in terms of section 34 of the Nursing Act.” A midwife specialist has advanced expertise in midwifery, hold an additional qualification in midwifery and is registered as such with the South African Nursing Council after a year full-time study including theory and practice at an accredited Higher Education Institution and clinical facility.

In the clinical field, it is still a tendency to refer to these nurses as “advanced midwives”. A specialist midwife has expanded competencies and skills to improve maternal health, reproductive health, genetic counselling and neonatal and child health (SANC Specialist Midwife Competencies 2014:1-7).

This research study revealed that 1 public health care facility did not have an appointed specialist midwife as the specialist midwife was transferred to the sub-district office. To compensate the sub-district appointed two retired specialist midwives to assist with complicated deliveries.

Some participants viewed patients as difficult, disrespectful, and uncooperative. When they requested assistance from senior midwives where a patient does not co-operate they were not assisted. Furthermore, midwives do have a challenge with complicated patients. These patients were informed that they should deliver at a hospital however they just arrived at the public health facility at an advanced stage in labour and the midwife had no choice but to deal with the delivery, and call in the specialist midwife.

The emotional, rational and behavioural dimension levels seem to have a negative effect on midwife employee engagement as most the findings proposed barriers in rendering maternity services. These midwives level of employee engagement are low and it may not be easy to retain them. At one public health care facility the specialist midwife specified that she is a

mentor for the younger midwives. This is an enhancer for rendering maternity services and the emotional, rational and behavioural dimensions are positive. The engagement level of this midwife is high and can be the catalyser to influence colleague's positive to render maternity services.

3.6.4 Training and development

Training and development were identified as a subtheme under 3.3.1. It is inferred that the sub-district managers do not prioritise and send midwives for specialist midwife training (one-year full- time academic and practical course). Midwives should have specialist training and short courses and continuous professional development. These are barriers in rendering maternity services and the emotional, rational and behavioural dimensions will be negative and employee engagement will be low. It will be difficult to retain these midwives.

3.6.6 Public Health Care Facility

For the purpose of this study "the public health care facility" to the infrastructure around the facility, the building itself, maintenance of the building and infrastructure, support services and the management thereof. Public health support services for the midwife include sufficient medication, ambulance services and enough space to conduct private deliveries.

Access to treatment by public health facilities is affected by ineffective health care systems which render services at a cost that the country/province/district cannot afford, long distances to public health facilities, as well as poor transportation thus making it difficult to reach public health facilities (Mokomane *et al.*, 2017:128).

The National Core Standards of South Africa (2011:26) defined clinical support services as specific essential services that include the availability of medicines, efficient provision of diagnostic, therapeutic and clinical support services including medical technology, as well as a system to monitor the efficiency of service delivery, in this study quality maternity services.

An audit of ambulance services found that 82% of paramedics who transferred patients by means of roads to next level of service facilities resulted in adverse events due to inadequate monitoring, absent venous access and cardiac arrest during transfers. Further training in advanced life support for paramedics and the use of a specialised team for maternity, new-born and paediatric critical care support cases can reduce adverse events (Venter *et al.*, 2016:58).

This study reveals that the environment was not conducive specifically for intrapartum service delivery as some public health facilities have only 2 beds next to each other which leave no room for privacy during the delivery of the new-born. There is also a shortage of equipment

such as cardiotocograph machines. A shortage of medications was also identified e.g. syntocinon which leads to the referral of pregnant women in the beginning stage of delivery to the next level facility, causing an overload on another public health care facility.

With this research barrier were identified with regards to public health facilities and the emotional, rational and behavioural dimension is negative and therefore employee engagement will be low. These midwives will be difficult to retain when they can get a post within a better work environment.

3.7 SUMMARY

In this chapter, open coding was used to analyse the data for initial codes and categories. Themes and sub-themes were identified, discussed and embedded with literature findings. Finally, the research findings were integrated with the theoretical model which was the scientific underpinning of the study. Concluding statements were derived and the level of employee engagement was highlighted. In Chapter 4, the overall conclusion, recommendations, and limitations of the study will be discussed.

CHAPTER 4

CONCLUSIONS LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In chapter 3 the outcomes of the empirical research embedded in literature findings were discussed as well as the integration of results with Gupta and Aileen's theoretical model that underpinned the study. Conclusions were derived based on the findings in order to determine which drivers are enhancing and which are barriers for employee engagement. In this chapter the researcher discussed conclusions, limitations and recommendations to improve midwife employee engagement in a rural sub-district of the North West Province. Recommendations are based on the theoretical model which served as the scientific underpinning of the research. Further research that needs to be done were also identified.

4.2 ENHANCERS AND BARRIERS FOR MIDWIFE ENGAGEMENT

In this study barriers and enhancers were identified. The integrated findings obtained from the analysis of data from the semi-structured interviews will be discussed according to the drivers that influence the dimensions of decision.

4.2.1 Team Work

This driver identifies only barriers in maternity service delivery and has a negative impact on employee engagement. It may be a challenge to retain midwives if a better employment in an urban situation becomes available. The barriers are:

- Shortages of midwives especially at night where both maternity- and emergency cases need to be managed.
- Large rural catchment area that public health facilities need to render maternity services to.
- Unbooked maternity patients arriving at public health care at a late stage of a complicated intrapartum phase who should rather be delivering at a hospital.
- Unbooked cases increase the tasks that need to be done e.g. HIV counselling and testing, ART management during the intrapartum phase and blood that needs to be taken as well as record keeping that takes longer. These unbooked cases complicate the implementation of policies and guidelines.
- No doctor available at these public health facilities.

- Shortage of specialist midwives as they cannot be on duty for 24 hours, they can however be called to come and assist if they are available.

4.2.2 The role of operational managers

The operational managers of public health facilities are responsible for maternity services. They are supported by a specialist midwife in an advisory capacity if the operational manager is not a specialist midwife. In this study, only one operational manager was a specialist midwife.

