



**UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA**

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**Faculty of Health Sciences  
School of Health Care Sciences  
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**THE ROLE OF ADVANCED MIDWIVES REGARDING MATERNITY CARE IN TERTIARY  
HOSPITALS IN GAUTENG**

**SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE**

**MCur  
in  
Midwifery**

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**DATE:** January 2017

## DECLARATION

I, Mbulaheni Rhona Luphai, hereby declare that the study entitled, *The role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng*, is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. I further declare that this work has not been submitted for any other degree at any other institution.

Mbulaheni Rhona Luphai

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Signature

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Date

## ACKNOWLEDGEMENTS

Above all I would like to thank God, my Heavenly Father, for giving me the opportunity, ability and inner strength to complete this study.

My sincere gratitude and thanks goes to the following individuals – without them in my life I would not have accomplished this enormous task.

- My supervisor, Dr Mariatha Yazbek, for the guidance and encouragement as well as her excellent motivation and patience throughout the study process.
- My co-supervisor, Dr Sanah Mataboge, for her motivation and support and also for being an outstanding organiser during the time of data collection.
- To my moderator, Dr Sonya Beukes, an excellent independent researcher who assisted me with the focus group interviews and collection of data.
- The management of the Chris Hani Baragwanath, Charlotte Maxeke, George Mukhari and Steve Biko tertiary hospitals for giving me the opportunity to conduct this study.
- To Ms Suzette M Swart for editing this work
- To Mrs Rohuliswa C. Sigidi for operating audio-tapes in focus groups.
- To my husband, Victor Mbulungeni, and my children, Mikovhe, Sedzani, Rohuliswa, Hangwelani and my daughter-in-law, Keamogetsoe as well as my son-in-law, Rudzani Sigidi, who supported me, never discouraged me and believed that I could fulfil my dream even at this age.
- To my mother, Lydia Mbulaheni Madzhia, and my late father, William Thidziambi Madzhia, for moulding me and encouraging me to be what I am today.

- To my loving sister, Dolly Munyadziwa Radzilani, and my loving brother, Gerson Maano Madzhia, for the support and encouraging words when I wanted to give up.
- To the Madzhia family (Khoru ya Vhaduhulu vha vho Maano), Luphai family (Khoru ya Vhaduhulu vha Vho Nyaluvhani Tshililo) and Tshamano family (Khoru ya Vhaduhulu vha ha Mukhufhi) – a sincere word of thanks to you for your support.
- To my grandchildren who loved and supported me even when I could not spend much fun time with them: Rinae, Umpha, Urifhe and Ompfa Luphai, Oluga, Ontonda and Ompfuna Sigidi.
- A sincere word of thanks to the advanced midwives in tertiary hospitals in Gauteng. There is an African idiom which says, “munwe muthihi a u tusi mathuthu”. This study would not have been possible without your valuable contributions.



## ABSTRACT

The researcher explored the role of advanced midwives allocated in maternity care in tertiary hospitals in Gauteng. Advanced midwives form part of the multidisciplinary team in Gauteng tertiary hospitals in accordance with the staffing norms as prescribed by the Maternity Guidelines of South Africa for advanced practice nurses. Advanced practice nursing (APN) strengthens nursing and advanced practices to assist and fill in where there is a shortage of physicians in rural and densely populated areas. The scope of practice in tertiary hospitals for advanced practice nurses is not explicit; the role of advanced midwives in these hospitals is not clearly defined and, as a result, the role of the advanced midwife and physician overlap in tertiary hospitals in South Africa.

A qualitative, exploratory, descriptive and contextual research design was followed. Advanced midwives allocated in three selected tertiary hospitals in Gauteng served as the study population. After conducting a pilot study at the fourth tertiary hospital in Gauteng, data collection occurred during three focus group interviews. Field notes were taken. Application letters for obtaining ethical permission and permission in the setting were sent to the chief executive officers (CEOs) of the three selected hospitals. All ethical principles were strictly adhered to. A moderator was used to conduct the focus groups in a quiet setting of each hospital. Participation was voluntary and informed consent was signed. The collected data was analysed by using the 8 steps of the Tesch's model of data analysis. Trustworthiness was adhered to with confirmability, credibility, dependability and transferability. The study findings were discussed and confirmed by literature control. The limitation of this study was highlighted.

The findings revealed three main themes: positive attributes of advanced midwives, responsibilities of advanced midwives in tertiary hospitals and challenges posed by patients who do not adhere to the admission criteria.

The recommendations were made for the support and supervision of the utilisation of advanced midwives in tertiary hospitals by the Gauteng Department of Health employing body, support by training

institutions/universities, support for advanced midwives by nursing management, and self-empowerment of the advanced midwife.

The conclusion was that advanced midwives are not optimally utilised. Support recommendations were made to different stakeholders on strengthening multidisciplinary team decision making on management of patient care. Further research studies on the placement of advanced midwives within tertiary hospitals were recommended.

## TABLE OF CONTENTS

DECLARATION	i
ACKNOWLEDGEMENTS	ii
ABSTRACT	iv

	Page
<b>CHAPTER 1: ORIENTATION TO THE STUDY</b>	<b>1</b>
1.1 INTRODUCTION AND BACKGROUND	1
1.2 PROBLEM STATEMENT	6
1.3 RESEARCH QUESTION	7
1.4 AIM OF THE STUDY	7
1.5 OBJECTIVE OF THE STUDY	7
1.6 SIGNIFICANCE OF THE STUDY	7
1.7 CLARIFICATION OF CONCEPTS	8
1.7.1 Advanced midwife	8
1.7.2 Tertiary hospital	8
1.8 RESEARCH PARADIGM	10
1.8.1 Constructive paradigm	10
1.8.2 Epistemological assumption	10
1.8.3 Ontology	11
1.9 RESEARCH METHODOLOGY	11
1.9.1 The researcher	14
1.9.2 The moderator	14
1.10 TRUSTWORTHINESS	15
1.10.1 Truth value	15
1.10.2 Applicability	15
1.10.3 Consistency	16
1.10.4 Neutrality	16
1.11 ETHICAL CONSIDERATIONS	16
1.11.1 Informed consent	16
1.11.2 Beneficence	17
1.12 OUTLINE OF THE STUDY	17
1.13 CONCLUSION	18

<b>CHAPTER 2: RESEARCH METHODOLOGY</b>	<b>19</b>
2.1 INTRODUCTION	19
2.2. Research design	20
2.2.1 Qualitative design	20
2.2.2 Exploratory design	21
2.2.3 Descriptive design	21
2.3 Study setting	22
2.4 Research method	23
2.4.1 Study population	23
2.4.2 Sampling	24
2.4.2.1 Inclusion criteria	25
2.4.2.2 Exclusion criteria	26
2.5 DATA COLLECTION METHOD	26
2.5.1 Focus group interviews	26
2.5.2 Field notes	28
2.6 ACTUAL DATA COLLECTION	29
2.7 PREPARATIONS FOR THE DATA COLLECTION PROCESS: FOCUS GROUP INTERVIEWS	30
2.7.1 Preparatory phase	30
2.7.1.1 Preparing the venue	31
2.7.1.2 Recruitment of participants, moderator and audiotape operator	31
2.7.2 Preparations for interview questions	33
2.7.2.1 Pilot testing	34
2.7.3 Conducting the interviews	35
2.7.3.1 Communication skills	37
2.7.4 Post interview phase	39
2.7.4.1 Identifying data of the participants	39
2.8 DATA ANALYSIS	39
2.9 MEASURES TO ENSURE TRUSTWORTHINESS	41
2.10 CONCLUSION	44
<b>CHAPTER 3: DISCUSSION OF FINDINGS AND LITERATURE</b>	
<b>CONTROL</b>	<b>45</b>
3.1 INTRODUCTION	45
3.2 DATA COLLECTION SUMMARY	45
3.3 OPERATIONALISING THE FIELD OF RESEARCH	45
3.4 DATA ANALYSIS PROCESS	46
3.5 DISCUSSION OF FINDINGS AND LITERATURE CONTROL	48
3.5.1 Theme 1: Position of advanced midwives in tertiary hospitals	48

3.5.1.1	Category 1: Perceived positioning of advanced midwives	48
	• Need for advanced midwives in tertiary hospitals	48
	• Own perception of advanced midwives of their position	51
	• Perception of medical personnel of the position of advanced midwives	52
	• Perception of institution	55
3.5.2	Theme 2: Responsibilities of advanced midwives	59
3.5.2.1	Category 1: Contribute to quality care	60
	• Monitoring and evaluation of quality care	60
	• Remaining skilled and knowledgeable	62
	• Be advocate and educator for patients	63
	• Participating in research	66
3.5.2.2	Category 2: Contribution through teaching	68
	• Teaching medical and nursing students	69
	• Teaching colleagues ( including registrars and midwives)	70
3.5.2.3	Category 3: Dealing with managerial issues	71
	• Deal with staff shortage	71
	• Deal with none human resources	75
3.5.2.4	Category 4: Dealing with challenges related to admissions of patients	79
	• Admission of unbooked patients and self-referrals	79
	• Collaboration with MOUs and district hospitals	84
3.6	CONCLUSION	87
	<b>CHAPTER 4: CONCLUSION, RECOMMENDATIONS, IMPLICATIONS AND LIMITATIONS OF THE STUDY</b>	<b>88</b>
4.2	CONCLUSIONS	88
4.2.1	Theme 1: Position of advanced midwives	88
4.2.1.1	Category 1.1 : Perceived positioning of advanced midwives	88
4.2.2	Responsibilities of advanced midwives	90
4.2.2.1	Category .2.1: Contribute to quality care	90
4.2.2.2	Cetegory 2.2: Contribute through teaching	91
4.2.2.3	Category 2.3: Dealing with managerial issues	93
4.2.2.4	Category 2.4: Dealing with challenges related to patient admissions	94
4.3	RECOMMENDATIONS	95
4.3.1	Support and supervision of utilisation of advanced midwives' knowledge and skills in tertiary hospitals by Gauteng Department of	

	Health as employer	95
4.3.2	Support by the registering body – South African Nursing Council (SANC)	96
4.3.3	Support by training institutions/universities	97
4.3.4	Support for advanced midwives by nursing management	97
4.3.5	Self-empowerment of advanced midwives through assertiveness	98
4.4	RECOMMENDATIONS FOR FURTHER RESEARCH	98
4.5	IMPLICATIONS FOR PRACTICE	98
4.5.1	Advanced midwives	99
4.5.2	Tertiary hospitals in Gauteng	99
4.5.3	Gauteng Department of Health/employing body	99
4.6	LIMITATIONS OF THE STUDY	100
4.7	FINAL CONCLUSION	100
5.	LIST OF REFERENCES	102
6.	LIST OF ANNEXURES	116

### LIST OF TABLES

Table 1.1	Methodology process	12
Table 3.1	Summary of the participants	46
Table 3.2	Summary of themes, categories and subcategories	47

## LIST OF ABBREVIATIONS

ALSO	Australia Life Support in Obstetrics
ARV	Antiretroviral
APN	Advanced Practice Nursing
CEO	Chief Executive Officer
CPD	Continuous Professional Development
CS	Caesarean Section
CTG	Cardiotocography
DC42	Sedibeng District
DC46	Metsweding District
DC48	West Rand District
DoH	Department of Health
EKU	Ekurhuleni Metropolitan
EmONC	Emergency Obstetrics Care and New-born Care
ESMOE	Essential Steps of Managing Obstetric Emergency
FIGO	Federation of Gynaecology and Obstetrics
FSB	Fresh Stillbirth
HDACC	Health Data Advisory and Co-ordination Committee
ICN	International Council of Nurses
KZN	KwaZulu-Natal
MDGs	Millennium Development Goals
MOU	Midwifery Obstetrics United
NHP	National Health Plan
NHS	Nation Health Service
PV	Per Vaginal Examination
SANC	South African Nursing Council

SANC REG	South African Nursing Council Regulation
SDGs	Sustainable Development Goals
TSH	Tshwane Metropolitan
UK	United Kingdom
UNICEF	United Nations Children's Fund
UP	University of Pretoria
USA	United States of America
WHO	World Health Organization
WITS	University of the Witwatersrand



# CHAPTER 1

## ORIENTATION TO THE STUDY

### 1.1 INTRODUCTION AND BACKGROUND

In this chapter the topic is introduced and the background to the study is provided. The problem statement, research question, aim and objectives of the study, significance, clarifications of concepts, research paradigm, ontology, and research methodology are presented. Trustworthiness and ethical considerations are attended to.

The advanced midwives' role requires from them to gain extended knowledge and acquire a wide range of clinical competencies and skills (Lathlean 2007:32). As advanced practitioners it is expected from advanced midwives to use complex reasoning and analytical intellectual processes to make crucial decisions in critical situations using expert clinical judgement for the benefit of the patients – the mother and the baby (Por 2008:87). Patients need a skilled and competent advanced midwife who will inform or refer to the doctor on time in case of an emergency (Hildingsson & Thomas 2008:128).

The attributes of advanced midwives mentioned by Spross and Baggerley (1989 cited in Por 2008:87) are self-evaluation, self-reliance, thoughtfulness, effective interpersonal skills, clarity of thought, confidence and the ability to reflect and analyse. An advanced midwife possesses a range of competencies such as direct care, consultation, collaboration, leadership, vacuum extraction and breech delivery (Spross & Heaney 2000:13). It is fair to postulate that the two hallmarks of advanced midwives are intellect and character since Gerrish, Nolan, McDonnel, Tod, Kirshbaum and Guillaume (2011:5) state advanced midwives value their knowledge which is gained through professional networks and experiences. Moreover, in a joint statement made by the World Health Organization (WHO), International

Confederation of Midwives (ICM) and Federation of International Gynecology and Obstetrics (FIGO) (2004:7) and reiterated by the WHO (2015:1), the possession of advanced knowledge and skills is central to advanced midwives' functioning.

The International Council of Nurses (ICN) recognises the role of advanced midwives worldwide (Elliott, Begley, Kleinpell & Higgis 2013:3). But, as these authors explain, the contexts in the different countries also differ. Expanding on this issue, Lathlean (2007:32) states although advanced midwives are globally regarded as registered nurses who acquired expert knowledge and also have the skills and clinical competencies to make complex decisions for expanded practice, these characteristics are shaped by the context of the country in which they are accredited to practice. In developed countries like Ireland, for example, advanced midwives are involved with vacuum deliveries and breech deliveries (Begley et al. 2012a:1-2). In Canada an additional skill is suturing of third degree tears while in Australia the same skills are considered to be above the advanced midwives' scope of practice (Smith, Leap & Homer 2009:119). In South Africa, advanced midwives are registered with the South African Nursing Council (SANC). The SANC curriculum outlines the advanced knowledge, competencies and skills that advanced midwives should possess; these range from providing direct patient care and having consultations with patients to collaboration with colleagues and multidisciplinary teams, taking leadership as well as performing vacuum extraction and breech delivery and it is supported by Spross and Heaney (2000:13).

