SUPPORT NEEDS OF MIDWIVES WHO EXPERIENCED PREGNANCY LOSS AND ARE PROVIDING MATERNAL HEALTH CARE SERVICES IN TSHWANE DISTRICT

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A dissertation submitted in partial fulfilment of the requirements for the degree of Masters in Nursing Sciences

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DECLARATION

I, Mosima Dina Mamabolo, Student number: 14153654, declare that:

SUPPORT NEEDS OF MIDWIVES WHO EXPERIENCED PREGNANCY LOSS AND ARE PROVIDING MATERNAL HEALTH CARE SERVICES IN TSHWANE DISTRICT

This is my original work and has not been submitted before for any degree or examination at any other institution. All sources that have been used or quoted have been acknowledged by means of complete reference in the text and bibliography.

Ms MD Mamabolo
20 December 2022

DEDICATION

The study is dedicated to all the midwives who have lost a pregnancy while working in the maternity unit.

SCRIPTURE READING FROM PSALM 121

"I raise my eyes toward the mountains. From whence shall come my help. My help comes from the LORD, the maker of heaven and earth. He will not allow your foot to slip or your guardian to sleep. Behold, the guardian of Israel, never slumbers nor sleeps. The LORD is your guardian; the LORD is your shade at your right hand. By day the sun will not strike you, nor the moon by night.

The LORD will guard you from all evil; he will guard your soul. The LORD will guard your coming and going both now and forever."

You are not broken.
You did nothing wrong.
You are strong,
You are brave
and there is
Hope

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For all the graces that you have bestowed upon me, dear Lord Jesus Christ, I thank you. You took the word impossible and converted it to **I am possible**. You carried me when I lost all hope, especially in the data collection phase, being sick and lacking participants. You kept me going even when I wanted to give up.

I have always asked that, even if I may have challenges, you never leave me to walk through the fire alone. You redeemed me, helped me walk more by faith and less by sight, and reassured me, “Do not be afraid, for I am with you”. In you, I found refuge.

To my loving late mother, Miriam Edwina Mamabolo, your efforts are noticed and acknowledged. Even through death, you still show up for me. My everlasting angel, when I registered for this degree, I made a promise to myself that it would serve as a dedication to you.

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ABSTRACT

Background

Midwives are expected to provide holistic care for pregnant women during antenatal, intrapartum, and postnatal care; however, who is caring for them psychologically when they experience loss of pregnancy? Midwives also need support during their loss as they go through pregnancy and maintain a relationship with the foetus. Providing maternal care to other pregnant women may remind them from time to time of their loss. Midwives who have experienced loss during pregnancy may need a companion on the journey to motherhood, a professional friend and an employer concerned about their wellbeing. Understanding their perspective may improve staff morale and increase their confidence in caring for pregnant women.

Research question

What are the support needs of midwives who experienced pregnancy loss and are caring for other women during childbirth?

Study aim and objective

This study aimed to explore the support needs of midwives who experienced pregnancy loss and are working in maternity units.

Research designs and methods

The study used a qualitative exploratory and descriptive design. The population were midwives who met the inclusion criteria. A non-probability sample method was used, focusing on purposive sampling. Detailed descriptions of the support needs of midwives were captured during in-depth interviews and recording of field notes where data was collected and analysed to ensure trustworthiness. Data was analysed through the coding process, where the data was organised into segments of text before bringing meaning to information. Data was labelled according to patterns identified and a theme was identified with categories and sub-categories. The research was conducted in the Tshwane district and ethical principles were kept.

Main findings

There is one theme identified and it entails the support of midwives who experienced pregnancy loss and are caring for a woman during childbirth. Sub-categories were outlined based on support versus lack of support from management, counsellor, EWP, colleagues, relation to sick leave including positive and negative support in ward allocation. Most participants verbalised they had support within the mentioned sub-categories of the organisation, while others also mentioned personal motivation. The study findings assisted in formulating recommendations that may

facilitate effective support strategies for midwives. This study explored the support needs of midwives who experienced pregnancy loss and are providing maternal health care services in the Tshwane district. The recommendations entail counselling sessions conducted in the institution by the EWP for the midwives who have lost a pregnancy.

Conclusion

The study showed the support needs of midwives who experienced pregnancy loss and are working in maternity units. One theme was identified which explored the support needs of the midwives who have lost a pregnancy. Most participants shared the same views regarding the support received. Recommendations were made to try and make it easier for the midwives to cope with the loss.

KEY WORDS

Pregnancy loss, District Hospital, Midwives, Support needs, Intrauterine Death (IUD), Miscarriage and Termination of Pregnancy (TOP)

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CHAPTER 1: ORIENTATION OF THE STUDY

1.1. INTRODUCTION AND BACKGROUND

Loss of pregnancy can occur in different forms; it may be due to miscarriage caused by medical conditions, trauma, and maternal chronic illnesses (Kalu 2019:1). It has been confirmed that about 2.7 million miscarriages and stillbirths occur each year, of which 40% occurred during labour, this includes midwives who lost a pregnancy as they also mark part of statistics of those pregnant women who are recorded (Yoshida, Martines, Lawn, Wall, Souza, Rudan et al 2016:2). Midwives are expected to provide holistic care for pregnant women during antenatal, intrapartum, and postnatal care, however, who is caring for them psychologically when they experience loss of pregnancy? Or are they only to be taken care of when in hospital? After discharge it is a different story. The midwives who have lost a pregnancy could be affected psychologically, resulting in emotional instability as much as this may affect any other woman who lost a pregnancy. They may experience grief that will affect their productivity at work, which may also decrease staff morale; therefore, after the loss, enough time should be given to them or even counselling outside the workplace and through employer wellness programmes to assist them through rehabilitation back into the working environment. This will assist them in being effective in the workplace.

In a study conducted in Ireland, pregnant women felt they needed to protect their babies in utero and consequently blamed themselves after the loss of the pregnancy; this also applies to the midwives who are pregnant (Kalu 2019:2). In another qualitative study conducted in the Unites States of America (USA), Murphy (2013:12) found that after the loss of their babies, some women's feelings were directly linked to societal ideals of womanhood, and they perceived that they failed their babies by not understanding what was going on in their body. All women, including professionals, need a safe environment to carry out their work effectively. Midwives have limited access to mental support, which may indicate that they need emotional and psychological support. According to an Australian study by Hurley et al (2018:35), women may require an organizational culture that supports their loss so they can be supported through the loss of pregnancy (Fernández-Basanta et al 2020:15).

Kalu et al (2018:72) identified psychosocial factors that impact the confidence of midwives to provide bereavement support for other women they are caring for at the time of their loss which is inner strength, organisational support and organisation of client care. Like any mother, these midwives may experience grieve when they care for a pregnant woman while they are still dealing with their unresolved emotions relating to their perinatal loss, but they tend to experience intense grief because of the physical and psychological relationship of the mother

to the baby in utero as they have established a more intense bond than fathers (Kalu 2019:1). The loss of a pregnancy can raise several questions and worries about the reason why it happened and the chances of recurrence (Bellhouse et al 2018:45). An Australian study relating to pregnancy loss while providing maternity healthcare services to other pregnant woman investigated the impact of pregnancy loss on relationships with family and friends. The study found that women often felt that their family and friends did not understand their experience and did not feel their loss as others validated it. The women reported feelings of helplessness, self-blame and guilt associated with the miscarriage, isolation, and loneliness. Furthermore, the study outlined that social networks and religion play an important role in supporting women following the loss of pregnancy (Bellhouse et al. 2018:2).

As such, there are different religions and spiritual beliefs, where religious and spiritual beliefs play a major role in many people's lives in Africa and worldwide. This includes maternity care, spiritual care, and empathy as they enhance women's birth experience . In Nigeria and other Sub-Saharan countries, Christianity, Islam, and traditional religions are the most commonly practised religions. Midwives are seen as carers that can meet the spiritual needs of the women, but their own support needs during own loss of pregnancy may not be catered for (Kalu 2019:7). This study explored the support needs of midwives who experienced pregnancy loss and are providing maternal health care services in Tshwane District while caring for pregnant mothers, this included their emotional experiences and how this affects their work including the cultural influences that may be taken into consideration and their relationships.

There is no evidence of studies conducted in South Africa regarding research on the support needs of the midwives who have lost a pregnancy and working in maternity units. While working in clinical practice, the researcher observed that some midwives in the Tshwane district have difficulty coping with their pregnancy loss. The gaps observed by the researcher while in clinical practice among peers are the lack of support by the employer and colleagues to the midwives. In South Africa, the form of support offered to women who have lost a pregnancy is stipulated in the Basic Conditions of Employment Act 75 of 1997 which indicated that, an employee who has a miscarriage during the third trimester of pregnancy or bears a stillborn child, is entitled to maternity leave for six weeks after the miscarriage or stillbirth whether or not the employee had commenced maternity leave at the time of the miscarriage or stillbirth. Although six weeks of maternity leave as support is not sufficient for a grieving midwife, the support needs to be revised as pregnancy loss is usually sudden and unexpected and there is no time to prepare for it, which contributes to the severity of the grief experienced irrespective of the gestation, which may be stillbirth, miscarriage or medical termination of pregnancy. All losses deserve the same type of maternity leave of six weeks.

1.2. RATIONAL OF THE STUDY

The researcher developed an interest in the topic when observing co-workers in the maternity units going through a loss of pregnancy without support from the employer and other colleagues. The emotional strain on them may result in an inability to be as effective with nursing care as before, leading to a lack of holistic care for pregnant women as they deal with their emotions. These midwives did not receive support from their employers. They worked long hours and, according to their skills, were placed in an environment where they nursed pregnant women and babies. No grieving period was given to these midwives, no referral to a hospital psychologist, and they may have exhausted their family responsibility or annual leave at the time of the incident.

1.3. PROBLEM STATEMENT

Midwives should manage childbirth safely, as the International Confederation of Midwives (ICM) indicated. Global Standards for Midwifery Education (2010) exists to decrease maternal and neonatal mortality globally (Bloxsome et al 2020:209). South Africa's perinatal mortality audit system records and classifies perinatal deaths at all 588 clinics across the country where clinical teams oversee deaths associated with maternal conditions (Lavin et al 2018:806). This includes midwives who lost a viable or non-viable pregnancy. There are expectations for these midwives to deliver quality care for pregnant women irrespective of how they feel after their loss (De Roose et al 2018:51). In the United Kingdom (UK), a study of midwives who do not have children encompassed an estimated 5% of the bereaved woman after loss of pregnancy with reactions of acute grief leading to mental health problems (Boelen 2017:405).

The affected midwives may use defence mechanisms to cope with daily living activities. These mechanisms may be associated with attachment in pregnant women (Fonzo et al 2020:1389). Midwives may be attached to their pregnancy as they bond with the fetus in utero. Defence mechanisms function at an unconscious level to prevent conflicts (Fonzo et al. 2020:1388). Midwives may experience countertransference, which is feelings experienced by the clinician towards the woman in her care and may struggle to show empathy (Fernández-Basanta et al. 2020:21). The midwives may project their emotions towards the woman consciously or unconsciously. Projection is when one redirects their emotions to others (Battaglia, American Psychiatric Association Publishing 2020:3). It is important to support the women and midwives affected as they may show their hidden emotions (Bellhouse et al. 2018:8). They may receive support through social networks more than any other platform (Alqassim et al 2019:3). Generally, all employers implement paid parental leave to help workers maintain a healthy work-life, and as such, mothers received maternity leave (Patton et al (2017:6).

The researcher observed that some midwives in clinical practice around the Tshwane district have difficulty coping with their pregnancy loss. Their wellbeing and ability to care for mothers who deliver were decreased as they cannot express how they feel, making the women feel little attention has been given to them (Elmir et al. 2017:4184). A study conducted in the UK associated with work environment outlines the importance of a healthy work environment. A stressful work environment, such as insufficient staff and material resources, may affect the quality of care. The midwives may experience physical and mental exhaustion related to the loss of pregnancy, and the environment may also contribute to that (Dixon et al 2017:5). This study was therefore conducted to explore support needs of midwives who experienced pregnancy loss and are caring for other women during antenatal, intrapartum, and postnatal care in Tshwane District.