The following enhancers were identified and relate to employee engagement of 50% of the midwives who participated in the research.

- Operational managers are helpful.
- They do not behave superior to the midwife.
- The Ubuntu principle is enhanced.
- They are objective, assertive and unbiased.
- Some operational managers are approachable.
- They are supportive.
- They assist in obtaining equipment.
- Some address the challenges of midwives satisfactory.

The following leadership barriers have a negative effect on midwife employee engagement according to 50% of participants of midwives:

- Unsupportive.
- Unapproachable.
- Unable to address clinical challenges in the sense that they cannot provide answers.
- Negate clinical challenges as instructions from the sub-district office.
- Some midwives state that there are relationship challenges with their operational managers.
- Midwives feel wronged when they discuss issues with operational managers.
- Favouritism and nepotism are present.

Considering these findings 50% of midwives identify enhancers that relate to the emotional, relational and behavioural dimension. It has a positive effect on midwife employee engagement. 50% of midwives are proud and satisfied with their allocated operational managers while the other 50% of midwives are negative about their allocated operational manager. The conclusion can be made that 50% of midwives could be difficult to retain.

4.2.3 Job characteristics

To render quality maternity services a midwife should have the required training and specialities as stated by the South African Nursing Council. Training is provided at an accredited Higher Education Institution that should be accredited and certified by the South African Nursing Council. Practical skills are obtained by an accredited health care facility. Barriers are as follow:

- One public health care facility does not have an appointed specialist midwife as the midwife was transferred to the sub-district office.
- Midwives experienced patients as difficult, disrespectful and uncooperative.
- If junior midwives request assistance from senior midwives when patients do not cooperate they were not assisted.
- Midwives have challenges with high-risk, complicated and unbooked patients.

Midwives' level of employee engagement is low and it may be a challenge to retain them.

One enhancer was identified for 4.2.3, Job characteristics. This can be a catalyst to influence midwife's positivity to render maternity services.

- In one public health care facility, the specialist midwife indicated that she is a mentor for the younger midwives.

4.2.4 Training and development

In this section, only barriers were identified. The level of employee engagement amongst midwives is low and it may be a challenge to retain them.

- Training as a driver for midwife job satisfaction needs attention.
- Lack of opportunity for continuous professional development.
- Sub-district does not prioritise midwife specialist training.
- Workshops rendered when maternity policies and guidelines change are usually attended by the operational manager.

- Lack of career advancement.

4.2.5 Public health facilities

The barriers in public health facilities are:

- The environment is not conducive specific for intrapartum service delivery as some public health facilities have only 2 beds next to each other. There is no room for privacy during labour and delivery.
- Unavailability of equipment such as cardiotocograph and baby warmer.
- Medication, i.e. Syntocinon out of stock.
- Delay in transfer of patients and the unavailability of the emergency ambulance incubator. There is one ambulance with an incubator for the Ngaka Modiri Molema District.

The level of employee engagement of these midwives are low and it will not be easy to retain them. Attention must be given to “Public health facilities” as a driver for midwife job satisfaction

4.3 EVALUATION OF RESEARCH OUTCOME

The research question “What is the experience of midwives’ regarding employee engagement within the public health facilities in a rural sub-district of the North West Province of South Africa?” was asked with the aim and objective and outlined as:

4.3.1 Research Aim

The aim of this research is to derive recommendations on how public health facilities could improve employee engagement amongst midwives, to enhance maternity service delivery and improve staff retention.

4.3.2 Research Objective

The objective of this study is to explore and describe the way in which midwives experience employee engagement in public health facilities in a rural sub-district of the North West Province of South Africa.

The objective of this study was reached after 23 semi-structure interviews were conducted with concurrent data analysis until no new information emerged. Data analysis was done by content analysis codes, themes and sub-themes were discussed. This research reached its aim as employee engagement seems to be very low in the rural public health facilities as proved by

more barriers than enhancers for employee engagement. Limitations are declared and recommendations are presented to support the sub-district, district and NWDoH management to improve midwife engagement.

4.4 LIMITATIONS

This study was conducted only in one rural sub-district of the North West Province. The findings cannot be generalised and extrapolated to other public health facilities rendering maternity services in the North West Province or rural facilities of other Provinces.

4.5 RECOMMENDATIONS FOR SUB-DISTRICT AND NWDOH MANAGEMENT

Recommendations are based on the scientific model of Gupta and Aileen and the integrated data analysis findings.

- Additional specialist midwife or midwife should be on call to address midwife shortages especially, during night shifts when more than one maternity patient needs attention and there are other emergency cases in the waiting room.
- Unbooked cases are difficult to address with the current staff shortages and limited support.
- Antenatal patients should be encouraged to reveal their HIV status to the family, this is the main reasons for the unbooked patient.
- Midwives should have the latest guidelines on their phones and follow protocols in case of unbooked maternity patients arriving at public health care at a late stage of the intrapartum phase that are complicated and who should deliver at a hospital level. The specialist or an experienced midwife should be called for assistance. This measure can assist with the additional workload caused by unbooked complicated cases.
- The shortage of doctors in remote rural areas will not be addressed overnight. However, the next level facility or doctor consulting high priority antenatal patients at the clinic mobile phone numbers should be available for assistance.
- The sub-district office should prioritise training of at least one experienced midwife to become a specialist midwife. The midwife should be selected according to performance and contract criteria such as a binding contract of 2-3 years to ensure that the midwife does not misuse the opportunity for career advancement.