Making use of specialist and advanced nurses in practice, thus including advanced midwives, is not a recent development in the nursing profession. In 1980 (to date almost 40 years ago) in the United States of America (USA) and Canada, the roles of advanced practice nurses (APNs) were established. Training of advanced midwives in advanced practice nursing (APN) was therefore commenced almost two decades before the adoption of the Millennium Development Goals (MDGs) in the early 2000s. The aim with this training was to increase skilled nurse practitioners to improve midwifery practice and was an effort to curb the already existing high global maternal mortality rate (Jokiniemi, Piitila, Kylma & Haatainen 2012:421; Begley et al. 2012b:1324). In this regard, an endeavour was also made in England to lower the high maternal mortality in the country and advanced care during labour was provided

by nurses, then known as 'clinical consultants', in British hospitals (Kennedy et al. 2012:721). The role of the clinical consultants was in the 1980s supported by the extension of the scope of practice by the United Kingdom Central Council for Midwifery and Nursing. This extended scope makes it possible for midwives and nurses to develop clinical skills that helps to alter midwifery practice and curtail the maternal and child mortality rate (Begley et al. 2012a:1-2). Another example is that in a study conducted in Ireland, it was found that advanced midwives contribute to high quality patient and client care which lowers the maternal and child mortality rate (Begley et al 2012a:2).

Interestingly, 17 years after training was started in developing countries (USA, Canada and England) the global high maternal mortality rate was mentioned by the WHO in its 1997 report on world health wherein it is stated: "Priority must be given to interventions aimed at reducing infant and child mortality" and "WHO's midwifery education, designed to equip health care workers to manage the major obstetric complications which threaten women's lives and technical support focused on the development of simple technologies for vital interventions that will also help to reduce the morbidity and mortality associated with childbirth" (WHO Health Report 1997:109,83). It was only at the beginning of the 21st century that world leaders launched the WHO's eight Millennium Development Goals (MDGs) of which reducing maternal mortality worldwide became one of the focal points (WHO, 2004:5).

In 2014 the United Nations released its Millennium Development Goals Report 2014, the most recent report examining the latest progress towards achieving the eight Millennium Development Goals (MDGs) in the developing world regions like Africa, Asia, Latin America and the Caribbean (World Economic Situation and Prospects (WESP), 2014:135). The 2014 UN report reflects in 2012, about 40 million births in developing regions were not attended by skilled health personnel and thus, at the end of 2013, the maternal mortality ratio in developing regions was 14 times higher than that of developed regions like Europe, the USA and New Zealand. Sub-Saharan Africa (which includes South Africa) "had the highest maternal mortality ratio of the developing regions with 510 deaths per 100 000 live births. An estimated 289,000 women died during pregnancy, childbirth, or within 42 days of termination of the

pregnancy, from causes (excluding accidental or incidental causes) related to – or aggravated by – pregnancy or its management.” (UN 2014, 28-29).

Esená and Sappor (2013:195) state in developing countries such as Afghanistan, Pakistan, India, Nigeria and Ethiopia have the worst maternal mortality rate as millions of women are still giving birth without a skilled birth attendant with only a family member or friend to help. In South Asia and sub-Saharan Africa, less than half of women give birth under the care of skilled birth attendants such as doctors, nurses or midwives. As such, more than half of women in South Asia and sub-Saharan countries deliver with no care or specialised care provided. For this reason, about 99% of all maternal deaths are estimated to occur in developing countries (Esená & Sappor 2013:195). Therefore, the need for advanced practice nurses to strengthen nursing and midwifery practice by providing care to women who present with complicated labour, especially in under resourced health settings, cannot be underestimated.

According to the maternal health fact sheet of the United Nations Children's Fund (UNICEF), it is estimated that 50 000 babies and young children could be saved every year in South Africa through high-impact healthcare interventions (UNICEF 2010). These interventions should address the five major causes of maternal deaths, namely non-pregnancy related infections such as HIV infections complicated by tuberculosis (TB) and pneumonia, obstetric haemorrhage, pregnancy-related hypertension, pre-existing medical conditions such as cardiac and diabetic mellitus, and pregnancy-related sepsis such as septic miscarriage and puerperal sepsis (Saving Mothers 2011-2013:7). Of significance is that these five causes of maternal deaths still remain a problem despite the fact that advanced midwives are trained to manage them. In South Africa at present it remains a challenge to ensure that the interventions benefit the health outcome of the mother and baby in district hospitals (MDG country report 2013:77) because some advanced midwives who ought to be in primary health settings are allocated to tertiary hospitals with no clearly stated roles to fulfil. Literature indicates the development of advanced midwifery practicing nurses with the purpose of assisting and filling in for physicians in rural and densely populated areas, lowers the maternal mortality rate (Christiansen, Vernon & Jinks 2012:1174). In South Africa, tertiary hospitals are training institutions which means

they are staffed with specialist obstetricians, registrars and medical interns. This staffing norm makes the role of advanced midwives not clear as there is a doctor available to manage patients presenting with any of the five major causes of maternal deaths including non-complicated obstetric patients.

Furthermore, unlike in countries such as Ireland where the roles and practice of advanced midwives are clearly defined and they are involved with complicated deliveries such as breech and vacuum deliveries (Begley et al. 2012a:2), in South Africa the absence of competencies and scope of practice for advanced midwives, especially in tertiary hospitals where some of these advanced midwives are allocated, poses a challenge as to what their role really encompasses (Daly & Carnwell 2003:159).

The South African perinatal and maternal mortality outcomes are still below the projected outcomes for the post MDG era as far as reducing the maternal and child mortality. The most recent statistics show the maternal mortality ratio has decreased from 176.22/100 000 live births in 2008-2010 to 154.06/100 000 live births (Saving Mothers 2011-2013:7) while the perinatal neonatal mortality rate for babies weighing 1000 g or more was about 25.6/1 000 births (Saving Babies 2010-2011:4).

The lack of properly trained doctors and midwives has been identified as the main contributory factors affecting the maternal deaths being recorded in saving mother of 2011-2013 as 15% and 8.8% for doctors and nurses respectively (Saving mother 2011-2013:7). The failure to attain the outcomes for maternal and child mortality reduction warrants new models to be developed that are based on inter-professional training and task sharing for the country. This new model should include the re-defining of professional accountability for maternal and child care (Schoon & Motlolometsi 2012:784). In addition, the new model of care should address the fact that to date the accountability of maternal care in tertiary hospitals in Gauteng lies in the hands of the medical doctors although providers of care in maternity units in tertiary hospitals include advanced midwives (Guidelines for maternity care in South Africa 2015:22). The impact that regulated competent advanced midwives can make towards positive maternal and infant health outcomes is seen globally; making use of advanced midwives will accelerates the progress towards the achievement of child

mortality and maternal mortality reduction. The researcher explored the role of advanced midwives allocated in tertiary hospitals in Gauteng.

## 1.2 PROBLEM STATEMENT

In rural areas in South Africa advanced midwives manage many obstetrical and midwifery complications independently while in urban and peri-urban hospitals, doctors are concentrated and always available to manage complications (Fraser, Cooper & Nolte 2010:10). A disproportion in the number of nurses/midwives versus physicians often results in having to make use of nurses to do physicians' duties such as performing complicated deliveries when there are no physicians. The nurse/midwife versus physician ratio is more visible in developing countries like African continent where there are fewer physicians than nurses (Schrober & Affra 2006:2)).

In South Africa, the multidisciplinary team in tertiary hospitals consists of medical internship practitioners, registrars and consultants including obstetricians and paediatricians that are in accordance with the requirements of the guidelines for maternity care in the country. Uys and Klopper (2013:2) suggest the ratio of the specialist registered nurse/midwife in tertiary hospitals to be 1.5 for a patient. It has been witnessed that all complicated deliveries are done by medical doctors while the advanced midwife only monitors the first stage of labour which can just as well be performed by a midwife who possesses no qualifications in advanced training. History indicates the development of the role of the advanced midwife for the purpose of assisting and coverage of physicians in the rural and densely populated areas is not happening in tertiary hospitals because physicians are always available (Christiansen et al. 2012:1174).

In South Africa, training of advanced midwives as a one-year centralised course was started in the 1980s in hospitals such as the Baragwanath Hospital (now the Chris Hani Baragwanath hospital) in Gauteng, the King Edward VIII Hospital in Kwazulu Natal, and the Ga-Rankuwa Nursing College in Gauteng, and the Groote Schuur Hospital in Cape Town. Institutions such as the Mowbray Maternity Hospital in Cape Town included competencies such as forceps delivery, vacuum delivery, the repair of second- and third-degree perineal tears and neonatal resuscitation in its curriculum.

These competencies also included the removal of a retained placenta, and assisting with other complicated deliveries to save lives (SANC Regulation R212) especially in primary healthcare and rural areas where medical doctors are not in attendance. Although registrars or obstetricians supervise the advanced midwife's training to acquire the aforementioned clinical skills in tertiary hospitals, the advanced midwives allocated in tertiary hospitals cannot use these acquired skills as their role is not clear in tertiary hospitals in Gauteng. Lesia and Roets (2013:55) confirm in their study on the placement of advanced midwives that 81.1% of the advanced midwives were not placed nor utilised correctly in South African urban areas. The advanced midwife's role within the multidisciplinary team is not clear because of the availability of and accessibility to physicians in urban hospitals. This study explored and described the role of the advanced midwife in tertiary hospitals in Gauteng.

### **1.3 RESEARCH QUESTION**

What is the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng?

### **1.4 AIM OF THE STUDY**

The aim of this study was to explore and describe the role of the advanced midwife regarding maternity care in tertiary hospitals in Gauteng to encourage the optimal use of this category of advanced nurses.

### **1.5 OBJECTIVE OF THE STUDY**

The objective of this study was to explore and describe the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng.

### **1.6 SIGNIFICANCE**

In this study the role of advanced midwives in maternity care in tertiary hospitals in Gauteng was explored and described. The placement and utilisation of the advanced midwife in the multidisciplinary team with regard to maternity care was included. If the role of the advanced midwives in tertiary institutions is specified and defined, their role and function in the multidisciplinary team would be much more clearly



understood by all members involved in rendering care in maternity. The findings of the study could be useful to make recommendations to policymakers for more effective utilisation of advanced midwives in tertiary hospitals in Gauteng. The knowledge gained from this study may be used by policymakers, managers and other stakeholders outside of the health services like politicians in supporting utilisation of advanced midwives. The correct utilisation of advanced midwives can contribute to the reduction of maternal and neonatal mortalities. Furthermore, the waiting period of patients in the maternity units of tertiary hospitals may be reduced if advanced midwives assist and fill in for physicians... Advanced midwives are empowered by the skills and knowledge they acquired during training. But they need accurate and complete clarification on their role in the multidisciplinary team. Central to retaining their unique and advanced skills is actually using it in practice. Advanced midwives will not only reach their full potential as advanced nurse professionals but by utilising their skills and knowledge they will also help to decrease maternal morbidity and mortality in tertiary hospitals in Gauteng. The study can also serve as a platform for more extensive research on the practice of advanced midwives in other tertiary hospitals or other similar settings.

## **1.7 CLARIFICATIONS OF CONCEPTS**

In this study clarification of concepts was done for the sake of simplicity and consistency throughout the study.

### **1.7.1 ADVANCED MIDWIFE**

Advanced midwives were introduced by the South African Nursing Council (SANC) (Schrober & Affra 2006:25). In the South African Nursing Act No. 33 of 2005, advanced midwife' is defined as a midwife who "is qualified and competent to independently practice midwifery in a manner and to the level prescribed and who is capable of assuming responsibility for such practice and is registered in terms of the Nursing Act". In this study the concept 'advanced midwife' refers to a midwife whose role has up till now not been clearly identified in the multidisciplinary team in the maternity departments of tertiary hospitals of Gauteng.



### **1.7.2 TERTIARY HOSPITAL**

A tertiary hospital (also called a ‘central’ or ‘tertiary care centre’) is a referral hospital that renders specialist and sub-specialist care to a number of regional hospitals and serves as a platform for research and training of healthcare workers. Tertiary hospitals also render some regional services. The hospital facilities have specialised equipment for the management of difficult obstetric patients or the very ill. (Guidelines for maternity care in South Africa 2007: 16)

According to Guidelines for maternity care South Africa (2015:22), the functions of a tertiary hospital includes all those in a regional hospital but also offers advanced prenatal diagnosis such as chorionic villus sampling and cordocentesis. A tertiary hospital additionally offers specialist combined clinics, supervision and support for district and regional hospitals in the management of extremely ill or difficult obstetric patients, and takes the responsibility for policy and protocols in the regions served. A tertiary hospital is therefore:

- a major hospital that usually has full complementary services such as paediatrics, obstetrics, general medicine, gynaecology, various branches of surgery and psychiatry,
- or a specialty hospital dedicated to specific sub-specialty care (paediatric centres, oncology centres and psychiatric hospitals).(Maternity Guidelines of South Africa 2015: 22)

After having been referred from a provincial hospital to a tertiary hospital or after major surgery, patients consult with sub-specialists. Sophisticated intensive care facilities are sometimes required. In this study the concept ‘tertiary hospital’ refers to a tertiary hospital providing obstetric and midwifery care to high care patients.

### **1.7.3 MATERNITY CARE**

According to the Maternity Guideline of South Africa (2015:13), “maternity care is an integral component of primary healthcare and a free health service for pregnant women. Within South Africa, the Maternal and Child Health programme is located in general development policies which focus on meeting the basic needs of rural and urban communities, maximising human resources potential, enlarging the economy, and spreading its benefits to all South Africans. To comply with these principles, the

then Minister of Health announced free health care services for pregnant women and children under the age of 6 years in July 1994”.

In this study, the concept ‘maternity care’ refers to antenatal clinic, labour and admission ward, and postnatal ward in tertiary hospitals in Gauteng.

## **1.8 RESEARCH PARADIGM**

A paradigm, according to Polit and Beck (2012:736), is defined as “a way of looking at a natural phenomenon from a world view that encompass a set of philosophical assumptions and that guides one’s approach to inquiry”. In this study the researcher used the constructivist paradigm to explore and describe the roles of advanced midwives regarding maternity care in tertiary hospitals in Gauteng.

### **1.8.1 CONSTRUCTIVE PARADIGM**

The constructive paradigm assumes that knowledge is maximised when the distance between those inquired and the inquirer is minimised. Constructivism is often referred to as the use of naturalistic paradigms as its interpretation reflects reality is not a fixed entity but rather a construction of individuals participating in research (Polit & Beck 2012:11). The participants in this study were the advanced midwives who shared competencies with the researcher and the distance between the researcher and the advanced midwives could be minimised as reality was not fixed. Not fully utilising the advanced midwives in tertiary hospitals in Gauteng was the real situation which could change since reality exists within a context, and many constructions of the existing context are possible (Polit & Beck 2012:12).

### **1.8.2 EPISTEMOLOGICAL ASSUMPTION**

Epistemology is the relationship between the inquirer (researcher) and those being studied (Polit & Beck 2012:13). The researcher is an advanced midwife who was employed in a tertiary hospital in Gauteng who is of the opinion that the potential of advanced midwives are not fully acknowledged and therefore not fully utilised.