1.4. SIGNIFICANCE OF THE PROPOSED STUDY

The study is about the emotional well-being of the midwife who has lost a pregnancy and is working in the maternity ward, as this will affect care giving and work relationships. The study may establish recommendations that may be implemented to try to assist the midwives who lost their pregnancy by identifying ways to deal with the loss of pregnancy, identifying ways to cope with their daily activities with minimal challenges and hopefully, the midwives will be able to communicate with their partners by expressing how they feel as a process to heal. It may, therefore, improve the psychological wellbeing of the midwives who lost their pregnancy and encourage them to talk about the loss of pregnancy to family and friends and perhaps colleagues, unlike strangers. The recommendations may assist other midwives in dealing with all the emotional challenges of safely speaking up in a safe space and possibly addressing the policy changes relating to the grieving period. The midwives or health system, including facility managers, may benefit from the study as it may assist midwives to cope with the challenges they are faced with effectively and to consider how to assist those midwives affected by the loss of pregnancy should it be implemented.

1.5. THE RESEARCH QUESTION

What are the support needs of midwives who experienced pregnancy loss and are caring for other women during childbirth?

1.6. AIM AND OBJECTIVE OF THE STUDY

The aim and objective of the study were to explore and describe the support needs of midwives who experienced pregnancy loss and are caring for women during childbirth in the Tshwane district. The researcher made recommendations on supporting these midwives who lost their pregnancies.

1.7. CONCEPT CLARIFICATION

In this study, the following concepts were referred to:

1.7.1. Support needs

Support needs are defined as the type of support where shared knowledge and experiences may be an attempt to gain support psychologically by easing the mind, socially by maintaining companionship, emotionally to easily verbalise feelings of concern and spiritually easily engage in own rituals, also relieve feelings of being stigmatised in a situation (Kalu 2019:2). In this study, 'support needs' will include the psychological well-being following the loss of pregnancy by midwives whilst continuing to work in a setting where there is a need to have a supportive environment.

1.7.2. Midwives

Midwives are defined as qualified personnel who have undergone four years of training and are registered with the South African Nursing Council (Nursing Act No 50 of 1978). Midwives may be defined as a person who helps a woman when she is giving birth, a trained and certified midwife (Nursing Act No 50 of 1978) . In this study, midwives are trained-personnel rendering maternal health care services in a health care facility in the antenatal, intrapartum and postpartum setting.

1.7.3. Pregnancy loss

Pregnancy loss is defined as a miscarriage if it occurs before 20 weeks gestation or a stillbirth which is a loss of a baby before or during labour (Bellhouse et al. 2018:2). In this study, 'pregnancy loss' is defined by the inclusion criteria, where the focus is on those participants who have lost a pregnancy, within three to six months after an incident and for up to two years.

1.7.4. Intrauterine Death (IUD)

Intrauterine Death (IUD) is the death of a foetus after viability, which is above 28 weeks of gestation, and this may occur before or during labour; it is also known as stillbirth (Dippenaar et al 2018:360), simply meaning it is the death of the foetus in utero (Dippenaar et al 2018:360). In this study, IUD was identified by death after foetal viability. Two participants were classified under this type of pregnancy loss.

1.7.5. Miscarriage

Miscarriage is a pregnancy that has terminated spontaneously before reaching foetal viability (Dippenaar et al 2018:224) and may also be termed loss of a pregnancy that occurs before 20 weeks gestation (Bellhouse et al 2018:2). In this study, miscarriage was identified by death before 20 weeks of gestation. Eight participants have experienced this type of pregnancy loss.

1.7.6. Termination of Pregnancy (TOP)

Termination of Pregnancy (TOP) is when a decision to end a pregnancy is taken, which will be done before the full term (Dippenaar et al 2018:360). In this study, one participant had undergone medical TOP because of pre-eclampsia, and TOP was done prior twelve weeks of gestation.

1.8. DELINEATION

The study was carried out in Tshwane District Hospital, Jubilee District Hospital, Steve Biko Academic Hospital, Kalafong Provincial Tertiary Hospital and Dr. George Mukhari Academic Hospital. There is no information addressing the number of midwives currently affected; therefore, there is no certainty of what number is required; however, the researcher encountered some midwives affected in clinical practice. It was conducted among those midwives who had experienced the loss of pregnancy and are currently rendering maternal health care services. Refer to sampling for inclusion and exclusion criteria.

1.9. METHODOLOGY

A qualitative, explorative, and descriptive research design was used to explore the experiences of midwives who lost a pregnancy while rendering maternal health care services. The methodology is reflected in Table 1 below:

Table 1.1. Summary of research methods

Aspect	Description
Research design	A qualitative, explorative, and descriptive study
Setting	Hospitals in Tshwane District around Gauteng province
Population	All midwives who lost a pregnancy and met the requirements for the inclusion criteria.
Sampling	Purposive sampling was used to obtain 11 midwives from different maternity units to get a wider perspective on the topic. Data saturation was achieved after nine interviews.
Data collection	One-on-one semi-structured interviews were conducted.
Data analysis	A qualitative inductive content analysis approach was used.
Trustworthiness	Strategies to enhance trustworthiness included credibility, applicability, dependability, conformability, and authenticity.

1.10. ETHICAL CONSIDERATIONS

Ethical considerations adhered to and outlined were the main principles of beneficence, respect for human dignity and justice.

The participant could withdraw at any stage as stated in the consent form and their identity was protected. A potential risk involved is that the study may pose an emotional threat to the participants, which can result in psychological harm as sensitive ethical issues may arise; thus, integrity should be applied, however in the study none of the participants showed any emotional distress during the interview (Moule et al 2017:362). The ethical principles were based on the Belmont report for research, namely beneficence, respect for human dignity, and justice were implemented (Polit et al 2021:133). The study proposal was approved by the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria. Additional approval was received from the hospitals via ethical approval from the Gauteng Department of Health through the website: https://nhrd.hst.org.za/.

1.10.1. Beneficence

Beneficence is the principle of doing good for research participants and society, preventing harm, and doing good, a fair selection of participants was done in the study relating to the inclusion criteria (Moule et al. 2017:103). The study had the potential for emotional discomfort during the discussion. The midwives who experienced discomfort needed support were encouraged to go to the hospital employee and wellness department. However, most of them preferred to go to private counselling sessions, and only a few went to the hospital's employee and wellness department.

1.10.2. Respect for human dignity

A participant information leaflet and consent letters were given to all participants. Interviews were conducted in English. Participants were informed that they could participate voluntarily and may withdraw at any point during the research process. Consent meant that participants had enough information about the research and can consent. Participants understood that the data they provide were for research only and will be kept for 15 years. They needed to understand that they would be encouraged to verbalize their feelings when ready and could postpone the interview (LoBiondo-Wood et al 2018:110).

1.10.3. Justice

The principle of being fair to participants and not giving preference to or not being discriminatory to some participants must come before the researcher and the study's objectives, in the study no discrimination was shown irrespective of qualifications or race, all participants were treated the same way (Moule et al. 2017:102). Confidentiality pertains safe

management of information or data shared by a subject to ensure that the data are kept private from others, in the study participants data was kept safe and private from others (Gray et al 2021:206). Anonymity is achieved by not using the names and addresses of participants and assigning each of them a unique study number, in the study, a unique number was given to the participants, participants are referred to as P1 or P2, which simply mean participant 1 and likewise (Moule et al. 2017:109). Confidentiality and anonymity were always maintained during data collection, analysis, and publication of results. No names were kept on record or in any publications of the findings. The researcher will keep raw data according to its policy for a minimum of fifteen (15) years as signed in the declaration of storage.

1.11. SUMMARY

In Chapter 1, the general idea of the study was indicated. The study aimed to explore and describe the support needs of midwives who experienced pregnancy loss and are caring for women during childbirth in the Tshwane district. Chapter 2 consists of an extensive discussion of the methods used during the study.

CHAPTER 2: RESEARCH METHODOLOGY

2.1. INTRODUCTION

In Chapter 1, the general idea of the study was indicated. This chapter discusses the methods used during the study, including the ethical considerations. A more detailed discussion of the methods used in the study to explore and describe the support needs of midwives who experienced pregnancy loss and are caring for women during childbirth in the Tshwane district. This includes the research method, population and sampling, data collection and analysis.

2.2. RESEARCH DESIGN

A qualitative, explorative, and descriptive research study was utilized to explore and describe the support needs of midwives who experienced pregnancy loss and are caring for women during childbirth in the Tshwane district.

Qualitative research is usually conducted to understand participants' viewpoints through shared experiences, and it was used in this study. Leavy (2017:5) described exploratory research as establishing facts, gathering new data, and then determining if there are interesting patterns in the data; thus, the study is exploratory. The study used a descriptive qualitative research design where the researcher penetrated data in any interpretive depth (Leavy 2017:124). The design uses narrative words with documentation as a data source to analyse material by identifying themes (Leavy 2017:124). The methods are flexible and evolving as the researcher may not know how to conduct research at the beginning of the study, which is where a pilot study came into place to assist the gaps (Harvey et al 2017:61). The study explored experiences of the situation in depth, considering context and its complexity, where the participants discussed the onset of pregnancy, how they prepared for the unborn baby, the mixed emotions they had during the loss whereby they explained what transpired, up until how they coped with the emotions experienced. The descriptive research design was used to comparatively find out more about the study, as little is known about the subject (Leavy, 2017:5). The study was used to explore and describe the support needs of midwives who experienced pregnancy loss and are caring for women during childbirth. The study focuses on midwives who lost a pregnancy and work in maternity units in Gauteng province around the Tshwane district. Semi-structured interviews were used to explore their experiences. This allowed the participants to describe their experiences during the interview. Providing maternal care to other pregnant women may remind them from time to time of their loss. Midwives who have lost a pregnancy may need a companion on the journey to motherhood, a professional friend and an employer concerned about their wellbeing.

The application of the qualitative design to this study is reflected in Table 2.1.

Table 2.1: Application of qualitative design to this study

Characteristic	Application to this study
Flexible (Leavy 2017:50).	Allows researchers to write field notes which describe what is seen, said, and done; this often becomes data as it offers flexibility and detail to content. (View section 2.2.1)
Broad interviews were conducted to obtain participants' views (Leavy 2017:14).	All the information obtained by the researcher was used to understand an individual's experience of living with 'loss of pregnancy' and the meaning it has in their lives. (View section 2.2.4)
The researcher is engaged in the study (Harvey et al 2017:62)	The researcher conducted in-depth interviews to generate data to identify hidden meanings and gain an understanding of the phenomenon. (View section 2.2.4)
Data collection and data saturation are achieved (Harvey et al 2017:61)	Data collection was done through interviews, and narratives were compiled using field notes. Data saturation was achieved when no new findings revealed new information regarding the study. (View section 2.2.4)

2.2.1. Research method

Research methods refer to when the data collector asks subjects to respond to a set of open-ended or close-ended questions in qualitative studies, such as interviewing and observation, and what kind of data will be collected (Harvey et al 2017:219). The researcher conducted interviews on a one-to-one basis and used semi-structured interviews with an interview guide. An interview can be referred to as verbal communication between the researcher and the subject during which information is provided to the researcher. It can be conducted as unstructured, where the participant controls the interview or structured, where the researcher carefully designs possible responses to questions in a conversation requiring face-to-face interaction. Semi-structured interviewing was a method of choice as the focus was on exploring experiences, thoughts, feelings, and support needs in a more descriptive manner and, in the study, the researcher used the statements the participants made to find in-depth understanding by using communication techniques such as reflection and clarification (Moule et al. 2017:309).

Audio recording and field notes were used to obtain detailed descriptions of the midwives' support needs, including written accounts of the things the researcher hears, sees, feels, experiences, and thinks about during the interview. The interview started earnestly with a

single broad question which is planned (Harvey et al 2017:219). The participants' language and literacy were considered as some preferred to use their own language during the interview. In this case, the broad question was: ‘‘Tell me about the support you received after the loss of your pregnancy’’. After an interview, the researcher found a quiet place to write the sequence of events that have transpired in the order they occurred and act as a mediator (Moule et al 2017:217).