- For training specialist midwife, the age of applicant should be criteria. If the oldest midwife is chosen it will not have any advantage because as this specialist midwife retire there will be a human resource gap again.
- The midwife should have the ability to deal with policies and new guidelines. Oversee training of all midwives and ensure implementation of the guidelines as far as possible.
- The chosen midwives should also have the ability to communicate and train midwives to deal with complications e.g. a breech or face to pubis delivery.
- The formulated criteria for a midwife or specialist midwife training program for continuous professional development should be provided by sub-district office to ensure midwives practice meet standards and updated with the latest policies and guidelines.
- Career guidance for advancement should be given by management and appointments should meet the criteria to enhance quality maternity service delivery.
- Operational managers with the necessary skills should be appointed. There should be specific training sessions at sub-district office focussing on leadership skills. Examples are, how to deal with conflict between employees and empowering of public health facility staff to ensure that quality service delivery can continue in his/her absence.
- Training for operational managers should focus on soft skills required by an operational manager, i.e. supportive, fair, objective, assertive and approachable.
- Operational managers should have sufficient knowledge of all services rendering by the public health facility but if not a specialist midwife utilise the specialist midwife to ensure quality maternity services. The specialist midwife can assist to address clinical challenges and escalate issues to the sub-district level.
- Clinical challenges will stay a reality and repeat unless steps are taken to address them.
- Favouritism and nepotism should be reported and dealt with according to the grievance procedure.
- Midwives experienced patients as difficult, disrespectful and uncooperative. Every maternity patient is unique and midwives should be supported by means of in-service training on how to manage maternity patients. Rude management of maternity patients will lower the image of a midwife in the community.
- The specialist and experienced midwives should support junior midwives requesting any assistance as skills and experience develop with practice.

- The multidisciplinary team and managers (sub-district-, mother and child health manager) should deal with maternity investigations sensitively. Most of the time actions are not completed and recorded and thus the reason for midwives to account for complicated patients. Midwives should also know that if actions are not recorded is not done.
- The environment of some public health facilities is not conducive for intrapartum services as these facilities have only 2 maternity beds next to each which leave no room for privacy during the delivery at remote rural public health facilities. With the increasing population growth and immigration, the facilities are inadequate.
- Operational managers should make budget provision, request and motivate equipment, medication, and staff needed to ensure safe practice during maternity services.
- The sub-district manager can budget for at least one mobile incubator which can be stored with ambulances to be available within the sub-district when needed.

4.6 FURTHER RESEARCH

The research was only conducted in one sub-district of North West Province. Further research is required in other sub-districts and districts. From the results of this study the following research topics are recommended:

- The midwives experience maternity patients as difficult, disrespectful and uncooperative. Qualitative research about how new mothers experience delivery at the public health facilities would be insightful experiences from both parties can be obtained.
- A research study to determine how the ideal multidisciplinary team looks will enhance quality maternity services.
- A research study eliciting the contribution to quality maternity services when at least 2 specialist midwives are allocated at rural public health facilities.
- A research study developing a training package for the needs of operational managers to manage human resources.

CONCLUSION

In this chapter the researcher identified the enhancers and barriers for quality maternity service delivery as obtained from the qualitative empirical research and the integration thereof with the Employee engagement model of Gupta and Aileen. The evaluation of the research indicates that the objective and aim of the research were met. The limitations of the study were outlined

and recommendations for the sub-district, district and North West Department of Health were formulated. Further research recommendations were identified.

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ADDENDUM A: HREC APPROVAL



Dr CE Muller
Nursing sciences
NUMIQ

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Web: <http://www.nwu.ac.za>

Health Sciences Ethics Office for Research,
Training and Support

North-West University Health Research Ethics
Committee (NWU-HREC)
Tel: 018-285 2291
Email: Wayne.Towers@nwu.ac.za

07 February 2019

Dear Dr Muller

APPROVAL OF YOUR APPLICATION BY THE NORTH-WEST UNIVERSITY HEALTH RESEARCH ETHICS COMMITTEE (NWU-HREC) OF THE FACULTY OF HEALTH SCIENCES

Ethics number: NWU-00105-18-S1

Kindly use the ethics reference number provided above in all future correspondence or documents submitted to the administrative assistant of the North-West University Health Research Ethics Committee (NWU-HREC) secretariat.

Study title: Understanding employee engagement among midwives in public health care facilities in a sub-district, North West Province

Study leader: Dr CE Muller

Student: VLT Mothwane-16098005

Application type: Single study

Risk level: Minimal (monitoring report required annually)

Expiry date: 29 February 2020 (monitoring report is due at the end of February annually until completion)

You are kindly informed that after review by the NWU-HREC, Faculty of Health Sciences, North-West University, your ethics approval application has been successful and was determined to fulfil all requirements for approval. Your study is approved for a year and may commence from 07/02/2019. It, however, requires the following further conditions specific to the progress of the study:

- Please provide the HREC with a copy of the goodwill permission letter from the sub-district Department of Health
- Please provide the HREC with copies of the goodwill permission letters from the hospital and the PHC
- Please provide the HREC with copies of the goodwill permission letters from the operational managers of the PHC and the maternity unit in the hospital

As the study progresses the aforementioned conditions should be submitted to Ethics-HRECProcess@nwu.ac.za with a cover letter with a specific subject title indicating "Outstanding documents for approval: NWU-XXXXX-XX-XX." The letter should include the title of the approved study, the names of the researchers involved, that the documents are being submitted as part of the conditions of the approval set by the NWU-HREC, the nature of the document i.e. which condition is being fulfilled and any further explanation to clarify the submission.

The e-mail, to which you attach the documents that you send, should have a *specific subject line* indicating the nature of the submission e.g. "Outstanding documents for approval: NWU-XXXXX-XX-XX". The e-mail should indicate the nature of the document being sent. This submission will be handled via the expedited process.