Advanced midwives are educationally and clinically equipped to perform most of the clinical procedures performed by medical doctors, but in tertiary hospitals the registrar, who may be still in the process of acquiring most of the competencies,

manages the care of patients in maternity. According to Polit and Beck (2012:720), an assumption is defined as a principle that is accepted as being based on custom or logic without proof. Assumptions are perceived as explicit as they influence the researcher on how she or he implements and develops research. The underlying assumptions need to be acknowledged as they lead to more rigorous research processes (Botma, Greeff, Mulaudzi & Wright 2010:107).

The epistemological assumption in this study was as follows:

The role of advanced midwives in tertiary hospitals in Gauteng is not clear and as such *these professional nurses' skills and knowledge are underutilised. If the skills of advanced midwives are fully utilised in tertiary hospitals, it might positively influence the maternal and child health outcomes.*

From the reality viewed by the researcher, the assumption influenced her to use the qualitative methodology to structure the study process and gather and analyse information relevant to the study question.

### **1.8.3 ONTOLOGY**

According to Botma et al. (2010:40), ontology is defined as “a branch of philosophy dealing with the nature of reality”. Ontology is mainly concerned with how we view the world or nature of reality. Researchers' ideas about the characteristics and nature of what they are studying and all subsequent decisions by them are influenced by the ontological questions.

The reality of how the role of the advanced midwife is viewed in tertiary hospitals in Gauteng was determined by the practice of advanced midwives.

## **1.9 RESEARCH METHODOLOGY**

Babbie and Mouton (2003:75) describe research methodology as “the process and procedure to be used in a study which is conducted in a systematic and logical way”. Polit and Beck (2012:741) agree the research methodology is the “techniques used to structure a study and to gather and analyse information in a systematic fashion”. The researcher selected a qualitative research design. The methodology process

which the researcher used is described in detail in Chapter 2, but briefly summarised in Table 1.1 below:

**Table 1.1 Methodology process**

ASPECT	DESCRIPTION
Research design	<ul style="list-style-type: none"> <li>• Research design (View section 2.2)</li> <li>• Qualitative design (View section 2.2.1)</li> <li>• Exploratory research design (View section 2.2.2)</li> <li>• Descriptive research design (View section 2.2.3)</li> </ul>
Study setting	<ul style="list-style-type: none"> <li>• Four tertiary hospitals in Gauteng was used for data collection (View section 2.3)</li> </ul>
Preparation for research process	<ul style="list-style-type: none"> <li>• Preparation for venue (View section 2.7.1.1)</li> <li>• Preparation for interview question question (View section 2.7.2)</li> <li>• Recruitment of participants, moderator and audio-tape operator (View section 2.7.1.2.)</li> </ul>
Study population	<ul style="list-style-type: none"> <li>• Advanced midwives working in maternity care in tertiary hospitals in Gauteng (View section 2.4.1)</li> </ul>
Sampling	<ul style="list-style-type: none"> <li>• Three tertiary hospitals in Gauteng (View section 2.4.2)</li> </ul>

Data collection	<ul style="list-style-type: none"> <li>• Focus group interview (View section 2.5.1)</li> </ul>
Data analysis	<ul style="list-style-type: none"> <li>• Tesch's methods of coding was used (View section 2.8)</li> </ul>
Trustworthiness	<ul style="list-style-type: none"> <li>• Lincoln and Guba's model was used to ensure credibility and reliability of the qualitative study (View section 2.9)</li> </ul>

A focus group interview is a carefully planned group interview which involves discussion and a collective activity determined by the researcher on a specific topic based on what the researcher wishes to obtain (Botma et al: 2101:212). An appointment was secured when more than six participants were available in each tertiary hospital as focus groups usually consist of five to 12 participants (Polit & Beck 2012:537 ). The participants in each of the four hospitals were made aware of the focus group interview. The information leaflets were read and given to participants. The discussion and collected information was based on what the researcher wished to obtain rather than the needs of the group. The venue, population group, researcher and the moderator were prepared for the focus group interview. all focus groups venues were finalised on the day of the focus group discussion though time and what would be expected was explained before the actual set day of the interview. (Polit & Beck 2012: 538).

The researcher welcomed the participants and introduced the moderator who then used the prepared interview questions to guide the interview as stated by Polit and Beck (2012:537). The main question, namely "what is the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng?" was posed first to the participants in each focus group interview. Follow-up questions for the focus group interviews were prepared (see Appendix C2) beforehand. These questions were asked when the participants' responses did not cover the scope of the main question. The researcher structured the questions focusing on areas to be covered during interview (Polit & Beck 2012: 537).

Various communication skills such as probing, listening and paraphrasing were used to elicit more data. The interview discussion per session was planned to last for

about an hour each. The audio-recorder was tested before and used during each interview session. Permission to use an audio-recorder was also obtained from the participants (Polit & Beck 2012:538). Field notes were also taken during the interviews by the researcher. for documenting what the researcher sees, experience and think in the course of the interview ( Botma et al 2010:2017).

### **1.9.1 The researcher**

At the time of study the researcher was (and is currently still) an advanced midwife practitioner. To avoid influencing the data collection process, the researcher used bracketing as part of her preparation to conduct the interviews. For example, she kept on reminding herself she would have bracket her personal feelings and beliefs in order to remain neutral during the interviews and not influence the participants in any way (Nieswiadomy 2010:172).

The researcher acted as a research assistant and her role was to organise and arrange the venue for the focus group interviews, to introduce the interview sessions and the moderator to the participants and to write field notes. Lastly, the researcher's duties were to thank the participants at the end of the interview. To ensure that the findings would be credible, a moderator was used for data collection because the researcher was immersed in the research setting as a manager. The researcher transcribed the gathered data verbatim from the audiotape. The transcripts were written in English which was the language used to conduct the focus group interviews with the assistance of the moderator.

### **1.9.2. The moderator**

The moderator guides the interview discussions from a written set of questions or topics to be covered (Polit & Beck 2012:537). An experienced moderator with extensive midwifery and research knowledge fluent in English was used to conduct the interviews. The moderator played a critical role in the success of the focus group interviews as she facilitated the progress of the focus group discussion. The researcher and moderator discussed the interview guide before the study process began. This assisted the moderator to introduce the topic at the beginning of the focus group interviews. After the researcher had welcomed the participants and introduced the moderator, the latter took over and posed the main question “what is

the role of the advanced midwife regarding maternity care in tertiary hospital in Gauteng?” The moderator used probing techniques such as confrontation, affirmation, validation and summarisation. Follow-up questions were asked if the desired scope of data gathering was not covered with probing.

## **1.10 TRUSTWORTHINESS**

Polit and Beck (2012:745) define trustworthiness as “the degree of confidence qualitative researchers has in their data, assessed during the criteria of credibility, transferability, dependability, confirmability and authenticity”. The researcher used the five epidemiological standards according to Botha et al. (2010:233-234) to establish trustworthiness. Trustworthiness is discussed in detail in Chapter 2.

### **1.10.1 Truth value**

According to Botma et al. (2010:233), truth value is used to determine whether the researcher has confidence that the participants shared information truthfully. It's just that she has to have confidence in the truth of the data and how it was interpreted. The truth value in this study was established with credibility strategies. The researcher reassured participants that the information given during the interview would not be used against them. Anonymity was maintained as coding was linked to participants by numbers only (and not names) in such a way that even the researcher could not link the participants to the collected data (Speziale & Carpenter 2007:65). All steps of the research were thickly described so as to provide the reader with details concerning the design and methods used.

### **1.10.2 Applicability**

According to Botma et al (2010:233) “Applicability refers to the degree to which the findings can be applied to different contexts and groups.” Applicability is the ability to use the findings in larger populations by applying the transferability strategy. The transferability of this study was addressed by the selection of sample, comparisons of the demographic data, data saturation and participants' descriptions which were thick and dense. It's all about ensuring there is sufficient descriptive data for when the study is done again or repeated with different participants and different settings.

Three settings were used for data collection to ensure the findings would be applicable to all Gauteng tertiary hospitals.

### **1.10.3 Consistency**

According to Botma et al. (2010:233), consistency is when the findings are consistent should the inquiry be replicated with the same participants and in a similar context. A dependability strategy was used. A dense description of the methodology and data sources used was included. The researcher kept an audit trail of all the relevant steps used during the whole study process. The supervisor and co-supervisor were consulted to assure consistency was maintained throughout the process.

### **1.10.4 Neutrality**

Botma et al (2010:233) states “neutrality entails freedom from bias during the research process and results description; and refers to the degree to which the findings are a function solely of the informants and conditions of the research, and not of other biases, motives or perspectives.” The researcher ensured freedom from any form of bias by making use of a confirmability strategy which included keeping an audit trail, triangulation of the data and reflexivity. The data was transcribed verbatim and all records were stored according to the university’s policy.

## **1.11 ETHICAL CONSIDERATIONS**

In any research study the researcher must adhere to the principles of ethics as stated in ethical codes such as the Nuremberg Code and the Declaration of Helsinki ( Burns & Grove 2005: 177). In this study intrusive and insensitive questions that might have undermined the participant’s autonomy was avoided by adhering to the following ethical principles: informed consent, beneficence, confidentiality, and human dignity (Polit & Beck 2012:152-156).

### **1.11.1 Informed consent**

Informed consent means that the candidates have adequate information regarding the research, are able to comprehend the information, and have the power of free



will allowing them to consent to or decline participation voluntarily (Burns & Grove 2011:205-208; Polit & Beck 2012:176).

The researcher used the approval letters from the University of Pretoria Research Ethics Committee and the Gauteng government as instruments to obtain permission to execute the study in the designated tertiary hospitals in Gauteng. All participants were informed about the study process and procedures so that they could take part voluntarily. For participants to disclose fully, the researcher was obliged to describe the participants' rights and the risks of participation in the study to all participants (Polit & Beck 2012:154). The participant information leaflet (Annexure M) included proof of the agreement from the institutions to conduct the study, the benefits of the study to the participants and the institutions were included as was the role of the researcher. The coding to be used during the data collection and analysis process which guaranteed anonymity was described fully. The informed consent further included the aim and objective as well as the significance of the study. Separate informed consent for participation in the focus group interviews (Annexure O) and the audio-taping of the interviews (Annexure P) was signed willingly by all participants. The participants were not coerced to participate neither were they given false promises such as receiving money to assure participation (Botma et al 2010: 9).

### **1.11.2 Beneficence**

The participating advanced midwives were protected from harm and discomfort during the study process (Botma et al. 2010:20). The researcher minimised harm and maximised the benefits of the study (Polit & Beck 2012:152). There was no anticipated harm in this study as the data was shared without disclosure of the hospitals and names of the participants. No personal or unsettling questions were prepared or asked and therefore psychological harm was also excluded.

### **1.12 OUTLINE OF STUDY**

The outline of the chapters is summarised below.

## **Chapter 1: Orientation to the study**

In Chapter 1 the topic and background to the study are introduced. The problem statement, research question, aim and objectives of the study, significance, clarification of the concepts, research paradigm, ontology, and research methodology are presented. The trustworthiness of the study and ethical considerations as well as the risk factors and benefits of the study are introduced in this chapter.

## **Chapter 2: Research methodology**

In this chapter the research methodology and design, the research instrument used, data collection methods and in-depth data analysis are presented and described thoroughly. Trustworthiness and all the measures taken to ensure the trustworthiness of this project are attended to.

## **Chapter 3: Results discussion and literature control**

In Chapter 3 the findings of the study are presented and discussed. The literature review conducted to validate the findings is also included.

## **Chapter 4: Conclusion, implications, limitations and recommendations of the study**

This chapter consists of the conclusion and implications of the study findings. The limitations are noted and recommendations are made for practice and further research.

### **1.13 CONCLUSION**

In the first chapter the study topic was introduced and the background was outlined. The problem statement, objectives and significance of the study were described. The key concepts were clarified and the research paradigm, ontology and methodology were described. Trustworthiness and ethical considerations were briefly addressed.

In Chapter 2 a detailed discussion of the study methodology is presented.

## CHAPTER 2

### RESEARCH METHODOLOGY

#### 2.1 INTRODUCTION

The introduction and background, problem statement, and the significance of the study were clearly explained in the previous chapter. The research question, aim and objective of the study were set. The researcher also clarified the concepts, explained the research paradigm and methodology as well as the study setting and described the ethical considerations followed during this study in detail.

In this chapter the researcher presents and describes the research methodology in detail. This includes the research design, the methods used and the research setting. The methods used to ensure trustworthiness are detailed. The research methodology informs the reader of how the research was carried out, in other words, what the researcher did to answer the research question. The role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng are explored and described qualitatively.

The research methodology informs the reader how the study was carried out, in other words, the techniques the researcher used to systematically structure a study to gather and analyse information to answer the research question (Polit & Beck 2012:741).

For the purpose of this study the researcher followed a qualitative paradigm which is a basic set of beliefs (Creswell 2007:19) that guided the researcher to thoroughly explore and describe the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng. Using this method allowed the researcher to obtain in-depth and detailed information on the study topic. According to Burns and Grove (2007:67), qualitative research is a way to gain insights through discovering meaning by understanding the whole. Understanding the whole enables the researcher to explore the richness, depth and complexity of the whole phenomenon under study.

Deciding to use a qualitative approach method in this study was appropriate since it was the researcher's aim to obtain in-depth, thorough and truthful data on the experiences of advanced midwives in tertiary hospitals in Gauteng. It was the researcher's belief that their role in maternity care could only be captured by describing what really occurs in their work environment; hence, the context in which they operate had to be incorporated to get a clear and rich understanding of their real life experiences as stated by Henning, van Rensburg and Smit (2004:36) and Creswell (2007:287).

## **2.2. Research design**

The research design is the protocol or particular plan followed when conducting a specific research study. Defined as "the overall plan for addressing a research question", the research design includes the specifications for enhancing the study's integrity, to obtain answers to questions being asked as well as how to handle difficulties if encountered during the research process (Kumar 2011:94). The research plan defines the elements, their inter-relationship and methods that constitute each piece of research. (TerreBlanche, Durrheim & Painter 2009:161; Polit & Beck 2012:741). According to Burns and Grove (1999:223), the design "guides the researcher in planning and implementing the study in a way that is most likely to achieve intended goal".

As the researcher intended to explore and describe the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng, she conducted a qualitative, exploratory, descriptive and contextual study. Exploratory qualitative research is designed to shed light on the various ways in which a phenomenon manifests on the underlying process and itself (Burns & Grove 2009:27).

### **2.2.1 Qualitative design**

A qualitative design is the investigation of a phenomenon conducted typically in an in-depth and a holistic manner. Data collection is done through rich narrative materials using a flexible research design (Polit & Beck 2012:739). Qualitative research is further defined as a systematic, subjective approach and is used to describe lived experiences and give meaning to these experiences (Burns & Grove 2011:20). Where little is known about the research topic or in an area where poor

contextual understanding exists, qualitative research is used (Polit & Beck 2012:60). It allows for researcher subjectivity and is useful for truth finding from unknown phenomena.