2.2.2. Research setting

The City of Tshwane is the metropolitan municipality that forms the local government of northern Gauteng Province, South Africa, in Pretoria. Some tertiary hospitals have a bed capacity from 400 to 800 at times and even more. These hospitals provide specialist-level services, intensive care services under the supervision of a specialist or specialist intensives and may provide training for healthcare service providers and receive referrals from regional hospitals not limited to provincial boundaries. Their services are rendered on a 24-hour basis and improve quality of life. Kalafong Provincial Tertiary Hospital, Steve Biko Academic Hospital and Dr. George Mukhari Academic Hospital are tertiary hospitals in Tshwane District (National Health Act, 2003 R185 Regulations). The study was conducted in Gauteng province. According to Polit et al (2021:42), study setting means the physical location and conditions in which data collection takes place. In this study the setting encompasses hospitals within the District of Tshwane. Midwives take care of pregnant women within these hospitals. There are also district hospitals that provide maternity healthcare services 24/7. The district hospitals are categorised into small (50 beds), medium (150 beds), and large (300 beds) district hospitals. The hospitals serve a defined population, provide patient care on a 24-hour basis, and improve quality of life. Tshwane District Hospital is a medium size district hospital, while Jubilee District Hospital is a large district hospital. The institutions receive outreach and support from general specialists based at regional hospitals (National Health Act, 2003 R185 Regulations).

2.2.3. Selection of participants

The accessible population is the aggregate of cases that conform to designated criteria and are accessible for a study (Polit et al 2017:249). The population were all midwives who had lost a pregnancy and are working in Tshwane District Hospital, Jubilee District Hospital, Kalafong Provincial Tertiary Hospital, Steve Biko Academic Hospital and the Dr. George Mukhari Academic Hospital, considering the inclusion and exclusion criteria which assisted in appropriate sampling and consent to participate.

2.2.3.1. Population

A population is defined by Creswell et al (2018:150) as a group of individuals or elements who are the focus of the research, and in this study, the target population was midwives from hospitals the National Health Research Database has approved for the researcher. The number of midwives eligible for the inclusion criteria was unknown until the initial visit to the institutions and pre-interview discussions were made. Upon the discussion, some of the midwives worked in various sections of the maternity units, such as the antenatal ward or clinic, labour ward or labour ward theatre, postnatal ward, and neonatal ward. Their daily job entails working with low-risk and high-risk pregnancies, first visits including unbooked patients, managing complicated labour that may require procedures such as assisted labour or caesarean section and resuscitation of neonates. The inclusion criteria also included those midwives who gave consent to participate in the study.

2.2.3.2. Sampling method

The non-probability sampling method is when the researcher cannot state the components of the population appearing in the final sample (Moule et al 2017:171). Participants are recruited because they have ongoing or prior experience of the phenomena that the researcher is exploring (Harvey et al 2017:61). The researcher chose participants by asking a main question about the topic through one-on-one sessions as the topic is sensitive after obtaining permission to conduct the research. Purposive sampling was used in this study which refers to a group of people or events with a specific set of experiences or characteristics used to gain insight into unique experiences (Moule et al 2017:173). Midwives working in maternity units in the Tshwane district, meeting the inclusion criteria, were invited to participate in the study.

2.2.3.2.1. Inclusion criteria

- Participants should be only registered midwives working in hospitals in Tshwane district, Gauteng.
- Participants should have lost a pregnancy within three to six months after an incident for up to two years prior to the study.
- Participants should have a minimum of 12 months of experience in the maternity unit.
- Participants should work in antenatal, intrapartum, or postnatal wards.
- Participants should be willing to participate in the study.

2.2.3.2.2. Exclusion criteria

- Midwives who have not experienced a loss of a pregnancy.
- Midwives who did not consent to participate in the study and are not from the Tshwane district.
- Midwives who are working less than 12 months in a maternity unit.

2.2.4. Data collection

Data collection refers to the planning and implementation of sampling, the role of the researcher and the research methods used for data gathering. The researcher can conduct an interview or observe the participants (Leavy 2017:50). Data was collected through individual semi-structured interviews.

Interviews were conducted once the Faculty of Health Sciences Research Ethics Committee of the University of Pretoria approved the proposal (refer to Annexure C), clearance certificates were issued by National Health Research Database (NHRD) (refer to Annexure D) gave the researcher permission, and the participants signed consent (refer to Annexure A). All participants were interviewed after considering the inclusion criteria. Participants were selected until data saturation was reached, meaning no new information was added to the existing information collected.

Qualitative research is based on the depth of the participant information and its quality rather than the sample size so that the research question can be answered with sufficient confidence (Polit et al 2017:522). Data saturation was reached after nine interviews, and two more interviews were conducted to ensure that no new information emerged after data saturation was reached. The data was collected over 14 months due to lack of participants and Covid-19 restrictions. The research topic was challenging, and all the questions were covered in each interview.

The researcher adopted the nurse-client relationship phases from Townsend et al (2018:141). These phases encompass the following: Orientation phase, working phase and termination phase.

2.2.4.1 Orientation phase

In this phase, one encounters preparation where obtaining available background information and initial assessment is done, including creating an environment for the establishment of trust and rapport (Townsend et al 2018:141). The researcher scheduled an appointment with the nursing managers of maternity units of the selected hospitals to introduce herself and the study. The researcher then requested the nursing managers to obtain permission from the participants to conduct the interviews. The researcher also asked permission to refer participants to the employee wellness department for counselling when needed and to utilize any available private room at the time to conduct the interviews. The study was conducted after signed written informed consent from the participants was obtained (refer to Annexure A). The researcher considered the privacy and confidentiality of the participants and created a therapeutic environment but ensured a noise-free environment and proper lighting in the venue to maintain eye contact. Water and tissues were provided in case of any emotional

breakdown. An audio recorder was placed on the table to record the interview. The researcher tried to explain the questions as clearly as possible to ensure that the participant understood what was asked, and follow-up questions were also asked. The information leaflet was discussed with each participant. The researcher allowed the participants to use English as a preferred language to easily express themselves in the language they understood, and then communication techniques such as using open-ended questions were utilized. Paraphrasing, reflecting, silence, and therapeutic touch was used when needed, and clarification was also used to clarify what the participants were saying regarding their experiences, thoughts, and feelings. All these were done to alleviate misinterpretations or even avoid misunderstanding (Middleton 2020:169).

2.2.4.1.1 Pilot interview

A pilot interview was conducted, which is described as a small test that is like the actual interview of the study to provide assurance to the researcher and assist with more questions rising from the interviews where changes are made because of the pilot interview (Harvey et al 2017:170).

The conversations that occur during an interview need to be purposeful and require preparation prior to the interview (Polit et al 2017:541). The researcher interviewed participants with their permission and agreed to audio recording and taking field notes during the interview. This pilot interview assisted the researcher in familiarising herself with how to ask the question. The questions were asked in such a way that the participant understood. The researcher was attentive and listened to the thoughts, feelings and narrated experiences shared from the time of loss of pregnancy, and there was a need for probing questions. In this phase, the researcher identified a few questions that were added to the interview guide that could improve the study by including support within the working environment and ritual aspects if indicated.

2.2.4.2 Working Phase

In this phase, the therapeutic work of the relationship is accomplished here. The researcher maintains a trusting relationship that allows the participants to explore feelings using therapeutic communication techniques (Townsend et al 2018:141). According to Leavy (2017:37), semi- or unstructured interviews and observation of participants are often used to collect data. The collection is often a combination of recorded audio or video tapes or field notes, then transcribed and transformed into words for analysis.

The interview phase refers to the actions taken in conducting a sound interview with the participants, where the researcher has a responsibility to master certain techniques to achieve the required results (Leavy 2017:35). The researcher dressed presentably in uniform and had

an introduction session prior to conducting the interviews. The participants were made aware that the study is sensitive and participating in the study could cause emotional discomfort. The researcher introduced herself as a student at the University of Pretoria doing a master's degree in nursing. The participants were approached in the institution while on duty. In order to avoid approaching them at inconvenient times, an arrangement was made to conduct interviews after hours or when it was convenient, as the intention was not to compromise the participants' duty hours to conduct the interviews.

The participants were physically and emotionally exhausted due to work and the pregnancy loss experience. The researcher considered their condition and tried not to overwhelm them. Time management was important during the interview, especially by observing non-verbal communication. Most of the participants displayed intense, sad moments hence there was silence during some interviews; however, none of the participants utilised the tissue and water provided during the interview. The researcher asked the participants if their leisure time at work, e.g. lunch, could be utilized to conduct the interview. The researcher tried to utilize a quiet environment to prevent interruptions and allow audio recording. The interview time was noted, and most individual interviews took approximately 10 to 25 minutes. One broad question was asked: 'Tell me about the support you received after the loss of your pregnancy'. The researcher also used a list of possible probing questions to obtain detailed information and ensure a rich description of the situation (refer to Annexure B). The questions were related to the aim of the study, and open-ended questions were used to encourage the participants to express their feelings and share their thoughts and experiences, which also assisted in having more clarity and supported the objective. The researcher listened attentively, allowing the participants to narrate their experience clearly by being patient (Leavy 2017:142). The researcher attempted to use facial expressions and nodding to show interest and put the participant at ease (Leavy 2017:39). Field notes were taken on information not mentioned, such as non-verbal communication observed during the interview, clarification of statements, therapeutic use of silence and touch where applicable. The participants were offered the researcher's contact details to communicate any questions they may have regarding the study after the researcher had left.

2.2.4.3 Termination phase

The phase includes the end of the interview, no new information or concerns and the recognition of feelings were displayed by the participants regarding the termination phase (Townsend et al 2018:143).

After the interview, the researcher thanked the participants for their participation, especially for their time, the opportunity to talk about their experiences, thoughts, and feelings, and for

allowing the researcher to ask questions. Four midwives experienced sad feelings, appeared to be gloomy, and preferred to continue talking to the researcher after the interview; however, they were uncomfortable being referred for counselling. A participant verbalized that the researcher relates well to the topic, especially the sense of relief the participant portrayed. No recording was done after the actual interview as the researcher already obtained the required prolonged engagement with the participants during the interview (Leavy 2017:139).

The researcher requested their contact details in case there is a need to communicate with them after the interview; however, with their consent and suitability of when to contact them. The participants were also informed that there might be a second interview if more information is required. The researcher included personal reflections outlined in detail in chapter 4. The researcher listened carefully to the recorded interviews several times to understand if the content was discussed and related to the aim of the study. An audio tape was used to obtain audibility and completeness of the information provided (Creswell et al 2018:190). Interviews were transcribed verbatim, and field notes were made to facilitate easier data analysis (Leavy 2017:136).

2.2.5. Data analysis

According to Creswell et al (2018:193), data analysis involves breaking down data, coding the different segments, and making sense of the text. The researcher transcribed and analysed the interviews while they were still fresh. The analysis begins by going back to the aim of the study. Once the researcher has all the data, it must be broken down into a manageable format that streamlines reporting. The researcher observed patterns in data collection and explained how raw data was handled, usually transcripts of recorded interviews. The researcher asked questions to self about those patterns and looked for more data and sorted the information (Moule et al 2017:367). The researcher read through all the data to obtain a general sense of information and reflect on its overall meaning by writing notes and general thoughts. Data coding was utilized, which is a process of organising the material into segments of text before bringing meaning to information. Coding is the data broken down into subparts and labelled to that part of the text. The labels provide a way for the researcher to begin identifying patterns in the data because sections of text coded in the same way can be compared for similarities and differences (Creswell et al 2018:193).

Labelling data into categories was done in English as most of the participants understood the language and participants were free to express their feelings and thoughts. The researcher contemplated the data and analysis followed by incorporating the coding steps as recommended by LoBiondo-Wood et al (2018:121) used to clarify the content.

2.2.5.1 Steps of the coding

1. ***Selection of data***: One document and/or a tape recording of the data obtained was selected. The researcher asked herself, 'what are the actual feelings of the participant' and wrote the underlying meaning. The researcher familiarised herself with the interview transcripts by repeatedly reading field notes and listening to audio recordings to understand the data and what it is about (Creswell et al 2018:193).
2. ***Compile a list of topics:*** The researcher read through several participants' data and compiled a list of all the topics that emerged, and the researcher checked whether all content detail was related to the aim. All data was divided into meaningful segments with unique identifying codes that the researcher came up with. Once the theme was identified, the data analysis and writing-up process began (Creswell et al 2018:193).
3. ***Create codes for data:*** The researcher took the list of topics and created codes relating to the data. One theme was identified that branched into categories and sub-categories. The researcher identified similar codes and dissimilar ones and created a theme. Words or sentences used frequently were considered and organised into theme. Identifying themes was the beginning of data interpretation to find meaning and application to practice (LoBiondo-Wood et al 2018:144).
4. ***Identify the descriptive word/s:*** The researcher identified the most descriptive word for the topics and turned them into categories. The categories were grouped in a way to reduce the list of categories. During the interview, the main theme was support of midwives who experienced pregnancy loss and are caring for women during childbirth, which assisted with a holistic overview of the responses. The categories were further divided into sub-categories, and for more details, refer to Table 3.4 in Chapter 3 where the categories are tabulated.
5. ***Create abbreviations for categories:*** The researcher did not create abbreviations for each category but arranged them according to need. The words of the participants were used by referring to the original text to stay closer to the original meanings and contexts (LoBiondo-Wood et al 2018:144).
6. ***Assemble data according to categories and subcategories:*** The researcher assembled the data material belonging to each category in one place and commenced with preliminary analysis. Interpretation and analysis were done simultaneously to discover the meaning by discussion after each sub-category. Data interpretation assisted in answering the research question. The researcher discussed with the participants how the research was undertaken, meaning the researcher alerted the participants about the results (Flick 2018:544). Recommendations are made from the

findings. The recommendations explored and described the support needs of midwives who experienced pregnancy loss and are caring for women during childbirth.