Continuation of the study is dependent on receipt of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation. A monitoring report should be submitted two months prior to the reporting dates as indicated i.e. annually for minimal risk studies, six-monthly for medium risk studies and three-monthly for high risk studies, to ensure timely renewal of the study. A final report must be provided at completion of the study or the NWU-HREC, Faculty of Health Sciences must be notified if the study is temporarily suspended or terminated. The monitoring report template is obtainable from the Faculty of Health Sciences Ethics Office for Research, Training and Support at Ethics-HRECMonitoring@nwu.ac.za. Annually, a number of studies may be randomly selected for an internal audit.

The NWU-HREC, Faculty of Health Sciences requires immediate reporting of any aspects that warrants a change of ethical approval. Any amendments, extensions or other modifications to the proposal or other associated documentation must be submitted to the NWU-HREC, Faculty of Health Sciences prior to implementing these changes. These requests should be submitted to Ethics-HRECAppl@nwu.ac.za with a cover letter with a specific subject title indicating, "Amendment request: NWU-XXXXX-XX-XX". The letter should include the title of the approved study, the names of the researchers involved, the nature of the amendment/s being made (indicating what changes have been made as well as where they have been made), which documents have been attached and any further explanation to clarify the amendment request being submitted. The amendments made should be indicated in **yellow highlight** in the amended documents. The e-mail, to which you attach the documents that you send, should have a *specific subject line* indicating that it is an amendment request e.g. "Amendment request: NWU-XXXXX-XX-XX". This e-mail should indicate the nature of the amendment. This submission will be handled via the expedited process.

Any adverse/unexpected/unforeseen events or incidents must be reported on either an adverse event report form or incident report form to Ethics-HRECIncident-SAE@nwu.ac.za. The e-mail, to which you attach the documents that you send, should have a specific subject line indicating that it is a notification of a serious adverse event or incident in a specific project e.g. "SAE/Incident notification: NWU-XXXXX-XX-XX". Please note that the NWU-HREC, Faculty of Health Sciences has the prerogative and authority to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.

The NWU-HREC, Faculty of Health Sciences complies with the South African National Health Act 61 (2003), the Regulations on Research with Human Participants (2014), the Ethics in Health Research: Principles, Structures and Processes (2015), the Belmont Report and the Declaration of Helsinki (2013).

We wish you the best as you conduct your research. If you have any questions or need further assistance, please contact the Faculty of Health Sciences Ethics Office for Research, Training and Support at Ethics-HRECAppl@nwu.ac.za.

Yours sincerely



Digitally signed by Wayne Towers
Date: 2019.02.07 09:12:08 +02'00'

Prof Wayne Towers
Chairperson: NWU-HREC



Digitally signed by Prof Minnie Greeff
DN: cn=Prof Minnie Greeff, o=nw, email=minnie.greeff@nwu.ac.za, c=za
Date: 2019.02.07 15:00:53 +02'00'

Prof Minnie Greeff
Head of Health Sciences Ethics Office for Research, Training and Support

Current details: (25239522) G:\My Drive\Research and Postgraduate Education\1.5.3 Letters Templates\1.5.4.1_Applival_letter_HREC.docm
30 April 2019

File reference: 1.5.4.1

ADDENDUM B: ETHICS APPROVAL DEPARTMENT OF HEALTH: NORTH WEST PROVINCE

Addendum B: Ethics Approval Department of Health: North West Province



POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Ms. V.L.T. Mothwane
North West University

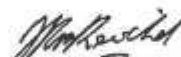
Physical Address : 11 Hoffmann Street
(Work/ Institution) : Patchefstroom
2531

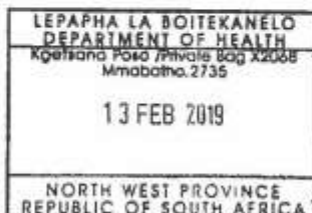
Subject : Research Approval Letter- Understanding employee engagement
among midwives in public health care facilities in a sub-district,
North West Province.

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

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

Kindest regards


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



12/02/2019
Date


P.P.C. E. Muller
Researcher

27/2/2019
Date



Healthy Living for All

ADDENDUM C: INFORMED CONSENT

Addendum C Mrs VLT Mothwane_ Cover Letter and Informed Consent

Cover Page of the semi-structured interview

Title of the study: Understanding employee engagement of midwives in public health care facilities in a sub-district, North West Province.

The purpose of the study is: To understand employee loyalty under midwives' in selected public health facilities in a quantile 2 rural sub-district of North West Province of South Africa. To derive recommendations which can be implemented in line with current retention strategies to enhance maternity service delivery and improve staff retention.

The objective of the semi-structured interview: To explore and describe midwives' perception of engagement in public health facilities in a quantile 2 rural sub-district of the North West Province of South Africa

Thank you for agreeing to participate in this study. My name is Valencia Mothwane and I am a Master student at the North West University. I am interviewing midwives on their experiences regarding commitment and loyalty; their work environment during intrapartum services delivery in the public health facilities. The interview will also include questions regarding the midwives relationship with their operational manager. I would like to ensure you that the response is confidential and private.

Please feel free to contact the researcher if there are any questions you would like to clarify: Mrs Valencia Mothwane, student number 16098005 – (c) 0825936210.



Private Bag X1290, Potchefstroom
South Africa 2520

Tel: +2718 299-1111/2222

Fax: +2718 299-4910

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

HREC Stamp	Facility number	
	Date	
	Participant number	

**INFORMED CONSENT DOCUMENTATION FOR
MIDWIVES INVOLVED IN INTRAPARTUM SERVICE
DELIVERY IN A PUBLIC HEALTH FACILITY**

TITLE OF THE RESEARCH STUDY: Understanding employee engagement of midwives in public health care facilities in a sub-district, North West Province.