The procedures for generating facts about the phenomenon are not formalised or strictly controlled but are flexible (de Vos, Strydom, Fouche & Delpont 2009:74). Qualitative researchers study issues in their natural settings which allow for the sense or meanings to be interpreted from the phenomenon. In other words, the meanings surface or are brought to people from within the phenomenon itself (Polit & Beck 2012:14). The researcher used a qualitative design in the exploration of the role of advanced midwives in the maternity care in tertiary hospitals in Gauteng to obtain in-depth information on the phenomenon.

### **2.2.2 Exploratory design**

According to Botma et al. (2010:185-6), exploratory research is more focused on grounded theory or theory development. An exploratory study begins with the phenomenon that is of interest to the researcher. The particular phenomenon cannot simply be observed and described. In order to acquire a description, the phenomenon needs to be investigated in the way in which it manifests (Polit & Beck 2012:18).

Exploratory research is used when limited information or knowledge exists about a particular subject and the purpose of the research is to gain a broader understanding of the phenomenon, situation or issue. Exploratory studies are all about exploring a relatively unknown field; therefore, the researcher chose to use an exploratory design as it was ideal to gain insight into and acquire a better understanding of the role of the advanced midwives regarding maternity care in tertiary hospitals in Gauteng since very little is known about this phenomenon (Polit & Beck 2012:727; Bless, Higson-Smith & Sithole 2014:60).

### **2.2.3 Descriptive design**

The main objective of descriptive research is to accurately portray the characteristics of the situation, people or groups or the frequency with which certain phenomena occur (Polit & Beck 2012:727). A descriptive design describes the findings of the phenomenon that was explored, the aspects in real life situations and it further

provides an accurate account of the characteristics of individuals, situations or groups (Brink 2006:102; Burns & Grove 2011:34). An analysis is done of the themes and patterns that emerge in the content and a comprehensive summary is given of a phenomenon (Polit & Beck 2012:505).

In this study the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng was identified, described and documented. The findings of the study revealed the actual role of the advanced midwives in maternity care as identified and described by the participants who were all advanced midwives working in tertiary hospitals in Gauteng. No literature on this topic in this context could be found.

### **2.3 Study setting**

The study setting is defined as the location and conditions in which the study is conducted (Burns & Grove 2011:40, Polit & Beck 2012:743). The current study was done in Gauteng, South Africa. Gauteng is one of the nine provinces in the country. It is a densely populated province; one of the strongest provinces and is divided into six districts. The study was conducted in the Tshwane Metropolitan district and the city of Johannesburg. Of the four tertiary hospitals, two are situated in Pretoria in the Tshwane Metropolitan district and one in Johannesburg. Advanced midwives allocated in these hospitals at the time of study were participants in the study. There are four tertiary hospitals in Gauteng. About 50 midwives and 30 advanced midwives usually work in the maternity unit of each of the hospitals where altogether between 12 and 30 deliveries in a 24-hour period are managed. The fourth hospital is situated in Johannesburg and was used for the pilot study.

The settings were prepared by sending application letters to the chief executive officers (CEOs) of the three hospitals requesting permission to conduct the main study there. The fourth hospital also received an application letter for the pilot study. The researcher visited the hospitals to verify the availability of a comfortable, quiet place such as a boardroom or a meeting room where she and the participants could meet for the focus group discussions. Such a venue was found and booked in each of the four settings. Refreshments would be provided by the researcher as eating together tends to promote group conversation and communication as stated by de

Vos, Delport, Fouché & Strydom (2005:309). During her visits to get the right settings, the study population from each of the hospitals was also prepared.

## **2.4 Research method**

According to Streubert and Carpenter (2011:366), the research methodology refers to the detailed discussion of the actual application of the design. The research method describes the techniques, methods and the procedures used in the process of implementing the research plan or research design. The research method relates to the procedures and the rules that specify how the researcher must study or investigate what he or she believes must be known (Botma et al. 2010:41). The methodological procedures included the population, sampling, data collection and data analysis presented and discussed in the next sections.

### **2.4.1 Study population**

The population includes the entire group of persons or objects with common defining characteristics which is of interest to the researcher (Polit & Beck 2012:59). The term 'population' thus sets the boundaries with regard to the elements or subjects the researcher is interested in studying. In other words, in this study all the individuals constituting the population had to meet the set criteria for inclusion in the study (Burns & Grove 2011:290; Polit & Beck, 2012:738). In this study, the population consisted of advanced midwives rendering care in maternity wards of the four selected tertiary hospitals in Gauteng. An additional characteristic was that the participants had to have Advanced Midwifery and Neonatal Nursing Science as additional qualifications at SANC.

In the setting the advanced midwives were allocated in the antenatal clinic, the labour ward admission, labour ward, postnatal ward ARV ward and administration offices. However, the researcher discovered the allocation of advanced midwives distribution differed in the hospitals. In some hospitals only the labour ward had more advanced midwives while in one hospital there were more advanced midwives in the postnatal wards. Sampling was done to represent the population.

## 2.4.2 Sampling

According to Polit and Beck (2012:742), sampling is the process used by the researcher to select a portion of the population to represent the whole population. Sampling is the process used by the researcher to select a subset of the population or part or fraction of a whole or a subset of a larger set based on the reasons directly related to the research and not based on the accessibility of the participants (Botma et al. 2010:13) for participation in a research study (Burns & Grove 2005:341). It is essential to select a representative sample of the population, one in which the same range of characteristics or attributes can be found in similar proportion as well as in the population itself (Somekh & Lewin 2005:217).

The researcher used purposive sampling to select between four to five participants per focus group. According to Botma et al. (2010:201), four to six participants are appropriate considering the time available for each focus group interview. In the case of this study the time schedule for each interview was 60 minutes. In this time period each participant had an opportunity to talk and share his or her thoughts, ideas and experiences. All the three interviews were successfully conducted within the time frame allowed.

Cresswell (2007:125) states purposive sampling is the intentional selection of participants for the study. This relates to purposefully choosing participants who can give meaningful information and relevant data to allow for a better understanding of the research problem. The researcher identified the population for this study according to Cresswell's (2007:329) mentioned advice on how the population must be identified. She first thought critically about the aim and purpose of the study as well as the parameters of the population and then chose the sample cases accordingly. According to Somekh and Lewin (2005:217), it is essential for the researcher to select a representative sample of the population; the sample must represent the same range of characteristics or attributes to be found in similar proportions as the population. The researcher followed this author's advice and made sure the inclusion and exclusion criteria criteria for the selection of participants were clearly formulated. (See Sections 2.4.2.1 and 2.4.2.2).



Sampling does not only depend on the candidates' availability and willingness to participate (TerreBlanche et al. 2009:139) but also on the time and costs (such as travelling costs) involved for both the researcher and the selected participants (Somekh & Lewin 2005:217). The advanced midwives who eventually voluntarily participated in this study were typical of the advanced midwives rendering care in the maternity units of the tertiary hospitals in Gauteng. Sampling was also purposeful as the researcher selected participants from all three tertiary hospitals in Gauteng and, furthermore, all three hospitals were used as sites for this study because the sample could purposefully inform an understanding of the research problem and control phenomenon in the study as stated by Burns & Grove (2011:125).

The aim of the focus group discussions was on sharing. All participants met the inclusion criteria.

#### 2.4.2.1 Inclusion criteria

The inclusion criteria, also known as the eligibility criteria, define the participants to be included in the population (Polit & Beck 2012:274). According to Botma et al. (2010:124), the inclusion criteria can be considered as the "theoretical departure point of the study as the criteria have implications for both the interpretation and the external validity of the results".

The researcher determined certain characteristics which were used to identify and select participants. The inclusion criteria used in the selection for this study are noted below.

- ❖ Participants had to have an Advanced Midwifery and Neonatal Nursing Science qualification.
- ❖ Participants had to be in the maternity wards rendering antenatal, labour and postnatal care.
- ❖ Participants were chosen from the four tertiary hospitals in Gauteng and therefore had to work in the maternity wards of one of these hospitals.
- ❖ Participants had to be working in maternity more than a year after completing advanced midwifery and neonatal nursing science training.

#### 2.4.2.2 Exclusion criteria

Exclusion criteria is defined as the characteristics of the people who must not be included in the study sampling (Polit & Beck 2012:274). The researcher used the exclusion criteria to filter out participants with specific characteristics which were not relevant to the study (Burns & Grove 2009:345). The exclusion criteria used in the selection process are mentioned next.

- ❖ Advanced midwives who were not directly rendering maternity care, for example, assistant managers.
- ❖ Advanced midwives who had been working in the setting for less than a year after completion of training, as the researcher considered them not experienced enough.

### 2.5 Data collection method

The data collection comprised of conducting focus group interviews and field notes taken during these interviews.

#### 2.5.1 Focus group interviews

According to Polit and Beck (2012:728), a focus group is “an interview with a group of individuals assembled to answer questions on a given topic”. Each of the three focus groups consisted of four to five participants who were interviewed together. The participants were a homogenous group of advanced midwives working in tertiary hospitals and the explicit stated sampling criteria were followed when selecting these participants (Bless et al. 2014:200). The participants were all able to communicate in English and all had Advanced Midwifery and Neonatal Nursing Science as additional qualifications. As a group, all members felt equal which made them feel comfortable and eager to share their experiences with the researcher and each other.

The purpose of the focus group interviews was to explore in-depth issues associated with their role as advanced midwives while reflecting on the actual role of the midwife. The prepared questions were used to guide the discussions. One focus group discussion was conducted in each of the three selected tertiary hospitals in Gauteng. The participants were encouraged to discuss the role of the advanced

midwife freely among themselves which assisted the researcher to obtain rich, informative and contextual qualitative data from the natural flow of the discussion. All discussions in the three hospitals lasted about 60 minutes each.

Because the researcher worked in the field herself, she had an understanding of the theme. Together with the assistance of an experienced moderator (see Chapter 1, Section 1.9.2) the researcher drew up a list of questions to elicit rich, in-depth data on the theme. The following main question was asked:

“What is the role of advanced midwives in maternity care working in Gauteng tertiary hospitals?”

Additional probing questions were also planned beforehand. The list of nine probing questions used by the moderator during the interviews is given next.

1. “When you hear the word ‘advanced midwife’, what is the first thing that comes to your mind?”
2. “What responsibilities should advanced midwives have in tertiary hospitals in Gauteng?”
3. “What procedure should advanced midwives be allowed to perform in tertiary hospitals in Gauteng?”
4. “What training role does the advanced midwife have in the clinical setting?”
5. “How are the advanced midwives involved in planning and management of patient care?”
6. “What good things are identified with the role of an advanced midwife?”
7. “What are the identified problems on the role of the advanced midwife in the multidisciplinary team?”
8. “What causes those problems in the utilisation of the advanced midwives in the multidisciplinary team of the tertiary hospitals of Gauteng?”
9. “How can we resolve the identified problems?”

The advantages of using focus group interviews in this study included that the participants, who were all working in similar contexts and under similar circumstances, were able to discuss the issues raised by the questions with each other openly and honestly. They learnt from each other, shared problems encountered and ideas on how to solve them and also discussed the various advantages with each other in a group setting. The participants further resolved important dilemmas with which they are confronted in clinical practice. The moderator gave every participant an opportunity to participate. According to Bless et al. (2014:200), participants' disagreements during focus group discussion must be handled with deeper understanding of the problem. The moderator used her skill, knowledge and experience as an interviewer and adhered to this principle during the focus group interviews.

The researcher took field notes during every focus group discussion.

### **2.5.2 Field notes**

Polit and Beck (2012:728) define field notes as “unstructured observations” made during a focus group interview and the interpretation thereof by the researcher. As mentioned, the researcher was responsible for recording the field notes during each interview held in this study.

The dynamics that took place in the group were mentioned in the written field notes. Additional notes written included what the researcher heard, saw, experienced and thought in the course of collecting or reflecting on the data obtained during the focus group interviews. According to Botma et al. (2010:217), the researcher is accountable for documenting the occurrences that are seen, heard, felt experienced and thought about during the course of a focus group interviews. Following the advice of de Vos et al. (2011:372), the researcher wrote down additional field notes immediately after each focus group interview.

The researcher as assistant facilitator took detailed field notes during the focus group interviews. The moderator also took notes which were discussed with the researcher immediately after each focus group interview. The field notes highlighted as much of the conversation and occurrences as possible: striking themes that arose; non-verbal behaviours such as eye contact, posture, individual gestures as well as

gestures between group members; the order in which people spoke to aid voice recognition; as well as the seating arrangements (de Vos et al. 2005:311).

According to Polit and Beck (2012:538), the advantages of focus group interview include the efficiency in the collection of the rich data from the viewpoints of many people which are received in a short time; the capitalisation of facts; and the fact that it provides for a much broader, interpretive and analytical view of the phenomenon being studied. These advantages were confirmed by the researcher who experienced firsthand that the collected data was broad, analytical and efficient even in the focus group with four participants.

## **2.6 ACTUAL DATA COLLECTION**

Data collection is a series of interrelated activities aimed at gathering good information from the selected participants to answer the emerging research question (Burns & Grove 2011:118; Polit & Beck 2012:518). The data collection plan is considered a plan for the precise, systematic gathering of information which is relevant to the research objective or purpose of the study being conducted. Data was collected through focus group interviews with the help of a moderator and a third person (the researcher's daughter) who operated the two audiotapes. The moderator was used because of her research knowledge which took care to solicit the input from all group members (Polit & Beck 2012:538) and the audiotape operator was used because of her scientific technology experience as the audiotapes were not the same and sophisticated. There was nothing which cannot be discussed from the topic in front of the mother and daughter as the audiotape operator was the researcher's daughter (Polit & Beck 2012:538).

Data collection commenced on 25 May 2016 and was completed on 14 June 2016. The researcher selected the focus group interview method for the collection of data since it is the most direct way of obtaining rich information from the participants (Botma et al. 2010:210). Additionally, the researcher could not add her own views or influence the responses. Distancing herself from the focus group interviews by making use of an objective moderator encouraged the participants to answer the original questions truthfully and in detail without attempting to provide answers or information the researcher wanted to hear or expected them to provide (Polit & Beck 2012:537). Focus group interviews allow the interviewer (in this case the

independent moderator) to encourage the free flow of the interview; participants are encouraged to share more information or to elaborate on an existing or emergent new theme by using probing, listening and paraphrasing (Polit & Beck 2012:537).

The researcher prepared the interview guide to facilitate a smooth flow of the interview during the focus groups. The interview guide was used by the moderator to ask a series of questions (Botma et al. 2010:212) to facilitate the focus group interview (Polit & Beck 2012:538). The audiotape was used after written permission had been obtained from all participants (See Annexure C4 ) (Botma et al. 2010:210). Finally, the field notes taken by the researcher added to the richness and truthfulness of what transpired during each of the focus group interview. Polit and Beck (2012:728) state field notes are activities undertaken by qualitative researchers to collect data in the field when a research study is conducted in a natural setting as was the case in this study.

## **2.7 PREPARATIONS FOR THE DATA COLLECTION PROCESS: FOCUS GROUP INTERVIEWS**

In this study the preparations made unfolded into four phases, namely the preparatory phase, pilot study, interview phase, and the post interview phase as presented and discussed next.

### **2.7.1. Preparatory phase**

The preparatory phase comprised of preparing the venue and recruitment of the participants, moderator and the audiotape operator.