2.3. TRUSTWORTHINESS

The researcher adhered to the standard truth value and determined the truth of the findings with the participants and the context in which the research was undertaken (Flick 2018:544). Trustworthiness refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study. It encompasses the authenticity and truthfulness of the findings and can be ensured through transferability, credibility, dependability, confirmability, and authenticity of the study (Kyngäs et al 2020:41).

2.3.1 Credibility

Credibility was enhanced by prolonged engagement, whereby the researcher spent time building rapport with participants, allowing participants to be relaxed to communicate freely. Participants were asked questions, and depending on the responses, information was compared and recorded appropriately by taking field notes and audio recording during the interview and then later making sense of the responses. Credibility also refers to confidence in the truth of the data and interpretation, including whether the research findings are credible and whether the researcher strove to establish confidence in the truth relating to the findings to conceptual interpretation of the original data (Kyngäs et al. 2020:42).

2.3.2 Transferability

Transferability refers to the extent to which the research findings can be transferred from one context to another by providing a dense description of the data (Moule et al. 2017:183). The researcher interviewed midwives working in various hospitals. The researcher believed the findings were transferrable to other settings because a midwife who lost a pregnancy experienced the same emotions in various hospitals when working with pregnant mothers. Transferability was enhanced through purposive sampling to enable participants interested in reaching a conclusion about findings as it also describes the degree to which research findings will apply to other fields or in contexts (Kyngäs et al. 2020:46).

2.3.3 Dependability

Dependability refers to the stability or reliability of data over time and conditions (Polit et al 2017:323). It was enhanced by repeating interviews using the same schedule for all participants, documented well and can be audited for trustworthiness. It can also be described as an assessment of the quality of the integrated processes of data collection and data analysis (Kyngäs et al. 2020:44), and the researcher also took field notes during the interviews.

2.3.4 Authenticity

Authenticity refers to the extent to which the researcher fairly and faithfully shows various realities (Moule et al. 2017:183). Authenticity was enhanced by audio recording of data as true evidence during the interview, including quotes that fairly and faithfully show reality and the researcher's written notes (Polit et al 2021:570).

2.3.5 Confirmability

Confirmability refers to objectivity, that is, the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning, including the measure of how well the study findings are supported by the collected (Kyngäs et al. 2020:46). Confirmability was enhanced through the use of coding and creating themes. An independent coder assisted with coding whereafter the supervisors checked the theme, sub-categories and categories. The researcher also kept an audit trail (Moule et al. 2017:183).

2.4 ETHICAL CONSIDERATIONS

Ethical considerations were adhered to and included the main principles of beneficence, respect for human dignity and justice. The researcher considered the ethical aspects of the study. Every interview was treated with dignity, and cultural and religious beliefs were considered. Before the interview, the consent form was discussed to allow the participants to have informed consent. Refer to chapter 1, where this was discussed in detail.

2.5 SUMMARY

Chapter 2 described the research design and methodology in detail, which included the collection of data, the setup of the interview, new information from the pilot study where more questions were added to the questionnaire, the data coding, which entails how the theme and categories are derived from, and the researcher applied the research design and methodology throughout the study. In Chapter 3, a detailed discussion of the research findings is outlined.

CHAPTER 3: RESEARCH FINDINGS AND DISCUSSION

3.1. INTRODUCTION

In chapter 2, the research methods used were discussed in depth. In this chapter, the findings are described along with a discussion of related literature, which could provide supporting or different opinions on the identified theme in the context of the analysis, where the researcher reviews the data until a common understanding is reached. Data were analysed using steps of coding (LoBiondo-Wood et al 2018:121).

3.2. OVERVIEW OF THE RESEARCH FINDINGS

Data was collected with face-to-face semi-structured interviews with midwives who have lost a pregnancy and are working in maternity units in Tshwane District within Gauteng province. One main theme was identified, namely, support needs of midwives who experienced pregnancy loss and are caring for women during childbirth. The theme was then further divided into categories and sub-categories (Du Toit et al 2019:97), as shown in Table 3.4.

3.3. DEMOGRAPHICS OF THE PARTICIPANTS

The participants in this study were from Gauteng Province in South Africa around Gauteng in Tshwane. The participants were from different maternity units such as the Neonatal Intensive Care Unit, Labour ward/ theatre, Postnatal and Antenatal ward. The participants were between 29 and 44 years old. All participants are midwives working in maternity units and lost a pregnancy. The researcher compiled the participant information which is tabulated. Refer to table 3.1 for a summary of the participant demographic data. All midwives who participated in an interview remained anonymous, as stated in the consent form.

The tabulated information in Table 3.1 includes the introduction of abbreviations as follows:

The letter ‘P’ with a number, e.g. P12, represents the participant. Gravity is depicted with “G” and refers to the number of times a woman has been pregnant (Dippenaar et al 2018:224). Parity is depicted with “P” and refers to the number of viable births (Dippenaar et al 2018:224).

Table 3.1: Summary of participant information

Participants	Age	Gravid and Parity	Type of loss	Maternity unit	Type of hospital
P1	44	G5 P5 IUD1	IUD	Labour ward	Tertiary Hospital
P2	37	G3 P3 IUD1	IUD	Neonatal ward	Tertiary Hospital
P3	42	G3 P1 M2	Miscarriage	Neonatal ward	Tertiary Hospital
P4	39	G4P0M4	Miscarriage	Antenatal ward	Tertiary Hospital
P5	38	G2P1M1	Miscarriage	Labour ward	Tertiary Hospital
P6	29	G2 P1 M1	Miscarriage	Labour ward	District Hospital
P7	37	G3 P2 M1	Miscarriage	Postnatal ward	Tertiary Hospital
P8	40	G4 P3 M1	Miscarriage	Antenatal ward	Tertiary Hospital
P9	34	G4 P3 M1	Miscarriage	Labour theatre	Tertiary Hospital
P10	36	G1 P0 M1	Miscarriage	Labour ward	District Hospital
P11	35	G2 P1TOP1	TOP	Labour ward	District Hospital

Out of the 11 participants interviewed, eight had miscarriages, two had an intra-uterine death, and one had a medical TOP due to preeclampsia. The researcher focused on experiences, thoughts and emotions which involved the individual participant. The theme emerged was support needs of midwives who had a pregnancy loss and are caring for women during childbirth, which include categories and their subcategories, as outlined in Table 3.4.

PRESENTATION OF THEME, CATEGORIES AND SUB-CATEGORIES

THEME: Support of midwives who experienced pregnancy loss and are caring for women during childbirth

The theme was based mainly on the midwives' support needs during the period of loss, mostly the experiences relating to how they viewed support within the work environment. The theme was then divided into two categories that look at general support needs of the midwives received within the organisation regarding the pregnancy loss. The categories are then further divided into various sub-categories. Support needs of midwives' experiences encompass, employee wellness programmes (EWP's) within the organisation, colleagues, and responses from colleagues. At the same time, organisational support entails experiences regarding triggers within the environment and issues relating to leave (see Table 3.4).

TABLE 3.4 SUMMARY OF THEME, CATEGORIES, AND SUB-CATEGORIES

THEME	CATEGORIES	SUB-CATEGORIES
3.4. Support needs of midwives who experienced pregnancy loss and are caring for women during childbirth	3.4.1 Support from management and other structures	3.4.1.1 Support versus lack of support from management
		3.4.1.2 Support versus lack of support from a counsellor
		3.4.1.3 Support versus lack of support from EWP
		3.4.1.4 Support versus lack of support from colleagues
	3.4.2 Organisational support of midwives who experienced pregnancy loss and are caring for women during childbirth	3.4.2.1 Support versus lack of support related to leave of absence (sick leave)
		3.4.2.2 Positive versus negative support in ward allocation/placement experiences

The researcher based the theme on how the participants discussed their experiences, thoughts, and feelings. Therefore, it was vital to dwell on support provided for the participants as this will assist in identifying if there is a mutual goal and understanding between the participants and the workplace environment and knowledge about how to support the participants (Du Toit et al. 2019:98). In the study, this represents a therapeutic environment for the participant (Townsend et al. 2018:141). According to Du Toit et al. (2019:980), the workplace environment may stipulate the characteristics of the type of support the participants will receive, for instance, in this stud, colleagues and the employer play a role in maintaining a safe environment for the participant (Du Toit et al. 2019:98). There are few emotional ties between people as this is a professional setting; thus, lines of communication are adhered to as the participants report directly to their immediate supervisor (Du Toit et al. 2019:98). Another characteristic is that people meet for a specific reason, for instance, for work purposes (Du Toit et al, 2019:98).

3.4. THEME: Support of midwives who experienced pregnancy loss and are caring for women during childbirth

In this theme, there is detailed information about the support provided by others to the midwives who lost a pregnancy or pregnancy, from colleagues and the employer. The support is outlined according to the experiences of the midwives. The lack of support from others, especially within the organisation, can contribute to a sense of stigma and may increase the risk of depression during pregnancy loss (Andalibi 2018:1).

CATEGORY 1

3.4.1 Support from management and other structures

Loss of pregnancy can clearly deeply distress a woman and put strain on her , but it may also have a psychological impact on the grieving mother; as seen in the study (Kersting et al. 2022:190). The sub-categories in this category are discussed based on the comparison between support versus lack of support by the management and colleagues. This includes the support offered by the counsellor and EWP within the organisation.

3.4.1.1 Support versus lack of support from management

The participants expressed what the support was like from the management. In this sub-category the management was not supportive to some participants, some quotes show management was ignoring the experience, and lacked empathy, however most participants had supportive experiences as evidenced by the quotes (Kersting et al. 2022:190).

Another participant reported that, her supervisor was aware of her predicament and even offer to assist with future pregnancies. The participant said;

"She counselled me and told me that I am still young you know, you can still do it again and then she made an example about the other colleague she once heard that she was Para 10, so don't even worry about that para" ***(P4)***

While the other participant reported that, her supervisor was willing to give the participant more days to have more time to try and do introspect about the pregnancy loss, however, the participant wanted to keep busy at work to avoid overthinking. The participant said;

"At work they were very supportive and like my OPM asked me how are you, are you coping are you sure you don't want us to book you off more days, and I was like no, when I am home it's even worse" ***(P6)***

On the contrary, one participant outlined how she did not receive support from management by indicating that she was having flashbacks thus reported late for duty but was scolded. The participant said:

"I remember one day when I get to work, I was late by an hour, so my manager was furious at me, because I remember that morning, I had flashbacks...So, I couldn't get up early I started crying at home but the minute I get to work it was very late when I started to apologize to her, she just scolded me" ***(P10)***

One participant verbalised feelings of isolation as no one from management communicated with her about the loss, thus felt she was not supported. The participant said:

"I remember they couldn't even call me in the office just to talk to me. They didn't even refer me to the employee wellness for counselling. If they offered, I would have gone" ***(P11)***

Pregnancy loss is typically experienced as a traumatic, critical event, which may lead to secondary psychological health disorders (Lwanowicz -Palus et al. 2021:2). Unsupportive organizational culture can be emotionally demanding for the midwives who have lost a pregnancy (Fernández-Basanta et al. 2020:8).

Discussion regarding to support versus lack of support from management.