ETHICS REFERENCE NUMBERS:

PRINCIPAL INVESTIGATOR: DR C E Muller

POST GRADUATE STUDENT: Mrs V L T Mothwane

ADDRESS: North West University Potchefstroom Campus

11 Hoffman Street

Potchefstroom

2520

CONTACT NUMBER: 018 299 1832

You are being invited to take part in a **research study** that forms part of a Masters study. Please take some time to read the information presented here, which will

explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU.....) and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- *We plan to do an interview where we describe midwives' experiences regarding commitment and loyalty and their work environment during intrapartum services delivery in the public health facilities. The interview will also include questions regarding the midwives relationship with their operational manager.*
- *This study will be conducted at your health care facility in a private comfortable room and will be done by experienced health researchers trained in ethics and how to conduct individual interviews. A minimum of 20 participants will be included in this study.*

Why have you been invited to participate?

- *You have been invited to be part of this research because you are a professional nurse with a midwifery qualification (either diploma/ degree/ advanced diploma) working or rotating in maternity section of public health care facility for more than 6 months and you are involved in intrapartum care.*
- *You will unfortunately not be able to take part in this research if you are a professional nurse without a midwifery qualification.*

What will be expected of you?

- *All the midwives will be invited to attend a power point presentation that will take approximately 20 minutes on two different occasion. This presentation will be done by the researcher to inform you about the research project. Afterward time will be given to ask questions about the research project. If you are interested to be part of the research project, you will be given two consent forms with a minimum of 12 hours to decide whether you would like to*

participate or not. If you decide to participate, you will take the two informed consent forms to the independent person, who will co-sign with you and keep one of the informed consent forms in a non-transparent box until the researcher comes to collect the forms. The other informed consent form will be given back to you for your own perusal.

- *You will be expected to take part in a semi-structured individual interview of 30-45minutes with six (6) questions on a day and time that will suit both you, the facility and the researcher. Interviews will be digitally recorded for data collection and analysis purposes and by signing the informed consent form you give permission to the researcher to digitally record the interview. The interviews will take place during October to November 2018. A follow up interview might be requested only if it is necessary to clarify misunderstandings.*

Will you gain anything from taking part in this research?

- *There will be no direct gains for you in this study.*
- *The other gains of the study is for the Department of Health sections under mother and child care and human resources, they will receive recommendations derived from this research to enhance maternity service delivery and improve midwife retention especially for rural areas.*

Are there risks involved in you taking part in this research and what will be done to prevent them?

The risks to you in this study are minimal the following table explains the risks of taking part in this study and the precautions.

Risks	Precautions
<i>It can happen that when an individual interview is scheduled you are busy with intrapartum care.</i>	<i>Intrapartum care cannot be given over to another midwife. If the researcher came across such a situation, the interview time will be scheduled for another time to ensure care to the patient is not interrupted.</i>
<i>Some questions can cause emotional feelings.</i>	<i>A psychiatric trained professional nurse will be arranged to be available for counselling purposes if needed. You can then be referred for counselling and will have the right to withdraw information provided if you would like to.</i>
<i>Risk of loss of confidentiality and privacy</i>	<i>The interview will be conducted in a private suitable room. The researcher will post a note indicating do not disturb on the door. The personal details or information discussed will not be revealed in any way.</i>

There are more gains for you in joining this study than there are risks. Your contribution can help to assist with suggestions to enhance maternity service delivery and improve midwife retention especially for rural areas.

How will we protect your confidentiality and who will see your findings?

- *Anonymity of your findings will be protected by using an independent person to assist in obtaining informed consent and the independent person will keep all the informed consent forms in a non-transparent sealed box, which the researcher will collect afterwards. Anonymity will be further ensured by not revealing identifying measures and not disclosing any information that could be connected to you. Your results will be kept confidential by removing your name from the transcript only a p for participant will be used. Your privacy will be respected by conducting semi-structured interviews in a private suitable room.*
- *Only the researcher, the supervisor, independent co-coder and transcriber will be able to look at your findings. Findings will be kept safe by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. As soon as data has been transcribed it will be deleted from the recorders. Data will be stored for five years in the supervisor's office in a lock cupboard for auditing purposes only. After the study all voice recordings will be removed from the researcher's computer and will be stored on the supervisor's computer with password protection.*

What will happen with the findings or samples?

- *The findings of this study will only be used for this study outcome only.*

How will you know about the results of this research?

- *We will give you the results of this research during August 2019 by means of a research report, which will be send to the operational manager of each facility. The operational manager will be asked to share it with all the midwives whether they participated or not. The researcher plan to present at the Society for Midwives of South Africa (SOMSA) and North West Health Research day and will contact the operational manager and provide details to him/her. You can attend as the sub-district is near the venue.*
- *You will be informed of any new relevant findings by the district specialist team member concerned with mother and child care.*

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

This study is not funded. No you will not be paid to take part in the study because there are no traveling costs for you and the interview will take place on duty at a time convenient for the Public Health Facility and you. Refreshments will be served after the completion of the semi-structured interview.

Thus there will be no costs involved for you, if you do take part in this study.

Is there anything else that you should know or do?

Addendum C Mrs VLT Mothwane_ Cover Letter and Informed Consent

- You can contact Valencia Mothwane at 0825936210 if you have any further questions or have any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I agree to take part in the research study titled: Understanding employee engagement of midwives in public health care facilities in a sub-district, North West Province.

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

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

.....
Signature of participant

.....
Signature of independent person

Declaration by person obtaining consent

I (*name*) declare that:

- I clearly and in detail explained the information in this document to

.....

- I did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

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

20....

.....
Signature of person obtaining consent

Declaration by researcher

I *Valencia Mothwane* declare that:

- I trained the independent person, whom explained the informed consent to the participant.
- I did not use an interpreter.
- I was available should the potential participant want to ask any further questions.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

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

.....