#### **2.7.1.1. Preparing the venue**

In focus group interviews, the participants, researcher and moderator need to meet in an environment or setting where they feel relaxed and comfortable, and the setting has to be prepared in advance. Polit and Beck (2012:743) define this setting as “the physical location and conditions in which data collection takes place in the study.” The current researcher obtained written permission from the CEOs of the identified three selected tertiary hospitals a month before the date on which the three main focus group interviews were scheduled. (See Annexures B4, B5 and B6). Written

permission was also obtained from the fourth tertiary hospital where the pilot study was done (See Annexure B3).

The researcher visited each of the three hospitals to view the boardrooms and other possible meeting rooms to identify a suitable place with tables and chairs (Polit & Beck 2012:538). In one hospital the venue was prepared beforehand and in three hospitals the venue was allocated on the day of the focus group interviews as their boardrooms were always in use which made viewing before the date a challenge.

In the three hospitals, on the day of the scheduled focus group interview, the researcher arrived early to view the area and make some arrangements. All chairs were arranged in a square around the table to maintain face to face positions during communications. Face to face interview yields quality of information, obtaining of in-depth data used to determine the individual's perceptions, opinions, facts and potential solutions to a problem (Burns & Grove 2007:544; de Vos et al. 2005:292; Polit & Beck 2012:265). A separate table was prepared for some refreshments which were provided by the researcher.

The dates and times for the meetings were again confirmed with the operational managers, area managers and participants to avoid interfering with patient care. The moderator and the audiotape operator were informed beforehand of the dates, times and venues for the different focus groups. Prepared questions were e-mailed to the moderator two weeks before commencement of the focus group interviews.

#### 2.7.1.2 Recruitment of participants, moderator and audiotape operator

The researcher recruited the participants, moderator and audiotape operator.

- **Recruitment of participants**

The recruitment of participants involves identifying eligible candidates and requesting them to participate (Polit & Beck 2012:286). The researcher worked through gatekeepers, application letters were sent to the relevant senior persons in the settings to request permission for conducting the study and for access to the institutions to recruit candidates. (See Annexures A1, A2, A3 and A4). According to Polit and Beck (2012:537), the homogeneity and right group composition recruited generates free-flow interviews containing useful data.

The researcher physically visited the selected hospitals to recruit participants. It was easier to recruit participants face to face than telephonically as Polit and Beck (2012:287) advice. The researcher could easily answer all questions asked by participants face to face. The researcher met with both the area managers and the unit managers in three hospitals and in one hospital the area manager was met. The researcher explained that she had permission to conduct the study and then requested their assistance with the recruitment of their staff members as possible participants. All four managers were very accommodating and helpful. She described the purpose of the study to them, the process and what would be expected from the participants. She also stressed this study had received ethical approval as well as permission from the hospital management and then proceeded to affirm anonymity and privacy of the participants would be guaranteed. She explained that the participation information leaflets she had contained all the necessary details about the study and the researcher's contact details. It also informed that permission had been obtained to conduct the study in the specific hospital. (See Annexure C1). The information included the aspects of voluntary participation, the freedom to withdraw at any stage without prejudice and it also emphasised that there would be no incentives (Botma et al. 2010:14).

At the first and the second hospitals participation leaflets with the information were left with the operational managers. And in the third hospital the information leaflets were left with area managers. However, final recruitments in all the three hospitals were done on the mornings of the scheduled focus group interviews as some of the advanced midwives who wanted to participate did not come to work on the day the researcher visited their hospital for recruitment.

The researcher and the unit managers and the area manager then chose the days on which the focus group interviews would be conducted. The dates depended on the days most of the advanced midwives and nursing staff were on duty to avoid disruptions to patient care and services (Polit & Beck 2012:287). After the dates and venues for the focus group interviews had been confirmed, the researcher thanked the managers for their time and assistance and left.

The researcher reminded the unit managers in hospitals 1 and 2 and the area manager in hospital 3 of the focus group meetings telephonically a day before the



focus group interviews and asked them to remind the participants of the appointment. In all three hospitals the researcher managed to recruit four to five participants for each focus group.

- **Recruitment of moderator**

The moderator was identified and recruited for this study in order to strengthen and direct the relationship between the participants during focus group interview (Polit & Beck 2012:734). The moderator identification was done with the assistance of the supervisors. The researcher recruited the independent researcher (moderator) telephonically which was followed by the submission of the research proposal via e-mail to the moderator. The moderator was selected for her experience in research and communication skills. Monette et al. (2005) (as cited by Botma et al. 2010:205) reflect that the quality and quantity of exchanged information in the group depend on the understanding, relationship management skills, and creativity of the interviewer. The researcher discussed the prepared questions which would lead the interview with the moderator. The moderator understood and agreed with the proposed questions. However, the moderator suggested making use of two audiotapes and the researcher purchased the second audiotape.

- **Recruitment of audiotape operator**

Different technical devices are used to record events, making it easier for the researcher to analyse or categorise data at a later stage. It is recommended that if targeted group is auditory, recording can be used for obtaining a permanent record (Polit & Beck 2012:317). In this study the researcher used advanced technology in terms of two auditory recordings to get good volume. The advancement in technology made it a bit of a challenge to operate. In addition, the audiorecorders were not the same. The researcher identified her daughter who had experience in operating scientific apparatus to assist in the research. The two audiotape recorders were handed to her three days before the pilot study so that she could familiarise herself with the equipment. The operator agreed to assist and she was used for all the focus groups. The audiotape operator did not sign any confidentiality form but she verbally agreed to keep everything she heard confidential.

## 2.7.2 Preparations for interview questions

The focus group interviews were guided by carefully formulated and essential questions based on the study topic, namely the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng. (See Annexure C2). The researcher took advantage of the group and used the interview guide to access rich information (Botma et al. 2010:201).

To test the feasibility of collecting rich data, a pilot study was done in the fourth tertiary hospital. The prepared series of questions which would be used to guide the main discussions as the key to an effective focus group was tested as the questioning route. The interview questions were tested and found to be effective (Polit & Beck 2012:538).

### 2.7.2.1 Pilot testing

De Vos et al. (2005:205) explain pilot testing as one way in which the prospective researcher orientates himself or herself to the project he or she has in mind. Brink (2010:166) further describe the pilot study as the preliminary study conducted on a smaller scale prior to the main study on a limited number of subjects from the population at hand. It is actually the pretesting of a measuring instrument as tested on a smaller homogenous group similar to the target group of the main participants. The main purpose of this pilot study was to improve the success and effectiveness to investigate the feasibility of the planned project in the current study and to bring possible deficiencies in the interview guide to the fore.

The researcher conducted the pilot study in one of the tertiary hospitals in Johannesburg as it was important to establish the content validity of the instrument (question list) and to improve probing questions. Cresswell (2003:158) states the number of participants who were used to adapt the questions in the interview guide and their comments are not to be incorporated into the final version of the interview guide. This was applied in this study

The pilot study was performed in a venue which was similar to the other three chosen tertiary hospitals. The placing of the tables and chairs were the same as was making use of two audiotapes. The purpose of the pilot study was met as the participants understood what the researcher needed; no changes were made to the

questions, no question was added nor was one discarded. No coding problems were detected that might have led to the same questions being asked in the three focus group discussions.

The timing of the pilot study was a bit of a challenge as it was done at 07h00 in the morning to include staff from night duty and those starting on day duty. The staff from night duty indicated they were tired and those coming on duty also indicated they would be behind in their ward routine; however, both groups decided to sacrifice of their time and the pilot study was conducted.

The information leaflet was read and explanations about the purpose of the study, duration of the focus group, expectations during the interview and the rights of withdrawal (that participation would not influence their employment status negatively) were included before the consent form for participating and also allowing audiotaping was signed. One participant decided to withdraw as she indicated she was tired and six participants remained.

The focus group interview lasted for an hour. The researcher thanked participants for their time and their contributions to the study.

### **2.7.3 Conducting the interviews**

Ultimately 14 participants were recruited from the three institutions. Each focus group had four to five participants. All focus group interviews processes took place in organised settings, were guided by prepared questions and conducted by an experienced moderator with research knowledge and with fluent English and midwifery experience leading the interviews. The researcher acted as the assistant facilitator (Botma et al. 2010:211). The interview began with the researcher giving some brief information about the reasons for the focus group interview, introduced the topic and also explained the frame of reference of the focus group interview.

There was a relaxed atmosphere among the participants in each of the focus groups before and during the interviews. Confidentiality and respect was shown and maintained (Burns & Grove 2009:513). Although the interview guide was used the moderator was very careful not to be directive during the discussions. (See Annexure C2). All focus group interviews were conducted in English as all participants were professional nurses who were conversant in English. Participants

were encouraged to discuss the issue freely among them to ensure capturing rich quality, in-depth data from the natural flow of the interviews. Probing questions were only used if there were unclear statements or quiet periods became too protracted.

The focus group interviews lasted approximately 60 minutes each, field notes were taken and the audiotaping done. (Participants gave written consent.) (See Annexures C1, C3 and C4). The discussions were interactive with fairly equal levels of contributions and interest from all participants. The moderator used communication skills such as probing, paraphrasing and reflection during the focus group interview in order to collect as much rich data. Data saturation was reached and the researcher was satisfied that data saturation had been reached and no new knowledge came forward (Polit & Beck 2012:742).

- **The moderator**

The moderator, also known as the facilitator, can be either an experienced outsider or the researcher. Of importance is that this person must have the necessary good communication and facilitating skills. In this study an experienced, independent researcher with excellent English-speaking skill and expert midwifery knowledge was used as the moderator. The moderator was an expert in the art of conversation with experience in probing and rephrasing questions. The moderator was able to communicate clearly and precisely, both in writing and verbally as she took quality field notes. The moderator avoided domination of discussion by one participant, dealt with dynamics that evolved, constantly checked behaviour against attitudes and challenged responses with opposite views. The moderator continued performing the primary function of directing and keeping the conversation flowing after the topic was introduced by the researcher (de Vos et al. 2005: 307). The moderator's time management was well demonstrated as starting times and finishing times were controlled and maintained.

- **The researcher**

The researcher acted as the assistant facilitator as indicated in the previous chapter of this study. The researcher organised the focus group, took field notes, and handled the environmental logistics and conditions. She made sure the venue door was closed. However, she forgot to put a notice on the door that focus group were in

progress to avoid unexpected interruptions. (de Vos et al. 2005: 307). Fortunately, all focus group interviews took place without interruptions.

- **Audiotaping**

Audiotaping is one of the technical devices in data collecting for recording behaviours, events, and making the categorisation of the data easier at a later time during data analysis. Audiotaping allows for much fuller record keeping than notes taken during the interview and it gives the researcher time to concentrate on observing non-verbal responses. In this study the two audiotapes were tested for proper functioning before the commencement of each focus group interview (Polit & Beck 2012:317; Merriam 2009:109). The third person was organised to operate the two audiotapes in all focus group settings including the pilot study setting. The reason for using two audiotape recorders was to avoid the loss of data in case of unexpected technical problems. All participants signed separate informed consent (see Annexure C4) for audiotaping the interviews before commencing with the recording of the interviews (Streubert & Carpenter 2007:62).

#### 2.7.3.1 Communication skills

As indicated in the above paragraph the moderator used paraphrasing, probing and reflection during the focus group interviews. The moderator listened, paraphrased questions, and probed participants whenever their contributions lacked depth or were vague, to elicit detailed and clear responses. The moderator used reflection for reminding the participants what has been said already during the discussions (de Vos et al. 2005:293; Polit & Beck 2012:738; Rossow 2003:144). Participants were encouraged to freely add more information or to reflect on points made after the moderator had reflected on what had been discussed.

- **Reflection**

The moderator used reflection to remind the participants of what they had already said so that they could link the subsequent interview with what they had already said (de Vos et al 2005:293; Rossow 2009:144). Reflection act as an echo to the participants on what words they already used to encourage them to elaborate more

on what they had already shared. Examples of the reflection the moderator used are mentioned. A participant said, *“I think an advanced midwife as is more skilled, she can make good decisions, right decisions especially now that we are training up and ... and coming young doctor. Some of the things they don’t know”*. The moderator’s reflection statement was, *“So you are training young doctors as well...?”*

- **Probing**

The moderator used the probing technique in a respectful and dignified manner in order to get more detailed information from participants. Prepared probing questions were asked to obtain more detail and clarity on the participants’ experiences (Munhall 2012:448). Probing is defined as “the technique used to elicit more detailed information from a respondent in an interview than was volunteered in the first reply” (Polit & Beck 2012:738). Probing is further explained as the technique that persuades participants to give more information about the issue under study (de Vos et al. 2009:290).

Participant’s comments were followed up in order to get meaning. For example, the moderator asked the question, *“So what comes to your mind when you hear the word advanced midwife?”* The participant stated, *“Advocate”*. The probing question stated by the moderator was, *“Tell us more about that”*, to which the participant replied, *“I think an advanced midwife is more skilled, she can make good decisions, right decisions especially now that we are training up and coming young doctors. Some of the things they do not know”*. The moderator also used paraphrasing.

- **Paraphrasing**

Paraphrasing is the way of preventing plagiarism; it needs one to capture the essence in one’s own way (Botma et al. 2010:69). Paraphrasing is the process of expressing the author’s word in one’s own words (Burns & Grove 2011:220). For example in this study, a participant stated, *“Like when the patient is bleeding I am not going to wait for the doctor to prescribe the oxytocin, I am going to put it up to stabilise the patient.”* The moderator paraphrased by saying, *“That means you have got dependent, interdependent and the independent functions.”* All participants responded with a *“yes, ya, yes, that’s right”* and the moderator asked whether they

wanted to elaborate. This helped to get in-depth quality information and good listening skills were used by the moderator.

- **Listening**

In a focus group interview the moderator plays a major role by taking care to solicit input from all participants (Polit & Beck 2012:538). According to de Vos et al. (2011:189), the facilitator must have good listening skills in order to obtain quality information from participants, gain better understanding and encourage them to talk more. In this study the moderator had good listening skills and that led to obtaining of in-depth quality information without interfering when participants were talking but technically encouraging them to give more information. Good eye contact was maintained throughout which gave participants confidence to talk more. The moderator demonstrated interest in the discussion by nodding and leaning forward as participants were expressing their experiences.

#### **2.7.4 Post interview phase**

The post interview phase occurred at the end of each focus group interview. In this phase the researcher took the opportunity after each session to thank the participants for participating, to demonstrate cooperation and showing respect for each other during the proceedings. The participants were reassured that they would be informed about the findings of the study and that anonymity and confidentiality would be maintained (Polit & Beck 2012:720).

##### **2.7.4.1 Identifying data of the participants**

Data was collected from the three tertiary hospitals and 14 participants participated in the focus group interviews. The names of the hospitals where the focus group interviews were conducted were used to identify focus group numbers 1, 2 and 3 for anonymity purposes. All the 14 participants were mature experienced female advanced midwives. For guaranteeing anonymity and for confidentiality to be maintained (also during the data analysis process), the participants were given numbers linked to the number of the particular hospital, for example the number used (F1, P1) indicated Hospital 1, Participant 2.