Management is regarded as an advocate of employees where in essence, the well-being of employees should be catered for, especially mental well-being. In this sub-category, most participants reported that their supervisors were supportive (Akhtar et al. 2020:623). Management is mostly concerned about productivity, and employee morale may be hampered in the long run. However in this case, there are some participants who felt their immediate supervisor was supportive in every way and even referred them to employee wellness for counselling (Akhtar et al. 2020:623). Management may display a negative attitude due to loss of productivity and the cost implications that may occur, as the absence of the midwives who lost a pregnancy will mean decreased productivity and staff shortage that will require management to outsource more staff. This is supported by three participants as they reported that management did not support them. The midwives had a common reason, which was that there was a lack of communication and patience by management, therefore they verbalised that encouragement, motivation and support from the employer were minimal or not there at all (Akhtar et al. 2020:623). This was evident by the participants' nonverbal cues during the interview and the cues were congruent to the effect and their behaviour was not enthusiastic when talking about the support the employer had shown.

The implications of results to nursing practice related to support versus lack of support from management:

The lack of support by management to these midwives may result in decreased morale of staff and midwives will be demotivated to resume duties, resulting in decreased productivity. Management may be required to outsource more staff, which will have financial implications for the unit, and all this will inhibit holistic care for patients which may result in complications that could contribute to the mortality rate.

3.4.1.2 Support versus lack of support from a counsellor

The participants expressed what the support was by a counsellor. In this study, 'support needs' include the need for psychological well-being following the loss of pregnancy by midwives whilst continuing to work in a setting where there is a need to have a supportive environment

(Watson et al. 2019:14). In this sub-category the counsellor was supportive to those participants who attended counselling sessions. This is supported by some quotes which show that the counsellor lended them an ear and showed empathy to their loss of pregnancy.

About five participants reported that they received professional help and reported that therapy was helpful to them. The participants said:

"I think talking to a therapist is always helpful. I can talk about it without being emotional, I can relate my event without tears rolling down my face" ***(P7)***

"The information that I received from the therapy sessions really helped me a lot and also my pastor, also he was involved in the situation." ***(P11)***

Three participants reported that they did not receive any professional help. The participants stated that:

"I have never received any professional help" ***(P2, P5, P6)***

On the other hand, two participants verbalised that the sessions they attended with the counsellor did not help them cope with the pregnancy loss. The participants said:

"They referred me, and it did not help me" ***(P8, P4)***

Discussion regarding to support versus lack of support from a counsellor.

A counsellor is directly involved in wellness programs for employees where the programs are generally designed to help employees better their health, especially emotionally; however, some employees may not view counsellors in that light (Perrault et al. 2020:8). The participants explained what the experience with a counsellor was like where they discussed the impact of attending counselling that helped them acknowledge the pregnancy loss (Akhtar et al. 2020:623). However, some participants did not attend the sessions. Those who attended reported that they received support from the counsellor. Communication skills are of the utmost importance to convey compassion, empathy, and understanding of how the loss impacts the participant (Chichester et al. 2021:29).The participants verbalised that at times they preferred a stranger, in this case, a counsellor, for objectiveness in an environment which is conducive or safe enough for the participants to feel at ease where they are able to verbalize their feelings, thoughts, experiences and be able to express their emotions without holding back (Chichester et al. 2021:29). The information was supported by the participants' quotes.

The implications of results to nursing practice related to support versus lack of support from a counsellor:

Lack of counselling may result in psychological problems for the midwife. The midwife may not be as effective as expected on duty regarding the responsibilities assigned. An absent mind in the workplace may result in making mistakes, which may be life threatening or cause complications for patients cared for. How will the midwife look after patients if she is unwell?

3.4.1.3. Support versus lack of support from EWP (Employee wellness programmes)

The participants expressed what the support was like from the EWP. Below is an outline of the kind of support the participants engaged with. There are reasons why the employees may not consult, as evidenced by the quotes, and one of the reasons includes negative perceptions of organization wellness programs (Perrault et al. 2020:9).

Those who received support from the EWP.

One participant changed her mind about the referral as she felt she is well. This is what the participant said:

"Initially I agreed to go to Employee wellness program, thinking that I need it, so while they were busy with the process organizing for me, I then changed my mind as I felt I am well" ***(P1)***

While the other participant felt she was not ready to talk about the pregnancy loss, therefore did not go. This was what was said:

"The EPW, but I didn't go, I felt that I wasn't ready at the time" ***(P9)***

Those who did not receive support from EWP.

One participant who verbalised it was not the first pregnancy loss. Previously she was referred, and things did not go well as she highlighted feelings of betrayal as she said there is no confidentiality and privacy were hampered. This is what the participant relayed:

"I have, but the institutional counselling, I didn't want it even if they could have offered me. I wouldn't have taken it, because there is no confidentiality" ***(P2)***

Discussion regarding support versus lack of support from EWP

The EWP is expected to advocate for employees providing physical, psychological, and emotional care so they can be more effective carrying out responsibilities. The participants explained the importance of advocacy in the workplace (Chichester et al. 2021:30). When the baby dies during pregnancy, the infant's presence disappears, leaving no tangible evidence that the baby ever existed, and the mother's grief can be unrecognized. Some participants declined to attend, the reasons disclosed included that they did not feel like it, while others

were referred but did not have a need to go as they became optimistic that all will be well (Chichester et al. 2021:30). In this manner the institutional EWP comes into place to care for those unseen emotions and promote health to the employees, most of the participants who were referred to EWP reported positively about the experience, while some participants verbalised a lack of confidentiality by the EWP department. They believe that there is no privacy and confidentiality in the institution as they related it to previous experiences.

The implications of results to nursing practice related to support versus lack of support from EWP:

The lack of support from the EWP would demotivate the midwife to voluntarily disclose any of her concerns relating to the pregnancy loss especially where confidentiality is a concern, therefore emotions intensify during working hours, leading to unpleasant emotions which may cause the midwife not to care for the patients effectively and efficiently. This will tamper with patient care. The EWP should be discreet to avoid such incidences.

3.4.1.4 Support versus lack of support from colleagues

In this sub-category some participants reported that colleagues were supportive while other participants verbalised that colleagues were afraid to talk to them about the pregnancy loss as seen in some of the quotes. The reception of the midwives who have lost a pregnancy may differ from person to person (Akhtar et al. 2020:622). According to some of the participants, colleagues showed support to them and even went an extra mile to shower them with gifts upon resuming duties and this is evidenced by the quotes.

Participants reported that they were supported by their colleagues about the pregnancy loss, while others were showered with gifts and some colleagues where more welcoming towards them and others lended the participants an ear. The participant said:

"Like some of my colleagues that were working with me, most of them bought me gifts when I came back, even the doctors" ***(P2)***

"My immediate colleagues they were very supportive, they were very understanding. I don't think the employer was sensitive to my situation, only my colleagues because I would have loved to be removed from the ward in question. Because for me, it brought back a lot of traumatic memories" ***(P7)***

The colleagues did not know how to approach the participants, only communicated to them if the participants brought up the topic about their pregnancy loss. while other colleagues felt they have more responsibilities and did not show support.

"If I don't talk, they wouldn't, you will see them on the face that they, it's like they are whispering at the back to say, how are we going to talk" ***(P11)***

"They didn't understand, I think they didn't understand my situation, or they didn't understand what I was going through because they told me that you have been away for quite some time but for me it was not enough for this" ***(P10)***

Discussion regarding to support versus lack of support from colleagues.

Colleagues are seen as workmates that impact the working environment and play a role in teamwork which can be positively or negatively (Akhtar et al. 2020:623). Some participants felt colleagues were not team players and they did not show empathy towards them, while other participants felt the colleagues are resentful. Participants believed that some colleagues resent them for over working them and that they may be exaggerating their emotions (Akhtar et al. 2020:623). The quality of support received from various sources and the professional demeanour of medical personnel also affect the midwife's psychological well-being and satisfaction with life (Lwanowicz-Palus et al. 2021:6). Some colleagues provided participants a safe space to communicate freely about the loss and were there for the participants. The participants mentioned that the colleagues showed courtesy by showering them with gifts upon resuming duties. On the other hand, some participants felt that colleagues were sidestepping, trying to avoid bringing up the discussion about the loss unless the participant commented or indicated that they want to talk about it (Lwanowicz-Palus et al. 2021:6). Then no one was willing to discuss the miscarriage, which most of the participants reported they would appreciate. Some colleagues did not show support at all, moreover they complained about additional workload on their side. Since maternity units are often understaffed, the workload increases, leading to unsatisfactory labour outcomes which impacts the emotional wellbeing of the midwives who had a pregnancy loss while working in the maternity units (WHO 2017:1).

The implications of results to nursing practice related to support versus lack of support from colleagues:

Lack of support by colleagues may lower the self-esteem of the midwife resulting in decreased in effectiveness when rendering nursing care affecting productivity as the midwife will not feel confident to conduct procedure which may result in emotional exhaustion. This may also lead to workplace litigations which may require more intense discussions in a court room.

CATEGORY 2

3.4.2 Organisational support of midwives who experienced pregnancy loss and are caring for women during childbirth.

Exposure to perinatal loss might add to profound distress; thus, coping strategies are required (Gandino et al 2019:66). The experience of everyone varies, and from the beginning of the experience to the end, a range of people are involved such as work colleagues and health professionals (Murphy 2019:1). In this section, the organisation is discussed (see Table 3.4).

3.4.2.1 Support versus lack of support related to leave of absence (sick leave)

The participants expressed what the support was like with regards to leave of absence (sick leave). In this sub-category the management was not supportive to some participants as they are more concerned with productivity. The sooner an employee resumes duties the lesser financial burden for the employer (Murphy 2019:1). Workplace wellness initiatives have gained popularity because they may save employers and employees money and enhance overall health (Perrault et al. 2020:9). Most participants felt the leave days allocated were insufficient to grieve. The shortest was a period of five days which is only a week, and the longest was six weeks which was according to the Basic Conditions of Employment Act. Some of the quotes show management did not allow more time to heal. One of the participants was verbally abused for being late as she had flashbacks. However, most participants were well supported as evidenced by the quotes.

One participant reported that the leave absence was awarded to her according to the policy hence they had no challenge with the period. The participant said:

"My manager was so supportive to me in such a way that she allowed me six weeks to stay home after my predicament" ***(P1)***

"At work they were very supportive and like my OPM asked me how are you, are you coping are you sure you don't want us to book you off more days, and I was like no, when I am home it's even worse" ***(P6)***

One of the participants reported that the period of absence was short and that more time was needed, as she felt emotionally drained and did not feel like working, and just preferred to be alone. The participant said:

"It was emotionally draining I felt tired, I felt like I don't wanna work, I just wanna sleep, stay at home and sleep and lock myself up" ***(P5)***

A participant reported that a leave of absence for a month would have been better to deal with the emotional trauma, but she had to resume duties within five (5) days. The participant said:

"*So, then I had to come back on duty, and I was saying but why can't they give me a month for me to stay at home, cry and then you know what, but no I had to get back to work*" ***(P11)***

Discussion regarding to support versus lack of support related to leave of absence (sick leave)

The Basic Conditions of Employment Act 75 of 1997 permits women four months maternity leave around the time of childbirth. With pregnancy loss, stillbirth or third-trimester miscarriage one is entitled to six weeks leave. In this sub-category, not all participants were entitled to this type of leave of absence as it does not cover loss of pregnancy below 20 weeks or medical termination of pregnancy, thus having limited time to heal (Akhtar et al. 2020:622). Should the participants have been covered by the Act, the support would be sufficient according to some of the participants as evidenced by the quotes from the participants. Irrespective of the period the participants stayed home, they all felt they needed more time away from work to process the grief, especially as they have to work in an environment where there are pregnant women and neonates. Working with pregnant women and neonates appeared not to be easy for them, especially just when resuming duties (Perrault et al. 2020:9). As a result of their absence from work, other colleagues showed some form of anger towards them as they are overworked due to the participants' leave of absence (Akhtar et al. 2020:622). Colleagues display resentful behaviour towards midwives who have lost a pregnancy because they had to do extra work or shifts due to the midwives' absence (Akhtar et al. 2020:623).

Implications of results to nursing practice related to support versus lack of support related to leave of absence (sick leave):

Pregnancy loss will require the participants to take time away from the workplace. There may be shortage of staff thereby increasing the more workload for the remaining staff. The time off forms part of the support for the participant but has a negative impact on the rest of the team. If this time off is not granted to the participant, there may be episodes of not reporting on duty depending on each participants' perception. Some may resort to resignation and try find a more work friendly environment.