Signature of researcher

ADDENDUM D: PROOF OF TRANSCRIPTION, CORRECTED

Mrs VLT Mothwane: Proof of transcript, corrected

1 PUBLIC HEALTH FACILITY D: PARTICIPANT 6

2 (Beep beep)

3 I: Oh, eh, eh, good evening, eh, my name is Valencia Motwane, I am a student from eh,
4 Potch University under North West, eh, University. And then, thank you for your interest
5 and participation in my eh, eh, eh study and then I'm going to ask you few question,
6 neh? Firstly, before I can ask you, eh, the word engagement will appear time and again,
7 so I just want to explain so that you will understand what is it. It is all about work
8 commitment, engagemente, eh, satisfaction... that can lead you into staying in the
9 organisation, other than leaving the organisation. And then, another, eh, concept will be
10 peri-partum phase period, which is the period from conception until delivery of the, of
11 the... baby. So, I'm just going to ask you few question. Okay, the first question that I am
12 going to ask you, what is your experience working at the clinic?

13 P: Clears throat. Sorry? Okay, I started working in this hospital as a midwife... in twe...
14 2009 because I went for Professional Nurse training from 2005 until twenty-eight, five,
15 six, seven, eight, then I started to work then, 2009.

16 I: Okay, so you started working at this clinic in 2009? (Long pause) ah...

17 P: No; I started, I started working here 1993 as general assistant... as general worker,
18 then I became general nursing assistant. Then, in 2005, is then when I went to do the
19 D4.

20 I: Hmm

21 P: Cos...

22 I: you are the most fortunate one, neh? Okay, so, in this maternity unit, when have you
23 started? When did you start... working?

24 P: In 2009

25 I: Oh, as a professional nurse as midwife

26 P: Yes

27 I: Okay, so I just want to know, are you advanced or are you trained, as an advanced
28 midwife?

29 P: Yes, I trained as advanced midwife in 20..15

30 I: Okay

31 P: Yes. Because...even this school, I... eish. We applied, neh? We were like, something
32 about nine. Others, they applied for... I don't know whether is it relevant answer or
33 what, because others apply for enrolled nurse, others applied for bridging courses then I
34 applied for advanced midwife. Midwifery. And then they gave us... the reply. Our study

35 leave was apparently approved ... then, later on, they called a meeting telling us that no,
36 we are not going to school any longer because they are telling us about the ... embargo...
37 there is no money apparently in the hospital they were telling us about shortage of staff.
38 Then I decided to go to Marata College of Nursing... on the day of, when they (inaudible)
39 open, it was on the first, the fifth of January. I explained my problem to the... principal at
40 the college (long pause) and then he understand my story he encouraged me to go and,
41 and, see the union...

42 I: Hmm

43 P: And then I lodged my complain, apparently they help me ... that is when ... I went to
44 the school.

45 I: Hmm, okay. And then, how does this experience eh, impac on your engagement. Isn't
46 it that you've got exper-, eh, eh, so much experience and you've seen things, eh, that,
47 eh, when you were work, as, ever since you started working here? How does it affect
48 your work commitment? (long pause) Just in brief of eh, what is going on here
49 experience that you eh, eh, eh, gained here, ever since you come working here? What
50 have you seen? What have you discovered? Ja... as a worker?

51 P: Experience – as... advanced or what?

52 I: No. As a midwife working in this eh, eh, hospital (long pause) What have you seen,
53 like, eh, what is going on in this maternity?

54 P: (mutter) What I can say here really in maternity, we are working under... pressure
55 (emphasised)

56 I: Ah-hm

57 P: And our management, we are trying our level best, but there is no appreciation. Like,
58 when we are working (pause), like I'm working night duty right now.

59 I: Mmm

60 P: I am working with, we are only two RN, in labour rooms. And this is the

61 I: Mmm

62 P: Level two hospital... is a referral, we are catering for clinics and patient from outside,
63 from the community, neh? And then, when it happens that, maybe we have emergency
64 to go to MPH, Mafikeng Provincial Hospital.... Our EMRS personnel, sometimes they
65 need... escort. Now we have to ... be alone. When other RNS escorted patient, they are
66 going to stay alone in labour rooms. There's caesarean sections in between emergencies
67 (pause) And, w... there is NNU unit and post-C-sections that they are admitting in this
68 unit. We have to work in labour rooms, and they expect us to come again, to work in,
69 NNU

70 I: Neonatal unit?

- 71 P: Yes
- 72 I: Okay.
- 73 P: Sometimes we will be busy in labour rooms, you don't have time to come this side...
- 74 they blame you for that.
- 75 I: Hmm. Okay. Other things you will eh, eh, talk when you are still – okay. Eh, how does
- 76 your experience of mothers during inter-partum phase impact on your engagement?
- 77 P: (long pause) I grew up admitting pregnant women here and then we are delivering
- 78 and in...
- 79 I: So, what can you say about then pregnant women who are coming here and then
- 80 patient who are being delivered whatever, anything that you can say about them? In
- 81 your work. Yes.
- 82 P: (Pause) I think I can say (long pause) Like when we are working in... my experience ...
- 83 mmmm... I don't know whether it was last year or when, neh? I was allocated in... post-
- 84 natal ward. We are calling it Hatfield ward. And then (pause). Let me just say, I was on
- 85 leave. When I came back, I was allocated here in labour rooms, neh? There was two
- 86 professional nurse... in, post-natal ward, also two... professional nurse. Then when I
- 87 came, our operational manager call the one... professional nurse at her office... tell him
- 88 to go and work in post-natal ward. And our labour rooms are so busy. We've got four
- 89 beds ... Sometimes, the beds will be full, other patient will be seating on the chairs.
- 90 Waiting for you to... complete her thing, assessing others, neh? And then I ask her, Why
- 91 are you saying this professional nurse must go and work in ... post-natal for, because we
- 92 know our labour rooms are so busy
- 93 I: So, Meaning that labour ward was going, gonna be left with one; sister.
- 94 P: Two
- 95 I: Oh, two
- 96 P: (Inaudible) there were two then, I was going to be the third one
- 97 I: Ah-hm
- 98 P: Then he take this one to, to go and that side, neh? And usually, PNC is, they allocate
- 99 two professional nurses
- 100 I: Ah-hm
- 101 P: Neh?
- 102 I: So,
- 103 P: And I think, because it was me, or (stammering) like, they can say, it was personal, I, I,
- 104 I don't know, but I can say that. Then I ask her, 'why are you saying this one must go and

105 work that side. Since when (inaudible) three professional nurses working post-natal
106 ward. Then she said, 'no, (stammering) PNC has got more work blah, blah, blah'. Then I
107 say, 'Oh, because (inaudible) oh, because I'm back, now you send other one to, to
108 (inaudible) but it's fine because, when we are sitting here, doing nothing. It's fine.