## 2.8 DATA ANALYSIS

Data analysis refers to what is done with qualitative research information once it has been collected, systematically organised and synthesised (Polit & Beck 2012:724). Data analysis methods should fit with the research design and research paradigm (Saks & Allsop 2007:410; TerreBlanche et al. 2009:86).

In order to collect rich and unique data, the audiotaped information which was collected during the focus group discussions was transcribed with the assistance of the moderator. The participants' names were not recorded to ensure anonymity during the discussion. The researcher will follow the stipulated policy rules of the University of Pretoria as the tapes will be kept for 15 years in the researcher's residence and thereafter be destroyed.

For retaining the uniqueness of each participant's lived experience while permitting an understanding of the phenomenon under investigation, the researcher made use of Tesch's methods of coding. The data analysis was done according to Tesch's eight steps for analysing data as follows (Botma et al. 2010:224-225):

- Step 1

All transcriptions from the audiotapes as well as the field notes from the three focus group interviews were carefully read and listened to and the researcher jotted down interesting or important points that emerged.

- Step 2

The researcher took the transcripts from a hospital and read through them while asking herself, "what is this about?". She wrote down points of interest in the margin and she followed the same process with each of the two remaining hospitals.

- Step 3

After completing reading all the transcripts, the researcher made lists of the topics and grouped similar topics together. She then grouped similar topics in columns as major topics, unique topics and leftovers. Main themes were identified from each focus group.

- Step 4



The researcher prepared a list of topics and went back to data. The prepared topics were abbreviated as codes. Themes, categories and subcategories were derived from the data. The researcher developed descriptive themes to categorise the research information according to similar clusters of information.

- Step 5

The researcher found the most descriptive cluster information for the topic and turned them into the main themes. Themes were reduced by grouping together the related categories. Lines were drawn between categories showing interrelationships and subcategories were formulated.

- Step 6

The researcher finalised the decisions made on the abbreviations for each theme and arranged the codes alphabetically. Finally, the themes, categories and subcategories were finalised.

- Step 7

The researcher placed data material belonging to each theme in one place and performed and assembled the preliminary analysis.

- Step 8

The researcher recoded the existing data in the study supporting it with literature.

## **2.9 MEASURES TO ENSURE TRUSTWORTHINESS**

Qualitative researchers use trustworthiness as a degree of confidence in their work. In qualitative research, the criteria to establish trustworthiness in the research process and the findings as outlined by Guba's (1985) model are contained in confirmability, credibility, dependability and transferability (Botma et al. 2010:234; de Vos et al. 2005:365; Polit & Beck 2012:745). Strategies were implemented to ensure trustworthiness throughout the research study process.

- **Confirmability**

According to Polit and Beck (2008:539), confirmability means to be objective about the accuracy, relevancy or meaning of the data. In this study the researcher

attempted to ensure that the findings reflected the “participants’ voice and conditions of the inquiry, not the biases, motivations, or perspectives of the researcher” (Polit & Beck 2008:539). Confirmability thus applies to establishing that the data truthfully represents the information participants provided, and that the interpretations thereof are not from the researcher’s own imagination. The findings must therefore reflect the participants’ own experiences and not the perspectives of the researcher.

In this study an experienced external moderator was used to facilitate the focus group interviews to prevent the researcher from influencing the data collection process. The moderator also checked the verbatim transcripts as she assisted with the coding of the data. The supervisor and the co-supervisor checked the verbatim transcripts to ascertain no influence took place by the researcher or moderator. The themes, categories and subcategories that emerged during the data analysis process were supported by direct quotations from the verbatim transcribed interviews to further ensure confirmability of the findings. The findings will be kept for future academic reference.

- **Credibility**

Credibility refers to the “confidence in the truth of the data and interpretation of them” (Polit & Beck 2008:539). Credibility means to perform the research study in such a manner that the believability of the findings is enhanced and to disclose the steps taken to enhance credibility to external readers (Polit & Beck 2008:539). Prolonged engagement also promotes data saturation (Polit & Beck 2010:495). Credibility implies that the participants can recognise the meanings that they themselves gave regarding the research phenomenon and the truth of the findings in their own social context (Holloway & Wheeler 2010:303).

In this qualitative study, credibility was ensured by the researcher's prolonged engagement in the study field. The researcher is also an advanced midwife, had experience in the facilitation of the Decentralised Programme of Advanced Midwives (DEPAM) training. She worked in a tertiary hospital in Gauteng for two years and at the time of study was a manager in the mother and child hospital in Gauteng. Similarly, the moderator was an experienced independent professional researcher, good English speaker with good interpersonal and communication skills. Prolonged engagement also promoted data saturation (Polit & Beck 2010:495). The 1-hour

focus group timing gave the participants time to discuss until saturation of data was reached

To further assure credibility three focus group discussions as well as a pilot study was conducted. All facilities were tertiary hospitals and were all in Gauteng. The researcher did the pilot test in one of the tertiary hospitals and the prepared interview guide which was used needed no alterations. The researcher worked through gatekeepers; application letters were sent to the relevant senior persons in the settings to request permission for conducting the study and for access to the institutions to recruit candidates. The participants were all advanced midwives rendering care in maternity in three tertiary hospitals in Gauteng. All focus group interviews were audiotaped with two good quality sophisticated tapes which were operated by a person experienced in technology. Using multiple data sources (focus group interviews, field notes and literature control) further enhanced the credibility of this study. Credibility of the data was also established by allowing the participants to revise their interviews as a check (member checks) as indicated by Memarian, Ahmadi and Vaismoradi (2008:48).

- **Dependability**

Polit and Beck (2008:539) refer to dependability as the stability or reliability of the data. Dependability refers to consistent and accurate research findings and is the “stability (reliability) of data over time and conditions”. Polit and Beck (2008:539) imply that should the study be repeated with different participants in a different setting the same or similar results will be obtained.

To assure dependability the researcher was supervised by the two supervisors who checked all the steps followed. Data was collected by identifiable sources namely advanced midwives and a thick and dense description of the methodology was provided. Moderator paraphrased questions and probed to get rich data and reflected the given information. For the code-recode process the coding of data was done by the researcher assisted by the moderator, supervisor and co-supervisor

- **Transferability**

Transferability refers to the “generalizability of the data, that is, the extent to which findings from data can be transferred to or have applicability in other settings or groups” (Polit & Beck 2008:539). The researcher provided a complete and thick description of the study setting and findings, field notes were used for comparison with the verbatim transcripts and to enhance the verbal data recorded so that the applicability of the data to other contexts can be evaluated and considered. Transferability refers to whether the research findings can be transferred to or applied to other settings or groups; in other words, transferability implies generalisability (Polit & Beck 2008:539; Holloway & Wheeler 2010:303). Transferability is viewed as the responsibility of the researcher who has to produce “sufficient descriptive data in the research report” so that consumers of research can evaluate the applicability of data to other contexts themselves

## **2.10 CONCLUSION**

The qualitative, descriptive, exploratory, contextual research design and focus group interviews used to collect data were discussed in detail. The analysis of the qualitative data is and literature control of the findings are presented and discussed in the next chapter.

## CHAPTER 3

### 3.1 INTRODUCTION

The research methodology, design, data collection methods and data analysis method used in this study were described in the previous chapter. In this chapter the researcher discusses the findings of the collected data and uses literature to support the findings and discussions. The findings reflected the identified roles by advanced midwives working in maternity care in tertiary hospitals in Gauteng. The data recorded on the audiotapes during the focus group interviews were transcribed verbatim and Tesch's method was used to analyse the data. Data was coded by the researcher with the assistance of the supervisor and co-supervisor. Consensus was reached and the coded findings were tabulated according to themes, categories and subcategories and the findings were controlled and validated by literature as stated by Burns and Grove (2009:93) and Polit and Beck (2012:558).

”

### 3.2 DATA COLLECTION SUMMARY

The collection of the data was done through focus group interviews which were conducted in the three tertiary hospitals in Gauteng by the researcher with the assistance of an experienced moderator. The moderator also assisted with the coding of data but the verbatim transcriptions were done by the researcher (Botma et al 2010:214). Two audiotapes were used during each of the three focus group interviews, information was transcribed verbatim and field notes were taken by the moderator and the researcher (the latter fulfilling the role of an assistant facilitator). In this qualitative study, data was analysed by the researcher as it gave the researcher the opportunity to become immersed in the data and added to the study credibility (Polit & Beck 2012:561).

### 3.3 OPERATIONALISING THE FIELD OF RESEARCH

Data was collected from three focus group interviews which were conducted in three selected tertiary hospitals in Gauteng. Each focus group consisted of 4 to 5 purposely selected participants. A total of 14 participants were divided into three focus groups. The first focus group consisted of 4 participants, the second one had 5 participants and the third focus group comprised of 5 participants. Table 3.1 below

illustrates a summary of the participants in the study. In this section, the abbreviation 'F' is used to indicate the focus group and 'P' to indicate the participant.

Table 3.1 Summary of participants

Hospitals	Focus groups	Participant number in focus group	Department where participants worked
Hospital 1	Focus group 1 (F 1)	Participant 1 (P1)	Postnatal
		Participant 2 (P2)	Antiretroviral (ARV) unit
		Participant 3 (P3)	Postnatal ward
		Participant 4 (P4)	Labour ward
Hospital 2	Focus group 2 (F 2)	Participant 1 (P1)	Labour ward
		Participant 2 (P2)	Antenatal ward
		Participant 3 (P3)	Antenatal ward
		Participant 4 (P4)	Postnatal ward
		Participant 5 (P5)	Postnatal ward
Hospital 3	Focus group 2 (F 3)	Participant 1 (P1)	Labour ward
		Participant 2 (P2)	Labour ward
		Participant 3 (P3)	Postnatal ward
		Participant 4 (P4)	Maternity casualty
		Participant 5 (P5)	Maternity admission

### 3.4 DATA ANALYSIS PROCESS

The researcher independently did the systematic organisation and synthesis of the study data. She listened to the audiotapes several times before transcribing the information verbatim. The researcher highlighted the verbatim transcribed phrases from the advanced midwives from each focus group on how they perform their role in maternity care of tertiary hospitals in Gauteng. Themes were identified and were further developed into categories which were divided into subcategories (Polit & Beck 2012:738). The researcher and the supervisors discussed the identified themes, categories, and subcategories and themes until consensus was reached. A thorough comparison of the field notes and verbatim transcripts of each focus group was done. Tesch's method of data analysis was used to analyse the collected data (Botma et al. 2010:223-224). The researcher summarised the findings in Table 3.2 which is shown below and used in the discussion of the findings and literature control

Table 3.2. Summary of themes, categories and subcategories

<b>THEMES</b>	<b>CATEGORIES</b>	<b>SUBCATEGORIES</b>
1. Position of advanced midwives	1.1. Perceived positioning of advanced midwives	<ul style="list-style-type: none"> <li>• Need for advanced midwives in tertiary hospitals</li> <li>• Own perception of advanced midwives of their position</li> <li>• Perception of medical personnel of the position of advanced midwives</li> <li>• Perception of institution</li> </ul>
2. Responsibilities of advanced midwives in tertiary hospitals	2.1 Contribution to quality care	<ul style="list-style-type: none"> <li>• Monitoring and evaluation of quality care</li> <li>• Remaining skilled and knowledgeable</li> <li>• Be advocate and educator for patients</li> <li>• Participate in research</li> </ul>
	2.2 Contribution through teaching	<ul style="list-style-type: none"> <li>• Teaching medical and nursing students</li> <li>• Teaching colleagues (Including registrars and midwives)</li> </ul>
	2.3. Dealing with managerial issues	<ul style="list-style-type: none"> <li>• Dealing with staff shortages</li> <li>• Dealing with none human resources</li> </ul>
	2.4. Dealing with challenges related to patients admission	<ul style="list-style-type: none"> <li>• Admission of unbooked patients and self- referrals</li> <li>• Collaborate with MOUs and district hospitals</li> </ul>

### 3.5 DISCUSSION OF FINDINGS AND LITERATURE CONTROL

The study findings reflected advanced midwives had both positive and negative experiences on their perceived role in the three tertiary hospitals in Gauteng. Advanced midwives seemed to be mostly excluded as advanced practitioners as there were specialists (obstetricians and paediatricians) in the maternity units of tertiary hospitals. In two of the tertiary hospitals the views of advanced midwives regarding their role was positive even though they did not fully practice their skills as advanced midwives. In one of the tertiary hospitals the participants in the focus group interviews voiced that they functioned as basic midwives because they were not given the opportunity to manage cases of women and neonates with complications. The findings are verified by verbatim transcribed quotes from the focus group discussions and literature supporting it. The data was grouped into two main themes, namely:

- Theme 1: Position of advanced midwives in tertiary hospitals
- Theme 2: Responsibilities of advanced midwives in tertiary hospitals

For the identification of participants the following will be used. Focus group one (F1) participant (P1); therefore, (F1, P1) refers to focus group 1, participant 1 and so forth.

#### 3.5.1 Theme 1: Position of advanced midwives in tertiary hospitals

The first theme which emerged was the position of advanced midwives in tertiary hospitals. The identified category under this theme was perceived positioning of advanced midwives. The category with its subcategories is discussed next followed by a literature control.

##### 3.5.1.1 Category 1: Perceived positioning of advanced midwives

- Need for advanced midwives in tertiary hospitals

In tertiary hospitals, advanced midwives are often forced by emergency situations to implement their skills and knowledge as confirmed by the following quotes from participants:

- *“And even the babies when you identify that maybe the baby is not breathing ... the colour, you check, you start to resuscitate the baby yourself. You will be asking somebody to go and call the doctor but you as an advanced midwife you have been trained to do neonatal resuscitation. How you are going to resuscitate those are the things you are to do, when the doctor arrives he will take over from you but you have already started the process.” (F1, P4).*



- *“The only problem that I think is becoming a challenge is when if something can go wrong maybe you are faced with fully dilated breech patient and the baby was coming out and get stuck and baby becomes fresh still born [FSB] ... then that is when it becomes a problem because they will say, ‘why didn’t you call the doctor, why didn’t you call the doctor?’ and when you look at it the patient was fully dilated and pushing, the doctor maybe was in theatre.” (F3, P3).*
- *The good thing about being a midwife is that we are also identified in Gauteng that they must train more advance midwives to be in help, to be improving patients’ care and patient life by identifying problems in the various aspect of care during labour, after labour even during pregnancy they[advanced midwives] were found even curbing maternal deaths like...” (F1, P1).*

**Discussion:** Globally, the International Council of Nurses (ICN) recognises the role of advanced midwives, although in different countries the contexts differ (Elliot et al. 2013:3). Different countries extend their scope of practice in a way that suits the context of the country. In other words, as stated by Atsalos et al. (2014:2874-2875), although the delineation of advanced practitioners differs from country to country, “role expectations are similar in nature”. In Ireland, advance midwives are involved with vacuum deliveries and breech deliveries (Begley et al. 2012a:1-2). While in Canada, an additional skill is suturing of third degree tears, in Australia the same skills are considered to be above the advanced midwives’ scope of practice (Smith et al. 2009:119). Australia also does not include the implementation of advanced skills in practice whereas the midwives’ scope of practice in the United Kingdom (UK) has been extended to implement the acquired skills in an effort to impact positively on the maternal and neonatal outcomes (Begley et al 2012a:1-2). Mead (2000), Clarke (2006) and Lowe et al. (2012) cited in Atsalos et al. (2014:2876), agree that international expectations “placed on advanced practice nurses and midwives are, however, that they will deliver optimal health care despite severe fiscal constraints”.