3.4.2.2 Positive versus negative support in ward allocation/placement experiences

The participants expressed what the support was like within the workplace. Some participants metioned that the environment reminded them of their loss. Triggers within the environment included intrusive thoughts and numbness, which can according to Kersting et al. (2022:188) continue for some time. In this sub-category the participants reported their different views of positive and negative support within the workplace. Pregnancy loss involves a loss of future life which is in contrast with grief in which the bereaved can draw on memories of the

deceased's life (Littlemore et al 2020:61-62). This was evidenced by the responses of some of the participants.

Positive support in ward allocation/placement experiences

Some participants reported that they were rotated to a different unit and did not work with newborn babies. The participant said:

"I was moved to another ward, it is more like a postnatal ward, but it was better as I was not in direct contact with fresh newborn babies and situations like hearing the first cry of a newborn baby after delivery" ***(P4)***

Other participants could not cope with daily duties and needed more time to gradually deal with the pregnancy loss, thus they were given an opportunity to have limited contact with the patients. The participants said:

"I was I just couldn't work with the babies for about a month when I came back, I was only doing administration because it was just too much for me" ***(P2)***

Negative support in ward allocation/placement experiences

Most participants reported that the challenge they faced was that they were still working in the same units with the same pregnant women and neonates, which was not easy for them. They experienced wondering thoughts and wanted to escape from the environment. One participant verbalized that it was overwhelming and she broke down while at work and tried to find a corner to hide and cry. Women often form attachments to their child early in the pregnancy, and therefore a pregnancy loss can be emotionally devastating regardless of the gestational age of the fetus (Wool et al. 2019:22).

"I remember one day I nearly crushed (sigh). I was looking at this baby, when I looked at the baby, I saw the baby as though it was the baby I had lost, just had to find a corner and cry" ***(P1)***

Some of the participants plead with managers that rotation of midwives who have lost a pregnancy and working in maternity units should be looked into to assist with the wellbeing of the staff. The participant said:

"Personally I would have preferred maybe to be removed from the current ward, like be put somewhere else until I felt comfortable enough to slowly fit back into maternity" ***(P7)***

Discussion regarding the negative and positive support in ward allocation/placement experiences

The participants were expected to function well in the same environment as though the loss had not occurred (Kersting et al. 2022:188). According to the participants it was difficult to face the pregnant woman and nurse them without triggering some thoughts that reminded them of what they had lost and what could have been (Kersting et al. 2022:188). Most of the participants preferred to be rotated to different units or given less duties to perform until they were fit enough to work with pregnant women and babies or were given duties that did not require patient contact. A shift in responsibilities is prioritised (Acutt et al. 2016:81).

Implications of results to nursing practice related to the negative and positive support in ward allocation/placement experiences:

Hesitation to work with pregnant woman and their neonates may occur as the participants experience triggering thoughts that are not pleasant resulting in emotional exhaustion. If not attended, it may lead to more serious conditions such as depression. On the other hand the pregnant woman and neonate may be neglected or even be treated with little empathy when facing emotional challenges when rendering care.

Conclusion of theme, categories and sub-categories

In conclusion, the employer plays an important role in leadership which is the responsibility to promote safe working conditions (Acutt et al 2016:81), which in this study was not evident as being prioritised. Management should provide a safe and therapeutic environment and support throughout burnout incidences, including the mental health of the affected participants (Du Toit et al. 2019:98). Some participants verbalized that they are still going through a grieving process because of a lack of support in the workplace (Acutt et al. 2016:327). Concerning shift in responsibility, most participants verbalised that it would have been better to be moved from the normal duties, like perhaps be rotated to a different unit. They felt strong enough to come back to the maternity unit when resuming duties, perhaps to do administrative work, but not work related to the delivery process, or be in direct contact with the patients. There is a great need to create awareness to workers as well as management regarding laws and regulations about maternity leave in the workplace (Akhtar et al. 2020:619).

3.5 SUMMARY

All the participants were midwives who lost a pregnancy and are still working in maternity units and are meeting the inclusion criteria as discussed in chapter 2. The theme, categories and sub-categories that emanated from the study were discussed in chapter 3. Chapter 4 concludes the study; the limitations were highlighted, and recommendations were made regarding support needs for midwives who lost a pregnancy while working in the maternity unit.

CHAPTER 4: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1. INTRODUCTION

The study findings were discussed and supported by literature in chapter 3. In chapter 4, the conclusions were made based on evidence collected from the individual interviews. Outlining the study's strengths, limitations, recommendations, and personal reflection by the researcher is part of chapter 4.

4.2. AIM, OBJECTIVE AND THE RESEARCH QUESTION OF THE STUDY

This study explores the support needs of midwives who experienced pregnancy loss and work in maternity units. The researcher described the impact of losing a pregnancy and their needs in perspective. The study used a qualitative, exploratory, and descriptive design where the perspectives of the participants were discussed. Data collection was done through interviews which captured detailed descriptions of the support needs of midwives during in-depth interviews and recording of field notes, and then data was analysed.

Despite challenges during data collection, the researcher strived to keep to the suggested questions. However, during the interview, other questions related to friendship, culture, religion, and rituals came to light, and those were also the questions asked of other participants. The research question was answered after extensive data analysis.

The researcher found it difficult at times to get appropriate recent references, as this topic has not much supportive literature as it is the first of its kind; however, the researcher did not give up. It was a learning curve. The researcher’s communication skills played a crucial role during the interviews. The researcher has learned from experiences, thoughts and feelings shared by the participants to see the study through their eyes, thus playing a vital role in personal and professional development, including interpersonal skills. The level of her self-confidence has also increased when talking about the study.

4.3. CONCLUSIONS

The conclusions are based on the theme that emerged in this study based on the support needs of midwives who lost a pregnancy while working in the maternity unit.

In this study, participants were asked, ‘‘Tell me about the support you received after the loss of your pregnancy’’. Most of the participants broadly responded to this question and elaborated on their support needs. The researcher did not repeat questions simply because the question posed was an open-ended question which allowed the participants to provide more details of their thoughts, feelings, and experiences. Some answered the follow-up questions from the main question.

They used verbal and non-verbal cues to support their statement. The researcher provided water and tissues in case there was a need; however, none of the participants needed them. The findings from this study showed that support needs of midwives who have lost a pregnancy should be considered when rendering services.

4.3.1. Support of midwives who experienced pregnancy loss and are caring for women during childbirth.

There are some participants who felt their immediate supervisor was supportive in every way and even referred them to employee wellness for counselling. However, three participants reported that they were not supported by management. Their common reason was that there was a lack of communication and a lack of patience by management.

The participants explained what the experience with a counsellor was like, where they discussed the impact of attending counselling that helped them acknowledge the pregnancy loss. However some participants did not attend the sessions. Those who attended reported support from the counsellor.

The institutional EWP comes should care for those unseen emotions and promote health to the employees. Some participants received the referral positively. Some participants declined as they did not feel like it, while others were referred but did not feel a need to go as they became optimistic that all will be well. Some participants verbalised a lack of confidentiality by the EWP department.

Participants felt that some colleagues were sidestepping them by avoiding a discussion of their pregnancy loss. Unless if the participant commented or indicated that they want to talk about it, no one was willing to have this conversation which most of the participants reported that they would appreciate. Some colleagues did not show support at all, moreover, they complained about an increased workload. However, some participants mentioned that their colleagues showed courtesy by showering them with gifts upon resuming duties.

Irrespective of the period the participants stayed home, all verbalised they felt that they needed more time away from work to process the grief as this was very sensitive to them, especially since they have to be in an environment where there are pregnant women and neonates. Most of the participants preferred to be rotated to different units or be given less duties to perform until they were fit enough to work with pregnant women and babies.

4.4. RECOMMENDATIONS

4.4.1 RECOMMENDATIONS FOR PRACTICE

The researcher recommends that the EWP offer counselling sessions for the midwives who have lost a pregnancy depending on the different challenges they face so that they can heal. In addition, to suggest support groups that will assist the midwives in the grieving process, the support group could be according to the midwife's preference; looking at the new evolution, some individuals may prefer social media platforms, whereas others prefer traditional face-to-face contact.

The researcher recommends that managers and supervisors take note of the emotional wellbeing of any midwife that has or is going through pregnancy loss and create a safe space for them. Thus, this will also encourage the midwives to verbalize their concerns and fears related to the triggers within the environment.

The researcher suggests that the immediate supervisors encompass possible rotation in different units upon resuming duties at least for two weeks or more so that the individual can orientate themselves back in the environment. In addition, to be aware that there will be triggers in the environment, therefore, be empathetic towards the individual. Supervisors should be given training regarding how to handle maternity bereavement for employees, in turn, conduct in-service training for all personnel in maternity units so they may understand the different ways to support midwives who have lost a pregnancy.

The researcher recommends that the various institutions have informative training for the personnel on supporting colleagues during pregnancy loss while working in the unit and be open to referrals from other nearby healthcare facilities according to the preferences of the midwife experiencing pregnancy loss. Hospital management should consider giving special attention to supporting the midwives who have lost a pregnancy while working in maternity units. This will assist participants in not neglecting their professional responsibility, and to familiarise themselves with pregnant women, including neonates.

4.4.2 RECOMMENDATIONS FOR FURTHER RESEARCH

The researcher recommends a comprehensive study that includes how midwives can be supported during and after the pregnancy loss based on their view and perspective looking at their different needs they have to cater for holistic services during maternity care.

Other research studies could develop a model that can be utilized by various health institutions where the model can outline different phases of support to midwives with a pregnancy loss. The phases should include principles of support during and after the pregnancy loss. However this will require observation as a method of data collection during which comprehensive field

notes will support the study. The study should explore patterns of behaviours the midwives encountered during care of the pregnant woman while grieving, including the non-verbal cues they portray towards the pregnant woman across the pregnancy until birth.

The researcher recommends revision of the revision of the Basic Conditions of Employment Act 75 of 1997 under maternity leave to cater for all types of pregnancy losses irrespective of the gestation, as a loss of pregnancy and emotional trauma is not defined by the gestation, and to consider adding medical termination of pregnancy in the policy. The amount of pain differs by the individual; however, that does not mean that the third trimester is more important than any other gestation. Furthermore, an additional clause should be included supporting the rotation of those midwives who experienced pregnancy loss for at least two weeks upon resuming duties provided the midwife is able to continue working in the same unit with no rotation or perhaps with minimal direct contact with the day-to-day births.

In addition, future studies can develop guidelines for support needs for midwives who have lost a pregnancy to help them to cope with daily activities. These guidelines will guide management and the immediate supervisors how to take care of personnel experiencing a pregnancy loss. Immediate referral to the EWP provided in the institution or the institution of choice and employee wellness programmes of the institution could be analysed statistically to restore confidentiality in the workplace.

4.5. PERSONAL REFLECTIONS

4.5.1. How the topic came about

The researcher was working in a maternity unit in one of the government institutions, where one day, the researcher went to the theatre for a patient to deliver an IUD through a caesarean section. It was a gloomy atmosphere as the researcher looked after this woman, who was now placed in the side room after the procedure to minimize contact with other pregnant women and postnatal women who sometimes overlap to the unit due to a shortage of beds. The researcher saw how the woman looked at the researcher as though there was more the researcher could do. What struck the researcher the most was when the husband came by and requested to see the demised foetus; their emotions were traumatic.

As the researcher stood there, allowing them to view the foetus and go through their emotions, she put herself in the woman's shoes. The question was: “How does one cope with the loss, especially if you have to face a woman who has given birth in the unit, the faint cries from neonates, the signs of pregnancy in another woman, yet you have lost a pregnancy?” “How does one cope?” “What about the surgical scar as she delivered via caesarean section?

A few years after the incident, the same question came back to thought as the researcher experienced this with some colleagues and midwives. A colleague worked with antenatal, postnatal and women during intrapartum, including neonates at delivery. The colleague was pregnant; unfortunately, the colleague lost the pregnancy and was booked off for the burial period and was only granted family responsibility days, which was just 5 days, only a week. No changes were made upon resuming duties, and the colleague was expected to continue delegation like normal days. This is how the researcher grew more interested in the topic but did not know how to phrase the topic. The researcher was fortunate to interview several colleagues who experienced pregnancy loss, encouraging the researcher to pursue the topic.