109 I: Okay,

110 P: And then it happens, I was, the following month, they allocate me to that post-natal
111 ward... and I was allocated alone. All (emphasised) professional nurses, they allocated
112 back to labour rooms. (pause) And, we'll be working with assistant nurse. It will be you,
113 professional nurse and assis-, two. And it's gynae, ANC, PNC. You have to work all those
114 ... wards. Gynae, there's abortions... PNC, you immunise the babies, you do the PCR's,
115 you check the the mother for PPH. ANC, you check the, the, the, if, when they are in
116 labour, you do the, the, the, what again? (pause). Click. You use partogram, you upload
117 them and transfer to, to, maternity. (pause) And there's ward doctors' rounds

118 I: Hm

119 P: Neh? And you will be alone (pause) Sigh, and then one day it happens (pause) I had
120 maternal death, and operational manager, from PNC, usually... always is not hands-on.
121 She'll be visiting (pause) to maternity, sitting with operational manager... of maternity...
122 doing nothing. You'll be going up and down, that is why I'm saying, or when we are
123 going to theatre, maybe like, there's elective Caesars. After elective Caesar, you are
124 going to start where you have ended. Kor, no one will say eh-eh, at least someone is
125 go(inaudible) so let me just give treatment or what, what. You have to go to elective
126 Caesar. When you come back, you will have to start, give patient treatment, do blah,
127 blah, ko re, or, eh-eh, this...I really don't know what to say...

128 I: Hmm.

129 P: But we are working under pressure. Really.

130 I: Hmm. Ja, I understand you. Umm, I just want to know, how does your experience of
131 your colleagues impact your engagement?

132 P: (Long pause) Go re, we are working with, eh, colleagues, we are not working alone

133 I: Mmm

134 P: Mmm (pause) I can say, we are trying to, to support each other because other, they
135 have just passed, some they don't have... that experience. Now we are trying to because
136 we, we, we see that management, they don't care for us, but, for us, at least we are
137 trying – there's teamwork. Team spirit, teamwork. At least we are... are getting there.

138 I: What did you do, if the management are not doing anything? What did you do? You
139 just left it like that. What have you done? As a staff?

140 P: Nothing.

141 I: (Pause) So, they are not aware?

- 142 P: They are
- 143 I:...That you, you, you, are like, working under pressure because you are not doing
144 anything. You are not reporting eh, eh, eh, anything
- 145 P: To them, or outside?
- 146 I: Like, you say, you are working under pressure... and then you don't get help from
147 them...
- 148 P: (Interrupts) No, no, no.
- 149 I: So, I just want to know...
- 150 P: (Interrupts) Let me rectify myself...
- 151 I: Hmm
- 152 P: Like, we'll be complaining to them. They'll be saying, 'there's no staff or blah, blah,
153 blah, but we do, complain, even on the meetings and what, what, what what. But for, to
154 reporting outside, eh, we have decided to, just leave it like that because we have always
155 complaining that, never taking us for gr-, into consideration.
- 156 I: And then, what is your experience of your relationship with the operational manager?
- 157 P: Oh, that one eh, is zero. I don't want to lie.
- 158 I: What is zero? I don't understand
- 159 P: Zero is like, I mean, when we are, when we are operational manager (long pause)
160 mmm, I think when you see this shortage of staff, we have to, to help your staff where
161 we can. But she came in, at seven o'clock, she'll be sitting on the table, she going to –
162 when the ambulance bring the patient, she'll be just saying, even if you are alone in the
163 labour room, they know that you alone, they going to work, you'll be alone; they'll be
164 just sitting there, they can't say, no, no, no, that one is, or they even don't care. Have
165 you had your lunch time or tea time? They'll just... take their bags at 16 hours and went
166 home, is their every day (pause) business. They do, they don't do anything, they say they
167 are doing something else and I don't think you can use that every day.
- 168 I: And then, I heard you saying that eh, there's a ward meeting somewhere, somewhere.
169 Have you ever tried eh, addressing this in the ward meeting? That you are not coping
170 and then, eh, you need help?
- 171 P: When there is conference, we, we, used to, to, to do the conference meeting. Kor, is
172 like that, we (pause) what ca-, how can I put it? (Pause) Like, when we are saying
173 something, they'll be, it, like, they are going to target you. Kor, always they'd be saying,
174 'you actually saying, we are not doing anything? Ko re they, they'll just be passing their
175 remarks, you see? Something like that.
- 176 I: (Long pause) Yoh!

177 P: So, when I

178 I: What kind of a manager do you think is your manager? If you can tell me.

179 P: Hm, that is why I am saying, I don't know, that if I'm saying like... (long pause)

180 I: Are you happy with your manager, or you are not happy?

181 P: I'm not happy. (pause) I am not happy at all

182 I: Hmm

183 P: Ko re, we are just working because we don't have choice or what. But really, we are
184 not (long pause) we are not happy. And they'll be gossiping blah, blah, blah, blah when
185 you have done something wrong, they can't call you, show you he-eh, you are not
186 supposed to do this and I, I don't know how can you rectify yourself if someone doesn't
187 show you that, no, here, you are not going on the right ro-(inaudible) they'll be just
188 gossiping, just (sigh)

189 I: And then, eh, eh, this relationship that you are having with your eh, eh, operational
190 manager, how does it eh, ke, how does this relationship impact on your experience of
191 commitment in your work? (Long pause) Whatever you eh, eh, experiencing, what has
192 this experience done to you? Re-, rela, your relationship with your manager, what has it
193 done to you?