In this current study, the determination to render optimal health care was shared by a participant who said as an advanced midwife who has been “*trained to do neonatal resuscitation*” she would “*identify that maybe the baby is not breathing ... the colour, you check,*” she would start resuscitating the baby, tell someone to fetch the doctor and “*when the doctor arrives he will take over from you but you have already started the process you start to resuscitate the baby yourself.*” On the other hand, according

to Gerrish et al. (2011:14) in some countries such as New Zealand the role of the advanced midwife is not clearly defined.

South Africa is one of the countries where the scope of practice of advanced midwives is extended. South Africa has a generic competency framework for advanced nurse practitioners (SANC R212) specifying guidelines for the practice of the advanced midwife. Although the scope of advanced midwives in MOUs includes performance of complicated delivery, in tertiary hospitals this task is designated to be carried out by doctors only.

According to Pattison (2015a:261), maternity care is considered to be safe if sufficiently knowledgeable and skilful healthcare providers observe women in labour and manage complications either by treatment or by stabilisation and referral. The idea that 'safe' maternity care depends on competent healthcare providers who can either assist with a birth or make a quick decision to call in help is confirmed by Magowe, Seboni, Rapinyana and Phetogo (2016:109) who did a study on the expected roles of nurses and midwives in Botswana. These authors found patients, community leaders and nurse leaders viewed nurses and especially midwives as "the backbone of the health care system" (Magowe et al. 2016:109). Nurse leaders specifically saw the midwife as the nurse responsible for delivering babies with the additional role of "caring for child-bearing families during pregnancy, labour, delivery, after birth, child care, family planning, family/maternal education and anticipatory guidance" (Magowe et al. 2016:110).

Pattison (2015a:262) recognises the importance of having advanced midwives as part of the staffing norms for maternity units in South Africa. These authors emphasise performing "assisted delivery (vacuum delivery) is not the scope of practice of professional nurses with midwifery, but is part of the skills set of Advanced Midwife". Maternal and neonatal health outcomes are important issues in South Africa because in the Countdown to 2015 Decade Report (2000-2010), South Africa was identified as one of only 12 countries where no progress had been made towards obtaining the fourth Millennium Development Goal (MDG 4). The baseline set in 1990 by the WHO was to reduce under-5 mortality by at least two-thirds by 2015 (Chopra, Daviaud, Pattinson, Fonn & Lawn 2009:1). In South Africa, the under-5 mortality rate raised from 56/1000 live births in 1990 to 73/1000 live births in 2000

and 67/1000 live births in 2008 (WHO, UNICEF 2010:9). Therefore, having advanced midwives can contribute to improve maternal and neonatal/foetal outcomes because part of the common goal they share is to optimise patient care (Atsalos et al. 2014:2881).

- Own perception of advanced midwives of their position

In this study the participants stated they were recognised for being more knowledgeable and more skilled in the field of midwifery than the other basic midwives. Some even mentioned the need for more advanced midwives to be trained as they are more knowledgeable and acquire essential skills to improve patient care by identifying complications during pregnancy, labour and puerperium. With regard to knowledge, a participant from one of the focus groups claimed the following:

- *“The good about it is that ... you are knowledgeable, you are more confident even with your patients or clients you know with the execution of whatever intervention you know you can do it without fear of going to the council [South African Nursing Council]...”* (F3, P5).

With regard to possession of skills a member expressed the following:

- *“I think as I am an advanced midwife, whatever situation I come into when I touch a patient, whatever thing I do to her, I analyse it critically ... and when I analyse it critically even the way I manage it, it needs to be different from a basic midwife because of the extra skills that I have been given ... I just see her or me as a special person because now I am doing extra to the normal things.”* (F2, P4).

**Discussion:** The participants believed they were professionally and emotionally equipped to deal with the process as well as the mother’s physical, emotional and psychological challenges (Jantjes, Strümpher & Kotzé 2007:85) during a difficult birth. One summarised her approach as not only analysing the situation critically and then managing it, but she added she saw the mother *“as a special person”* for whom she was *“doing extra to the normal things”*. Por (2008:87) agrees advanced midwives are advanced practitioners who utilise *“complex reasoning and analytical intellectual processes to arrive at the expert clinical judgement”*. In the view of Sutton

and Smith (1995 cited in Por 2008:87), the following are some of the attributes of advanced midwives, namely self-evaluation, self-reliance, thoughtfulness, effective interpersonal skills, clarity of thought, confidence and the ability to reflect and analyse. This is confirmed by one participant who said “*whatever situation I come into when I touch a patient, whatever thing I do to her, I analyse it critically ... and when I analyse it critically even the way I manage it, it needs to be different from a basic midwife because of the extra skills that I have been given*”.

Gerrish et al. (2011:5) state advanced midwives value their knowledge which is gained through professional networks and experience. Having advanced knowledge and skills is central to the advanced midwives’ functioning (WHO, ICM & FIGO 2014:7; WHO 2015:1). According to a participant, she had the confidence and knowledge to do “*whatever intervention you know you can do it*”. Advanced midwives possess a range of competencies (Spross & Heaney 2000:13) such as direct care, consultation, collaboration and leadership and can perform vacuum extraction and breech delivery. They are registered with the South African Nursing Council (SANC) as such. Patients need an advanced midwife who is skilled and competent and who will inform or refer to the doctor on time in case of an emergency (Hildingsson & Thomas 2007:128). It emerged that the advanced midwives in this study possessed the necessary skills to assess complicated cases and manage them accordingly.

- Perception of medical personnel of the position of advanced midwives

The participants agreed that teamwork lacked, or was limited, when decisions had to be taken about a patient’s management. Some comments were made reflecting that some doctors belittled advanced midwives’ knowledge and skills. This upset the participants because it inhibited free and open communication among professional team members who all wanted, or were supposed to strive towards positive patient outcomes for the mother and infant. In support of this finding, the following verbatim quotes are presented:

- “*We did not see you at the university when we were doing our seven years, who are you sister?*” (F2, P2).
- “*Eeh ... we never met in the campus [university campus].*” (F2, P4).

- *“Mmm ... they will end up saying, ‘we didn’t meet you at the corridor [university corridor].” (F2, P5).*

What disturbed another participant was the attitude of some doctors who seemed unwilling to cooperate with advanced midwives and work together with them even if complicated births were attended to. The following quote verifies this finding:

- *“I don’t know because in the antenatal ward some of the doctors are so reluctant to take advice from advanced midwives. The doctors are always rotating. I don’t know whether they don’t know that you are an advanced midwife like even when you say, ‘call the reg [registrar]’ you can see like when you say, ‘can I do it like this?’ they will take a long time, dragging and even delay[ing] patient management.” (F3, P2).*

According to the current participants, although some doctors and advanced midwives formed a solid team and first discussed whether a Caesarean section was the best option for both the mother and infant, increasingly no discussions occurred with a Caesarean section. This is evidenced in the following statement:

- *“Yah ... to add on that even those other patients who are being referred from level 2 or MOU when they come this side [to the tertiary hospitals] there are some doctors who do respect the advance midwife’s opinion. You can assess and say, ‘let us deliver this patient’ [by normal vaginal delivery] but there are those who feel uncomfortable to rely on [an] advance[d] midwife and they end up just cutting the patient [performing a Caesarean section without discussing the possibility of a normal vaginal delivery first].” (F3, P2).*

**Discussion:** According to Guise (2007:626), “labour and delivery units are complex, dynamic places where highly trained professionals from many disciplines work in a fast-paced, unpredictable environment. During obstetric emergencies, time-critical decision-making, team communication and cooperation can make the difference” where saving lives are concerned. Guise and Segel (2008:937) write in the USA it is the norm that whether “seeing a patient in the ambulatory clinic environment, performing a delivery or managing a critically ill patient, obstetric care is a team

activity. Failures in teamwork and communication are among the leading causes of adverse obstetric events, accounting for over 70% of sentinel events”.

The global consultation on providing quality midwifery care supported the current participants’ concerns about the lack of teamwork in decision making. According to WHO who conducted a study on Midwife voices, midwife realities, findings from a global consultation on providing quality midwifery care, 36% of midwives indicated they encountered disrespect from senior medical officers and 32% of African midwives stated that they value being listened to and being included in decision making (WHO 2016:2). “Subordination by medical profession” was mostly quoted by midwives together with limited legal and regulatory support. The midwives also ascribed most of the bad treatment they received from medical officers to discrimination against women and gender inequality. African midwives further verbalised disrespect in the workplace “extends to harassment-verbal bullying and physical and sexual abuse” and added it affects their “feeling of self-worth and their ability to provide quality care” (WHO 2016:2).

Advanced midwives are trained with the sole purpose of applying their knowledge and skills so that “continuous support by a specially assigned midwife during labour” (Sydsjö, Blomberg, Palmquist, Angerbjörn, Bladh & Josefsson 2015:page 2 of 5) can have a positive effect on the birth outcome even if there may be some lack of teamwork among the multidisciplinary team members in maternity. Guise (2007:631) argues that the advanced midwives’ skills are important, but the ability to use them effectively in a team and within the team is crucial. In the current study, the utterance by a participant that a doctor would simply “*end up just cutting the patient*” without proper team involvement. The author further reports that from malpractice claims, sentinel events, and the review of literature it was consistently found that teamwork and communication are among the top contributors to malpractice claims and adverse events (Guise 2007:631).

According to Newhouse, Stanik-Hutt, White and Johantgen (2011:230), there is high level of evidence that advanced midwives provide effective, safe, quality care to a number of specific populations in a variety of health settings; advanced midwives work in partnership with physicians and other healthcare providers and they have a significant role in health promotion. Moreover, many tasks such as management of

obstetric emergencies these days reaches complexity and needs a wider breadth of knowledge, skills and ability which makes organisations rely on a multidisciplinary team. The multidisciplinary team is also seen as a strategy to increase team performance which in turn improves the quality of decision making leading to innovative problem solving (Fay, Borrill, Amir, Haward & West 2006:553; Siassakos, Crofts, Winter, Weiner & Draycott 2009:1030). Newhouse et al. (2011:248) state “the ideal health system is the one which consists of multiple healthcare providers who communicate with each other and are accountable to each other to deliver coordinated care”.

According to Xyrichis and Ream (2007:233), teamwork is seen as very crucial and is emphasised in UK in such a way that “in the United Kingdom (UK), the National Health Service (NHS) Plan [Department of Health (DoH) 2000] clearly states that throughout the NHS previous hierarchical ways of working should give way to more flexible teamwork between the different healthcare professionals”.

Lack or no teamwork in decision making on patient management contributes to perception of institution.

- Perception of institution

The SANC curriculum outlines the advanced knowledge and skills advanced midwives possess, but the study findings reflected there was a lack of opportunity in the three settings or them to practise their acquired skills (skills which were in indeed in accordance with the requirements of the 2015 Guidelines for Maternity Care in South Africa) and also identified by Uys and Klopper (2013:2).

The findings revealed all complicated deliveries in the tertiary hospitals were done by medical doctors while the advanced midwife only monitored the first stage of labour which could just as well have been performed by a midwife who possesses no qualifications in advanced training.

History indicates the development of the role of the advanced midwife for the purpose of covering for doctors in rural and densely populated areas is not happening in tertiary hospitals because doctors are always available (Christiansen et al. 2012:1174).



Although advanced midwives are allocated in the maternity units of tertiary hospitals to implement the knowledge and skills acquired during their training, it was apparent from the findings that this was not the case. According to the participants, it was their experience that accountability lay with the doctors in the tertiary hospitals. The advanced midwives who had been trained to provide advanced midwifery care and who possessed the knowledge as well as the skills were not given the opportunity to practise their skills when the doctors were present. The advanced midwives only performed routine care. This finding is verified by the following quotes:

- *“With this hospital it is different because whatever that is complicated, we call the doctor. We do not practice our skills as it needs to be like in the Midwifery Obstetric Unit [MOU] of the primary hospital. Whatever [happens] here we’ve got to call doctors of which our skills are not practiced accordingly.” (F2, P3)*

Another participant said:

- *“In the tertiary [hospital], with me particular I see the role of advanced midwife [as] limited in the sense that they rely mostly on doctors’ decisions as much that at the end of the day the skill that you are [trained] to practise, for instance to do the vacuum you ... because there is no practice at all. Like you cannot stand and say ‘I can do it’ even if you see the need because now the doctor has to come in.” (F2, P1).*

A third participant added:

- *“The other [option] one will be to assist to be an assistant in operating theatre if that is allowed for us to assist because you find that maybe they were doing delivering breech or transverse because in this hospital the theatre sisters are just theatre trained, you as a midwife but standing there, you have the work [but] you are a ... away [not part of the team]. If you were assisting you might say, ‘Don’t turn the baby to this position because the position is already a problem’.” (F3, P3).*

**Discussion:** The WHO (2016:2) report on global consultation and providing quality midwifery care in low-, middle- and high-income countries revealed midwives are deeply committed to provide quality care for newborns, their mothers and families, but they are frustrated by the many obstacles that hinder their efforts. These



obstacles include not being able to utilise their skills by being placed in the wrong hospital and lacking opportunities in practice. Atsalos, Biggs, Boensch, Gavegan, Heath, Payk et al. (2014:2880) state many “clinical nurse/midwifery specialists [advanced midwives in this study] take leading roles in the redesign of existing clinical services and the initiation of new multidisciplinary projects, despite the many associated problems.”

Although being advanced midwives who had specialised knowledge regarding difficult births and problematic deliveries where the lives of the mother and baby may be at stake, the participants agreed they could not apply their wealth of experience and knowledge to enhance their clinical effectiveness as also stated by (Atsalos et al. 2014:2875) in the tertiary hospitals the way they could in primary hospitals. The statements they made pertaining to the particular tertiary hospitals included “*it is different because whatever that is complicated, we call the doctor*” and “*they rely mostly on doctors’ decisions as much that at the end of the day the skill that you are [trained] to practise [it]*” seemed to have no significance in the tertiary hospitals as the final decision on care and care delivery seemed to lie with the doctors. In this regard, the implication is that the specific tertiary hospitals’ policies still dictated the advanced midwives’ role; however, this policy is not in compliance with the Guidelines for Maternity Care in South Africa (2015:54).