4.5.2. Supervisors

The researcher is grateful to the supervisors who ensured that the researcher received support. The researcher remembers meeting them for the first time during her interview. They already showed interest in the topic and somehow had a better way of rephrasing the topic than how the researcher had tried to develop the preliminary topic, and the study's main aim was not altered at all. The researcher found the advice given by supervisors very helpful in terms of increasing the quality of the research report, and they ensured their availability any time of the day, even during weekends. However, the researcher had difficulties attaining participants as the participants felt the topic was intense; for some, it was so sensitive that they could not take part no matter the situation, thus delaying my completion. This was when my supervisor advised me to apply for an extension and keep trying, and feedback was given to the supervisor now and then about the progress. The researcher took 14 months to obtain approval from institutions, find participants, and conduct the interviews. With all this, the supervisors kept the researcher going.

4.5.3. Data collection

Initially, 3 hospitals, namely Tshwane District Hospital, Jubilee District Hospital and Pretoria West hospital, were the hospitals of choice for data collection. The process of applying for approval in the institutions took longer. When the approval came, data collection was restricted due to the Covid-19 pandemic in Tshwane District Hospital, whilst Jubilee District Hospital and Pretoria West hospital were hospitals the participants verbalized, they were not comfortable discussing the loss or taking part in the research. The researcher, therefore, reapplied for approval in other institutions. While waiting for a response, the researcher fell sick and had hoarseness of voice for 3-4 months, which was from 1 September 2021 to 15 January 2022 and had to wait till her voice was better, which meant the researcher would not complete her degree as stipulated, the researcher, therefore, applied for an extension of study and her supervisor guided her on how to go about it. The researcher then received approval from the HOD and Dean and could register.

The researcher has also applied for approval in the following institutions, including NHRD:

Mamelodi Regional Hospital

Phedisong 4 CHC

Kgabo CHC

Soshanguve 3 CHC

Odi District Hospital

Dr. George Mukhari Academic Hospital

Kalafong Provincial Tertiary Hospital

Steve Biko Academic Hospital

Laudium CHC

Stanza Bopape CHC

Eersterust CHC

Bronkhorspruit Hospital

Temba CHC

Refentse CHC

As stated in the proposal that the researcher would request study permission from unit managers, the researcher did so. The unit managers were welcoming and gave permission prior to conducting interviews.

4.5.4. Interview setting

Field notes were written, and the interview was recorded. During the interview, nonverbal cues were observed. The researcher used English as a medium.

Participant 1 preferred to be interviewed when she was off and at her home. The researcher went to her home as requested. The room was private as it was only the two of us. There was good lighting and ventilation; however, there was noise during the interview since they were busy renovating the kitchen. There was a sense of relief when communicating with her, as the nonverbal cues were congruent with what was being discussed. She was comfortable talking about the loss of pregnancy.

Participant 2 The interview was conducted in the OPM's office, which is closer to the neonate's cubicle with monitoring machines on and some staff members discussing a work-related issue; hence there was noise during the interview and there were interruptions as one colleague opened the door where we were conducting the interview, greeted us and left. The participant wanted to communicate more with the researcher after the interview as she felt comfortable talking to the researcher who was friendly and showed interest and support.

Participant 3 The interview was conducted in the hospital in a room closer to the cubicle; hence there was noise during the interview, but no interruptions occurred. The participant preferred to do the interview during her break to avoid disturbing the daily ward routine. The room was private. A pen was dropped during the recording. Silent moments occurred between questions.

Participant 4 The interview was conducted in the hospital, in the tearoom closer to the cubicle; hence there was minimal noise during the interview, and interruptions occurred by one of the colleagues. The participant preferred to do the interview prior commencing with duty.

Participant 5 The interview was conducted in the hospital, in the unit manager's office.

Participant 6 The interview was conducted at the participant's home, there was privacy.

Participant 7 The interview was conducted in the hospital in the OPM's office.

Participant 8 The interview was conducted in the hospital in the OPM's office.

Participant 9 The interview was conducted in the hospital in the OPM's office.

Participant 10 The interview was conducted in the hospital in the OPM's office.

Participant 11 The interview was conducted at the participant's home as she needed a familiar environment that would enable her to talk freely. The room used was close to the kitchen, there was someone in the kitchen hence there was noise during the interview of a door opening, but no interruptions occurred.

4.6. STRENGTHS AND LIMITATIONS

The researcher experienced the following strengths and limitations as stated below:

To begin with, the approach used to conduct the interview became the researcher's strength. However, before commencing the interviews, the researcher had an incident and was afraid of observing a participant breaking down during the interview. Thus, the in-depth interviews revealed that emotions are hard to ignore during such an intense topic. When the researcher listened to the tape recordings while trying to analyse the data, it was overwhelming not to be in sync with emotions. The researcher noticed that there was some form of sympathy rather than empathy towards the participants during the interviews. However, the researcher noted that and improved as more interviews were conducted.

Data collection was a serious challenge as the researcher struggled to find participants. The researcher approached different institutions seeking approval, as stated in 4.5.3 under data collection. It took 14 months to find eligible and willing participants. The researcher was also sick, with no voice for 4 months. Hence during the first participant's recording the researcher's

voice was hoarse. The researcher established rapport with managers. The researcher was assisted by the managers to identify possible participants who were more than willing to help as they saw that colleagues might not be supported as it is rare to talk about the loss of pregnancy. They verbalized they were looking forward to the study recommendations. A few participants initially agreed to participate and later withdrew their consent to participate, which was a limitation as fewer participants were interviewed.

4.7. CONCLUSION

This study explored different ways of support for midwives who lost a pregnancy while working in maternity units and are caring for women during childbirth. A qualitative, explorative, and descriptive research design was used, and 11 midwives were interviewed. They shared different views about their experiences and support as individuals in different institutions. The findings from this study showed that the loss of pregnancy poses various challenges, especially emotional discomfort and trauma encountered as a trigger in some situations, such as working with neonates. However, they verbalized during interviews that the situation is manageable. Recommendations were made on how to best support the midwives who have lost a pregnancy while working in maternity units.

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ANNEXURE A

- Informed consent -

INFORMED CONSENT DOCUMENT

STUDY TITLE: SUPPORT NEEDS OF MIDWIVES WHO HAVE LOST A PREGNANCY AND ARE CARING FOR OTHER WOMEN DURING CHILDBIRTH IN TSHWANE DISTRICT

Principal Investigators: MD Mamabolo
Institution: University of Pretoria

DAYTIME AND AFTER-HOURS TELEPHONE NUMBER(S):
Daytime numbers: 073 475 1712
Afterhours: 073 475 1712

DATE AND TIME OF POST INFORMED CONSENT DISCUSSION:

Date	**Month**	**Year**

:
Time

Dear Participant

Dear Mr. / Mrs. .... date of consent procedure …....../…....../….......

1) INTRODUCTION

You are invited to volunteer for a research study. his information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about all the procedures involved. Please take note that no remuneration will be awarded for participation in this study.

2) THE NATURE AND PURPOSE OF THIS STUDY

You are invited to take part in a research study. The aim of this study will be to gain an in-depth understanding of the support needs of midwives who have lost a pregnancy and are caring for other women during childbirth in Tshwane district. You are considered as being a very important source of information and are thus requested to volunteer to take part in this study. The following are proposed to achieve the aim of this study:

- The aim and objective of this study is to qualitatively explore the support needs of midwives who have lost their pregnancy and working in maternity units and to describe the impact of losing a pregnancy through their eyes.
- The researcher intends to recommend coping strategies/programs can be employed for midwives who have lost their pregnancy.

3) EXPLANATION OF PROCEDURES AND WHAT WILL BE EXPECTED FROM PARTICIPANTS

Midwives who have lost a pregnancy working in maternity units are requested to participate in the study. This study involves unstructured interviews. The researcher will ask you some questions about your experiences of losing a pregnancy. The interview may be recorded with your permission, notes will be taken also just review the answers and ask more question as the need to clarify arises.

4) POSSIBLE RISKS AND DISCOMFORT INVOLVED

There are emotional risks that may occur in participating in the study. You will be referred to the hospital psychologist if necessary. The interview will take about 45-60 minutes of your time.

5) POSSIBLE BENEFITS OF THIS STUDY.

Although you will not benefit directly from the study, the results of the study will enable us to understand experiences of midwives who lost a pregnancy in your institution.

6) COMPENSATION

You will not be paid to take part in the study.

7) YOUR RIGHTS AS A RESEARCH PARTICIPANT

Your participation in this study is entirely voluntary. You will be allowed to withdraw from participation in the study or stop at any time without giving any reason. You will not incur any penalty from withdrawal from the study.

8) ETHICAL APPROVAL

The Faculty of Health Sciences' Research Ethics Committee at the University of Pretoria and your Nursing Education Institution has given written approval for this study. The study has been structured in accordance with the Declaration of Helsinki (last updated: October 2013), which deals with the recommendations guiding nurses in research involving humans. A copy of the Declaration may be obtained from the investigator should you wish to review it. Please feel free to contact the Research Ethics Committee, if you need any clarification pertaining to ethical approval. Faculty of Health Sciences University of Pretoria’s Office: Tel: 012 356 3084 or 012 356 3085.

9) INFORMATION

If you have any questions concerning your participation in this study, you should feel free to contact the principal researcher: Mosima Dina Mamabolo - Cell: 073 475 1712.

Email address: modimams@gmail.com

Or contact my supervisors	: Dr M Yazbek	082 576 3558
	: Mrs C Jordaan-Schlebusch	083 357 2311

10) CONFIDENTIALITY

All records obtained whilst in this study will be regarded as confidential. Your input into this study will also be kept strictly confidential. Results and reports will be published in accredited scientific journals and presented in such a manner that your identification as a participant will remain anonymous.

11) CONSENT TO PARTICIPATE IN THIS STUDY

The content and meaning of this information leaflet have been explained to me. I agree that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously managed into study reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way. I hereby volunteer to take part in this study.

I have received a copy to sign this informed consent agreement.

....	....
Participant's name (Please Print)	Date
....	....
Participant's signature	Date
....	....
Investigator's name (Please Print)	Date
....	....
Investigator's signature	Date

....

Witness's name Date

....

Witness's signature Date

ANNEXURE B
- Interview guide -

INTERVIEW GUIDE

Main question: 'Tell me about the support you received after the loss of your pregnancy'

What measures related to support have you used to cope with the loss of pregnancy and how else do you think you can be supported?

Probing questions

1. How were you supported during the loss of your pregnancy through miscarriage or stillborn?
2. Upon resuming duties after your loss, how did you feel working with pregnant women and neonates, yet you have lost a pregnancy?
3. Have you received professional help after the loss?
4. How did your colleagues show care and support you during this time?
5. What support did you receive from the employer? If so, how were you supported? If not, what was the best way you think you could have been assisted?
6. Tell me more about the expectations you had regarding to the kind of support you had from your employer after the loss of pregnancy.
7. What measures have you taken to support yourself after the loss of pregnancy?

ANNEXURE C

- Ethical Clearance -

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IORG #: IORG0001762 OMB No. 0990-0279 Approved for use through February 28, 2022 and Expires: 03/04/2023.

13 April 2021

Miss MD Mamabolo
Department of Nursing Science
Faculty of Health Science
University of Pretoria

Dear Miss MD Mamabolo

RE: Submitted document for Protocol Number Other Docs

Number	**694/2020 – Line 1**
Title	**SUPPORT NEEDS OF MIDWIVES WHO HAVE LOST A PREGNANCY AND ARE PROVIDING MATERNAL HEALTH CARE SERVICES IN TSHWANE DISTRICT**
Investigator	**Miss MD Mamabolo**
Supervisor	**Dr M Yazbek**
Sponsor	-
Document(s)	**Other Docs - Hospital approvals** **Other Docs - hospital approvals** **Other Docs - Hospital approval** **Other Docs - NHLS**

We hereby acknowledge receipt of the documents received on 2021-03-01 and note the content thereof. They were considered on 2021-03-31 as resolved by its quorate meeting and found acceptable.