194 P: (inaudible)

195 I: Or, are you learning something, for, what have you learnt? (Stammer)

196 P: Ha-ah, mmm-mmm, I'm not learning anything from her. Even ... I remember in 29,
197 two thousand and nine, I was newly-qualified... and then I was delivering a patient, and
198 that patient was so uncooperative. And I was alone in the labour room. And I came and
199 called her, 'could you please come and talk to this lady cos she's so uncooperative?'
200 Then he said to me, 'when she's not listening to you, now... how I'm going to tell her?
201 What, what can I do? For you. Then I go back to labour rooms, then I spoke nicely to that
202 lady, at least she listened to me and then she delivered. That is when I can see that,
203 how, what kind of operational manager was. Then when I'm having problem, I just call
204 the doctor ... that's it.

205 I: So it, it means you are, you are not at, like (stammer) good working relationship with
206 your manager?

207 P: Uh-uh.

208 I: Hm, okay. And then, what is your experience of implementation of new guideline? In
209 reference to your engagement at work? (African speak) There are new guidelines that
210 has been developed in maternity and they sent you to, to, to, maternity department.
211 What are (stammer) what is your, this experience about implementation of this
212 protocols, that are of, maternity protocols that are being sent to... maternity? (Long
213 pause) Have you ever, eh, received any new protocol, new guidelines? For an example,

- 214 what I am talking about eh, at times, they say (stammer) this is a protocol on eh, maybe,
215 eh, eh, eh magnesium sulphate, eh, PIH, there's a new changes that has been done.
216 They sent you guidelines and they say, you must read it, eh, the, the hospital must read
217 it and they must, eh, change the way they've been using. So, what are you doing here,
218 what eh, eh, about the guidelines.
- 219 P: Uh-uh. No, we don't have the, the, the, new guidelines
- 220 I: But each hospital receive new guidelines
- 221 P: Uh-uh.
- 222 I: You've never received?
- 223 P: No, I don't remember
- 224 I: Like, if the head office is receiving (stammer) there's a new guideline in maternity,
225 maybe protocol on induction of labour or re, or re, or (tocolisis) of labour, they send or
226 re, to different hospital.
- 227 P: Uh-uh, that one is, we are using the old, old (Inaudible) we are using, I don't, I don't
228 know...
- 229 I: So you are... does it mean you are using outdated information?
- 230 P: I think so, because when the patient came in, let me say she's ... pre-eclampsia... we
231 are going to, I'm going to give her...five gram in each buttock and then four in 200 mls
232 normal saline. And then, we take the bloods for, for...
- 233 I: So, there's, they don't send you any new, new protocols (inaudible) Yoh! Okay, and
234 then, em, ... okay, this is the last question that I'm going to ask you. What ... what other
235 aspect have you experience that have an impact on work engagement?
- 236 P: (Long pause) Here..
- 237 I: Okay, ja.
- 238 P: (Inaudible) changes, I'm going to talk about like, off duties.
- 239 I: Ooohhh
- 240 P: Let me start first with off duties. We working seven-sevens, like ... two days. Let me
241 say Monday, Tuesday... we work seven, seven-seven, neh? And then Tuesday,
242 Wednesday we'll be off. Weekend, Friday, Saturday, Sunday we'll be in seven-seven.
243 Because of shortage, neh? And then, management, the CEO... and then he called us, and
244 then he said he want ... because this one, it was ... more with... eight, eight hours, neh?
245 And then we were saying, no, this, we are doing this because... of shortage. That is when
246 I am working with you this, you'll be (inaudible) then she, he'll be saying, 'I want 40
247 hours of duties... And then, we change off duties... to that 40 hours... Apparently that 40

248 hours... at labour rooms. When, professional (African speak) we'll be two in labour
249 rooms

250 I: Ah-hm

251 P: When one logging at 16 hours, we have to be alone in labour rooms.

252 I: Hmm

253 P: And (inaudible) is a referral hospital. (pause) You'll be alone

254 I: Have you shown, eh, eh, talk about it with your manager?

255 P: Yes, it was (inaudible) it was a meeting. Then he said, (stammer) 'it's my final
256 decision'.

257 I: (Long pause) Okay

258 P: Eh

259 I: Hmm

260 P: And then, they expect me like, when I'm working in, like in maternity, when the sister
261 in post-natal (mumble) ward, maybe she's booked sick off or what, what. Let me say
262 maternity and (inaudible) is er, one ward. They expect me to go again and work in...
263 post-natal ward. When we ask them, if something happens when we are ... that side,
264 who is going to be accountable? (Pause) There's no answer, again for that (whisper)
265 (Pause) Or that sister, who's working in post-natal ward... maybe, there's no one
266 (inaudible) tween labour rooms, maybe one of us is booked sick off, they'd be saying
267 that one must come to... maternity. She'll be leaving the ward with assistant nurse.
268 Then, when we ask them, if something because it's gynae, is PNC, is ANC. If something
269 happens that side, who is going to be ... we don't know.

270 I: Shoh!

271 P: But really, we are working under stressful situation... in this hospital.

272 I: Hmm, is that all you can say?

273 P: (Long pause) I, think that

274 I: Ke, I just want to know, if it's that all you can talk about, have you exhausted all your
275 points?

276 P: I think so

277 I: Oh. Thank you very much for your participation. Right.

278 END