Yours sincerely

Professor Werdie (CW) Van Staden
MBChB MMed(Psych) MD FCPsych(SA) FTCL UPLM
Chairperson: Faculty of Health Sciences Research Ethics Committee

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

Research Ethics Committee
Room 4-60, Level 4, Tswelopele Building
University of Pretoria, Private Bag x323
Gezina 0031, South Africa
Tel +27 (0)12 356 3084
Email: deepeka.behari@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

ANNEXURE D

- Clearance certificates -

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. Manei Letebele-Hartell
Tel: +27 12 451 9036
E-mail: Troy.Mashabela@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 22/02/2021
PROJECT NUMBER: 09/2021
NHRD REFERENCE NUMBER: GP_202011_067

TOPIC: Support Needs of Midwives Who Have Lost A Pregnancy and Are Providing Maternal Health Care Services in Tshwane District

Name of the Lead Researcher: Ms Mosima Dina Mamabolo

Name of the Supervisor: Dr M Yazbek
Dr I Ramavoya

Facilities: Tshwane District Hospital
Jubilee District Hospital
Pretoria West Hospital

Name of the Department: University of Pretoria

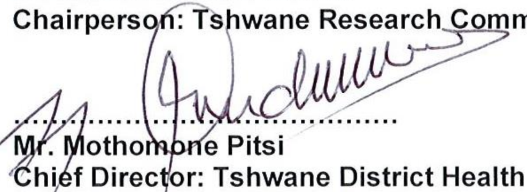
NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

……………………………………
Dr. Manei Letebele-Hartell
Chairperson: Tshwane Research Committee

Date. 22/02/2021



……………………………………
Mr. Mothomone Pitsi
Chief Director: Tshwane District Health

Date: 25/02/2021

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. Manei Letebele-Hartell
Tel: +27 12 451 9036
E-mail: Troy.Mashabela@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 15/06/2022
PROJECT NUMBER: 41/2022
NHRD REFERENCE NUMBER: GP_202205_026

TOPIC: Support Needs of Midwives Who Have Lost a Pregnancy and Are Providing Maternal Health Care Services in Tshwane District.

Name of the Lead Researcher: Ms Mosima Dina Mamabolo

Name of the Supervisor: Dr M Yazbek
Dr I Ramavoya

Facilities:

Refentse CHC
Temba CHC
Tshwane District Hospital
Jubilee District Hospital
Mamelodi Hospital
ODI District Hospital
Pretoria West Hospital

Name of the Department: University of The Witwatersrand

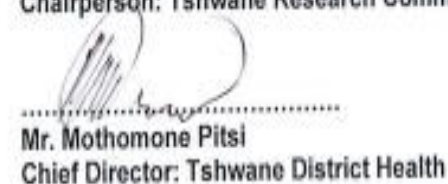
NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: **APPROVED**

Dr. Manei Letebele-Hartell
Chairperson: Tshwane Research Committee

Date: 15/06/2022



Mr. Mothomone Pitsi
Chief Director: Tshwane District Health

Date: 2022-06-17

Annexure 1

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DECLARATION OF INTENT FROM THE PHC MANAGER FOR TSHWANE PROVINCIAL CLINICS

I give preliminary permission to **Ms Mosima Dina Mamabolo** to do his or her research on **"Support Needs of Midwives Who Have Lost a Pregnancy and Are Providing Maternal Health Care Services in Tshwane District"** In **Refentse CHC (ODI) and Temba CHC**

I know that the final approval will be from the Tshwane District Research Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the PHC Manager to the Researcher are

The researcher to have an entry meeting with potential facilities before starting with the data collection.

Mr M. Makhudu
Primary Health Care: Tshwane
Date: 21/6/2022

ANNEXURE E
- Data analysis coding certificate -

RESEARCH DATA ANALYSIS REPORT

FOR: MD MAMABOLO
14153654

STUDY: SUPPORT NEEDS OF MIDWIVES WHO EXPERIENCED PREGNANCY LOSS AND ARE CARING FOR WOMEN DURING CHILDBIRTH IN TSHWANE DISTRICT

INDEPENDENT CODER: Annatjie van der Wath

Saturation of data was achieved related to the major themes – The researcher conducted eleven interviews

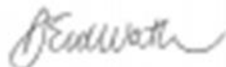
Dr Annatjie van der Wath (M Cur, PhD) annavdw@mweb.co.za

Qualitative Data Analysis

This serves to confirm that Annatjie van der Wath has co-coded the following qualitative data: Eleven interviews for the study:

SUPPORT NEEDS OF MIDWIVES WHO EXPERIENCED PREGNANCY LOSS AND ARE CARING FOR WOMEN DURING CHILDBIRTH IN TSHWANE DISTRICT

I declare that the candidate and I have reached consensus on the major themes and categories as reflected in the findings during a consensus discussion.



Annatjie van der Wath (M Cur, Ph D) annavdw@mweb.co.za

ANNEXURE F

- Verbatim transcribed interview/s -

VERBATIM TRANSCRIPTION: 11 Participants

MD Mamabolo 14153654
Masters' student 2022

R: Researcher
P: Participant

PARTICIPANT 1
21:46.09 MINUTES
The participant preferred to be interviewed when she is off and at her home

R: (inaudible) hence I am recording. I have shown you the letter which is approved from the university as proof for you to see they are updated and then another thing the risk that can be involved because this topic is very sensitive it's more on emotional wellbeing, discomfort. You find out you are trying to deal with the situation and here I come again then I am asking questions however on the proposal there is a clause there that is why I looked for this letter so that they can give me,
P: mmm
R: Again, they can refer you for counselling should there be a need
P: Ok
R: Should you need it
P: Who will be referring me there?
R: At the EWP as I will give them the results so they can refer you at work
P: Ok
R: Counselling at work
P: By the employer
R: In the institution
P: Ok
R: Yes
So, but it depends if you are comfortable to go to the institutional counselling or not, or should you choose to have a private counselor or not, but however there is no compensation for the study given to any individual
P: Ok

R: So, it's only just to understand the experiences of each and every participant as we do not have the same experiences

P: Mmmm

R: Because the support will also be different

So, on the back of the page, you will find a consent you give when you agree to take part in the research interview

May you kindly write your name and surname here (showing the participant), date and then signature

P: Ok

R: I will fill in the rest and go over it, so when you are ready

P: Oh, so you need my name, but you are not going to publish my name

R: No, this is just for auditing purposes at school so they can see I have conducted the interview

P: Ok

R: Remember I can just go and say I conducted the interview only to find out I did not go

P: Alright

R: So, they can know that I have conducted the interview, hence on the last page (showing fieldnotes) it's just for them to see in case they need to verify if there was an interview with that person but has nothing to do with publishing

P: Mmmm

R: Even now that we are also recording so they can get the information for validation

P: Oh, you are going to record our conversation

R: Yes, so they can see I conducted the interview, because at some point the experiences are better when you are quoting them as they are, to say if it was more than one session or not depend on the other participants too on how they see it, perhaps you find out that you have the same content or its not it's just for you to know but confidentiality wise this information will not be taken anywhere. This form is showing you basically the criteria that they are looking for (fieldnotes), they need to know the occupation, they need to know if you are married or not because of the questions that will be posed, you will see with some of the questions why certain information is needed (referring to demographic data)

P: Mmmm

R: Perhaps maybe let me start by this, can I have your name and surname

P: Oh here

R: Yes, I will write on this page so you are able to see what we will discuss (referring to fieldnotes)

P: My name is ……..

R: Oh, perhaps let me let you fill in your details and will take it from there

P: I was thinking let's do the questions if its ok with you then I will fill in my details afterwards including the consent form
R: Ok no problem
Ok the main question is 'Tell me about the support you received after the loss of your pregnancy' for you as an individual, how was the experience and how were you coping, the experience
P: Ok, obviously there is pain, you know the pain in which way, like in my case its was IUFD at term, so the pain in such a way that I kept asking myself "why God, why did you allow me to carry it up to this far, knowing that I am not going to achieve, I am not going to hold this baby"
R: Ok
P: Yes, I felt I was blaming God, I felt the pain but at the same time I was blaming myself, as a midwife how can I miss something like this while I work in this area daily
R: Mmmm and that thing that you know what happens
P: Yes
R: So, like what precautions could you have taken
P: Yes
R: So basically, the most experience was self-blame than any other
P: Mmmm
R: Ok when you were looking for support, what kind of support did you get to overcome the situation because right now the main aim you were blaming yourself for the situation, so how did you cope
P: The support in terms of my employer
R: No, from yourself before the employer, only you now, to say as an individual how did you deal with it on your own
P: I just told myself that I will forget, I am not a small child whereby I will always only be focusing on the loss alone, I told myself life must go on and this was my fifth pregnancy. I was comforted that at least I have these other four children
R: Ok
P: Mmmm
R: So, in a way its that thing of saying yes, I lost but I still have hope because I still have other children
P: Yes, and that I am not the first person to go through this and I will not be the last person to, especially as I see this happening daily at work
R: Ok
And then now, during the period of the loss, how long were you booked off before you went back to work

P: Six week as per the maternity leave policy
R: Ok, and then after you came back to work how was the environment
P: The environment was weird in such a way that, you are asking yourself that what will people think, I am a looser and maybe I am even stupid
R: Mmmm
P: In such a way that I am a midwife, but I missed something of this nature which is even part of my job description, and it is my job to identify such things to save life
Yes, and the fact that I felt like I am healing, and people are going to come again and start asking questions
R: It starts again
P: Yes, it starts again especially the pitying
R: Oh, and obviously it will take you back to that again
P: Yes
R: So, now when you are working and experience a mother who is losing her child, how did that affect you
P: Yoo, I felt like it was me, especially immediately after resuming duties
R: Mmmm
P: Like I would take the situation the woman is in and have the same experience as she does
R: So, you are more sympathetic
P: Yes, you look at the woman as though it is you
R: Eish
P: Like you become completely empathetic not sympathetic, like you are in this person's situation now
R: Yes, but with sympathy it's more like when I cry you cry but with empathy if I cry you try to say, how best can we solve this, so, it's more towards sympathy
P: Sympathy
R: Because sympathy you can be uncontrollable
P: Mmmm
R: If that mother comes to you and try to talk to and tells you how they feel, it's just that way
P: Mmmm
R: And then did you like look for any professional help after seeing the challenges that you were facing at that time
P: No
R: Do you perhaps know why you didn't look for help
P: I think I felt like I am coping
R: Ok

P: Mmmm

R: Like the normal routine you use to do it the same way as if you are coming back from work and your routine is to do wash clothes, you continue with the tasks, like bathing etc.?

P: Yes

R: Then nothing was changed is just the feeling that you had

P: Yes, and that thing of saying that sometimes you think you feeling well but occasionally, I would have flashbacks

R: Yes

P: Yes

R: And then your colleagues at work, how did they show support towards you

P: Eish, my OPM suggested that she can refer me to EPW

R: Yes, ok

P: Yes, Employee Wellness

R: Program

P: Yes, initially I agreed to go thinking that I need it, so while they were busy with the process organizing for me, I then changed my mind as I felt I am well

R: Ok

So, you felt like you didn't want to talk to anyone else about this?

P: Yes

R: Was it because it will be a different person like a stranger, or you felt like you would rather talk to someone you are close to about the situation.

P: I think on my case, I kept having this thing of saying that I am not a child I cannot keep crying, like by that time I was 41 years old. I kept telling myself that I must be strong I am not a child

R: Mmmm

P: If maybe I always expect people to pity and all those things

R: From people

P: Yes

R: Its like taking you back again

P: Yes

R: And then besides the OPM, how did your colleagues especially those who work hands on with you, like when you conduct a delivery they are there, how was the treatment or the environment, how did they make you feel supported

ANNEXURE G

- Editor coding certificate -

REGCOR
ENTERPRISES PTY LTD
(2015/375453/07)

Date: 20/12/2022

Dear Sir/Madam

This letter is to certify that I, Sarah Louise Cornelius, of Regcor Enterprises Pty Ltd, have completed the initial editing of the dissertation titled *SUPPORT NEEDS OF MIDWIVES WHO EXPERIENCED PREGNANCY LOSS AND ARE PROVIDING MATERNAL HEALTH CARE SERVICES IN TSHWANE DISTRICT* by Mosima Dina Mamabolo.

I have ten years of experience in the field, having worked on multiple doctorates. Currently, I am a member of the Professional Editor's Guild (PEG).

All recommendations and errors have been noted in the comments. Any changes or lack of corrections done to the document after editing is not a reflection of the editing services provided. The onus is on the student to make sure the document is fully corrected before final submission even if that requires multiple edits.

Kind Regards
Sarah Louise Cornelius

Professional Editor's Guild
Associate Member
Membership number: COR003
Regcor Enterprises Pty Ltd
Registration no: 2015/375453/07
Contact no: 0768156437
Email: sarah@regcor.co.za