Fraser et al. (2010:603) emphasise that advanced midwives are competent and independent practitioners who are trained and knowledgeable to handle emergency procedures which used to be done by doctors only. But, in the South African context, due to the high risk conditions of the patients in tertiary hospitals, all patients are seen by doctors. Advanced midwives in South Africa possess skills such as vacuum delivery, breech delivery and repair of third degree tears which are all within their scope of practice (SANC R212). However, in the present findings the presence of doctors and being placed in the wrong departments made it very difficult for advanced midwives to use their skills in practice. The participants felt ignored and excluded during the birth process. They were not asked for their input; they therefore felt they were perhaps “secondary in status” as Marks (2001:212) suggests. One participant explained their frustration by stating “*the theatre sisters are just theatre trained, you as a midwife but standing there, you have the work [but] you are a ... away [not part of the team]*” while another said “*I see the role of advanced midwife [as] limited...*”

Marks (2001:212) refers to the “dualisms in health service” meaning in spite of the fact that professional nurses (advanced midwives in this study context) became

more specialised in knowledge and acquired “new, better-rewarded skills” they are often reduced to the “more menial tasks”. In this study, participating midwives stated they felt excluded from and not part of the multidisciplinary delivery team. Remarks from the participating midwives included: “that is, if we are allowed to assist” and, although they were employed as advanced midwives (“you have the work”) who could and had the right to deal with unforeseen complications quickly and expertly, they experienced exclusion from decision making as they would just be “standing there”. Also, if they were allowed to assist (“be an assistant in operating theatre”), advanced midwives were not autonomous; if they were assisting they could contribute by suggesting “you might say, ‘Don’t turn the baby to this position because the position is already a problem”” but the doctor still made the final decision on patient care.

According to the Guidelines for Maternity Care in South Africa (2015:22), advanced midwives need to be allocated in tertiary hospitals where, apart from the fact that they are trained and skilled to perform procedures such as vacuum and breech deliveries (Guidelines for Maternity Care in South Africa 2015:54), their “expert client-centred care and consultancy within their defined specialty” need to be optimally utilised (Atsalos et al. 2014:2875). According to the findings, those skills are not utilised in the tertiary hospitals in Gauteng unlike in rural areas in the country where advanced midwives manage many obstetrical and midwifery complications independently (Fraser, Cooper & Nolte 2010:10). A study done in South Africa by Lesia and Roets (2011:168) describing the practice of advanced midwives, revealed 81% of the participants (advanced midwives) were not placed correctly nor not utilised correctly and therefore lacked the opportunity to practice their skills. The reason for not correctly utilising their skills and knowledge was their allocation – most were allocated in hospitals and institutions in urban areas where there were many doctors and the advanced midwife’s voice was seemingly remarkably modest. Lowe, Plummer, O’Brien and Boyd (2011:677) assert advanced midwives contribute to healthcare deliveries in various countries but the valuable contribution of nursing is lost if the ability to express their function does not exist.

So, because the advanced midwives in this study experienced that they did not practice their skills “*like in the Midwifery Obstetric Unit [MOU] of the primary hospital. Whatever [happens] here we’ve got to call doctors*”, the participants felt they were losing their skills. Lesia and Roets (2011:168) confirm that advanced midwives lose their competence if they do not practice their skills and is considered a loss to both the Department of Health and the advanced midwives. This poses the question in staffing norms as per the Guidelines for Maternity Care in South Africa (2015:22) on whether advanced midwives’ placements in tertiary hospitals allow for the optimal usage of their skills and knowledge if a more urgent need for it exists in other areas and settings.

Nielsen and Mann (2007:88) assert to “reduce errors and improve outcomes” in obstetrics, teamwork involving all staff members, including physicians, nurses and

support groups is pivotal. These authors assert the main function of advanced midwives is to reduce or minimise preventable management of errors within the multidisciplinary team. The requirement for introducing a teamwork-based change in labour and delivery is supported by Doyle (2004:29) who states even if the multidisciplinary team has a good system in place (for example, making use of team meetings to discuss their failure or success of births) room for improvement and review needs to be constantly considered by the team. In this regard, Bryant-Lukosius and DiCenso (2004:533) emphasise “there must be balance between medical and other stakeholder viewpoints. Medicine often dominates Advanced Practice Nurse (APN) role development; yet, optimal outcomes may be achieved when APN roles have a strong nursing orientation.” The effectiveness of the advanced midwives and their practice depends on the acceptability to the host and autonomy (Brooten, Youngblut, Deosires, Singhala & Guido-Sanz 2011:909).

Although the findings indicated advanced midwives obviously lacked opportunities to practice their skills in the tertiary hospitals, there were still opportunities and circumstances in clinical practice which they could practise their skills.

The SANC curriculum outlines the advanced knowledge and skills advanced midwives possess, but the study findings reflected there was a lack of opportunity in the three settings or them to practise their acquired skills (skills which were in indeed in accordance with the requirements of the 2015 Guidelines for Maternity Care in South Africa) (Uys & Klopper 2013:2).

The findings revealed all complicated deliveries in the tertiary hospitals were done by medical doctors while the advanced midwife only monitored the first stage of labour which could just as well have been performed by a midwife who possesses no qualifications in advanced training.

History indicates the development of the role of the advanced midwife for the purpose of covering for doctors in rural and densely populated areas is not happening in tertiary hospitals because doctors are always available (Christiansen et al. 2012:1174).

Tertiary hospitals cater for very ill patients and patients with obstetric complications hence the need for advanced midwives who are empowered and enabled to take responsibilities.

### **3.5.2. Theme 2 : Responsibilities of advanced midwives**

The second theme which emerged was the responsibilities of the advanced midwives. The four categories under this theme were contribution to quality care, contribution through teaching, dealing with managerial issues and dealing with challenges related to admission of patients. Each category with its subcategories is discussed next followed by a literature control.

### 3.5.2.1. Category 1. Contribute to quality care

The following four subcategories emerged under category 1, namely, monitoring and evaluation of quality care, remaining skilled and knowledgeable, be an advocate for patients and participate in research.

- Monitoring and evaluation of quality care

The advanced midwives reported that due to their presence in tertiary hospitals there were observed interventions which they applied to ensure positive maternal and neonatal/foetal outcomes. Several processes of outcome monitoring were also mentioned by them and included nurses' maternal and neonatal meetings and auditing of records. A participant communicated this information as follows:

- *“And they [advanced midwives] are involved in the national programmes like when they do notification of maternal death ... the advanced midwives will be employed there as an assessor. Even when they do neonatal deaths advanced midwives will also be employed so they recommend the midwives like our categories first they will call them ... trying to indicate more responsibility ... do you know these notification of maternal death ... involves analysis of the files, analysis and auditing of the files from other institutions so they sit in a certain area ... That work is done by the advanced midwives. They will take an advanced midwife from this hospital or from this unit to be involved ... The good thing about being a midwife is that we are also identified in Gauteng that they must train more advance midwives to be in help, to be improving patients' care and patient life by identifying problems in the various aspect of care during labour, after labour even during pregnancy they were found even curbing maternal deaths like...” (F1, P1).*

Participants gave evidence of how they monitored the care provided:

- *“... as quality assurance because as an advanced midwife we are a team where we sit and discuss the mishap and come up with the quality improvement plan on that.” (F3, P1).*
- *“If there is a mishap whether ruptured uterus, maternal death, ectopic pregnancy, any fresh still birth (FSB) those are the files we discussing.” (F3, P1).*
- *“We are to choose the file to be discussed and audited or which case you going to present, sitting in are all different categories of nurses.” (F3, P5).*

**Discussion:** According to Brodie (2013:1075), the global impact by regulated, competent advanced midwives shows positive maternal and infant health outcomes and is reflected as central to the effort to accelerate progress towards the achievement of the Sustainable Development Goals (SDGs) which were adopted on

25 September 2015 by the WHO In order to attain SDG 3 which is to promote health for all, well-outlined steps need to be implemented in maternity units.

Globally, advanced midwives have in-depth awareness, knowledge and skills of the needs to improve quality patient care, but their voices are rarely heard. Subsequently, the key issues of the strategic plan of improving quality patient care are absent from international, national and local policies (WHO 2016:3). Well-defined roles and the extended scope of practice in MOUs contribute to positive maternal and neonatal/foetal outcomes (Kennedy et al. 2011:721). Similarly, in tertiary hospitals in this study the presence of advanced midwives impacted on maternal and neonatal outcomes. They have the main resource, namely the knowledge skill, which empowers them to take part or take the lead in facilitating positive maternal and neonatal/foetal outcomes. Advanced midwives achieve positive change in maternity care by facilitating, encouraging, motivating and enabling colleagues in maternity care (McIntosh & Tolson 2008:220).

To evaluate the quality of care, health professionals who are able to identify values, set objectives, describe patient care in measurable terms, set security measurements, evaluate results, and take action are needed (Sale 2005:13-14). The study findings revealed formal exercised monitoring of the care provided is done by implementing the maternal and mortality meetings and file audits. The current participants gave evidence of how they monitored the care provided:

- *“... as quality assurance because as an advanced midwife we are a team where we sit and discuss the mishap and come up with the quality improvement plan on that.” (F3, P1).*
- *“If there is a mishap whether ruptured uterus, maternal death, ectopic pregnancy, any fresh still birth (FSB) those are the files we discussing.” (F3, P1).*
- *“We are to choose the file to be discussed and audited or which case you going to present, sitting in are all different categories of nurses.” (F3, P5).*

**Discussion:** Continuous evaluation and monitoring of own practice is needed for service improvement. Unit-based perinatal audits were introduced in the Netherlands between September 2007 and March 2010 (van Diem, Timmer, Bergman, Bouman, Egmond, Stant, Ulkeman et al. 2012:4). Studies on perinatal and mortality and neonatal/foetal audits in South Africa revealed audits were introduced as early as 1997 for the evaluation of maternity care in rural areas of KwaZulu-Natal (KZN) (Wilkinson 1997:161). Training basic midwives to advanced midwife level was identified as the initial intervention in the maternity system to improve quality care (Wilkinson 1997:164). An audit is used to identify weaknesses in the delivery of healthcare and strategic plans are designed to target interventions and evaluate the impact of the interventions (Wilkinson 1997:162). The auditing of patient files aim at identifying avoidable human errors in order to develop strategies to prevent

unnecessary recurrence of such errors. Avoidable human errors occur in health systems, but with regular file auditing and in-service training to staff those errors can be stopped (Wilkinson 1997:162).

According to the Guidelines for Maternity Care in South Africa (2015:16), medical and nursing audits must be done on the different levels of care. In this study it was revealed that some tertiary hospitals have scheduled medical and nursing audits, but in others only medical audits take place. In the current study participants agreed that all nurse categories sit down to discuss “*a mishap whether ruptured uterus, maternal death, ectopic pregnancy, any fresh still birth (FSB)*”. The lack of proper nursing audits may fail to highlight nursing practices that may negatively impact on maternal and neonatal outcomes. It is therefore the role of the advanced midwife to assure that the audit meetings are conducted and nursing care provision is improved. In a global consultation on providing quality midwifery care it is stated “the evidence shows us that midwifery plays a ‘vital’ role, and when provided by educated, trained, regulated, licensed midwives, is associated with improved quality of care and rapid and sustained reductions in maternal and new-born mortality” (WHO 2016:1).

Positive and negative maternal and neonatal outcomes are affected by how obstetric emergence drills are practiced by healthcare providers in tertiary hospitals in Gauteng.

- Remaining skilled and knowledgeable

The maternal and perinatal audits show that in many cases healthcare providers fail to timeously and effectively recognise and manage complications which contribute to the low standards of care. The participants confirmed the importance of skill drills in the following statements:

- “...oh you know the way I cater for my clients it has to be advanced, you know you also looking at the ESMOE which is the essential steps of managing emergency cases for an advanced midwife is more like the same. If I am an advanced midwife I will be performing better, and then a registered midwife will be going for ESMOE, just to know equal my level but is just that with me I have got a national diploma so which means I am expected to work independently and .I need to excel.” (F3, P5).
- “ESMO ... trainings on emergency cases. It’s a programme from the Department of Health but recommendation is that it must be run by advanced midwives in Gauteng and this programme is started in Gauteng.” (F1, P1).

**Discussion:** Advanced midwives are part of a multidisciplinary team that must have skilled attendants who can prevent, detect and manage emergency obstetric conditions in order to reduce maternal deaths and obtain good outcomes in maternal and foetal conditions (Birch, Jones, Doyle & Green 2007:916).



Skill drills in other countries were initiated in 2000. According to Penny and Murray (2000:388), in the USA and UK emergency skills courses are designed to enable healthcare practitioners to respond quickly in an emergency situation. Role simulation of clinical skills improves preparedness and responses to obstetric emergencies (Guise 2007:626). The outcome of skills drill training is seen as improving the physical organisation of emergency equipment in the labour ward, increasing confidence in emergency teamwork and bettering knowledge about convenient locations for the telephone, postpartum haemorrhage pack, post-mortem Caesarean section pack and eclampsia box or defibrillator (Anderson, Black & Brocklehurst 2005:374).

According to Ameh and van den Broek (2015:1077), the prevention of unnecessary maternal and childbirth death can be achieved through building the capacity of healthcare providers who can recognise and manage complications. The authors explain “skill-and-drills competency-based training in skilled birth attendance, Emergency Obstetric care and early Newborn Care (EmONC) is an approach that is successful in improving knowledge and skills. There is emerging evidence of this resulting in improved availability and quality of care”. Instilling skills are done through in-service or on-the-job training (Ameh & van den Broek 2015:1080). In the UK the obstetric emergency drill has been recommended by the Confidential Enquiry into Maternal and Child Health (Anderson et al. 2005:372; Birch et al. 2007:916).

In the UK maternity care was identified and recognised as the area with the greatest sustainable improvement risk management, the essential component of after the utilisation of skills drills (Birch et al. 2007: 921). The skills drills are used as the approach to maintain competencies in obstetric emergencies to doctors and midwives (Birch et al. 2007:916).

In Australia, the Advanced Life Support in Obstetrics (ALSO) is the inter-professional course which develops and maintains skills and knowledge of healthcare professionals and it is mandatory for those who provide intra-partum care. However, the ALSO course can supplement and consolidate the clinical experience but cannot substitute it (Walker, Fetherston & McMurray 2013:525). ALSO began as early as 1990 in the USA with the aim of assisting health professionals in developing and maintaining their knowledge and skills (Penny & Murray 2005:388).

Responsible advanced midwives advocate for the patients care.

- Be advocate and educator for patients

Health workers are to empower patients through health education which is part of the advanced midwives role as confirmed by participants who commented:

- “...as educator we use to teach the students and mothers as well on how to take care of their children ... for babies how to take care of babies.” (F1, P1).

- *“...the other one [midwife] will be allocated maybe to be with a nurse allocated maybe to give the topic on breastfeeding or wound care there ... you are there to rectify if the information is not sound.” (F1, P3).*
- *“Yes that is our interdependent function. Assessing because patients ... on arrival from different institutions we are the first people to screen and assess yes ... after documentation and everything then we advocate that doctor here is the patient presenting with one, two, three [symptoms or signs] then doctor takes over. If patient is dire emergency [it is] also is my responsibility to advocate for the patient.” (F3, P5).*
- *“It [education] also focuses on patient, that is why we do health education and we have got our health education book because with the courtesy rounds [are] ... part of teaching as well. When doing courtesy rounds you want to check on the well-being of the patient in the therapeutic environment where they are at the moment. Yah but at the same time you know you can teach them about breastfeeding, that is what we are re-enforcing as a mother-baby friendly initiative and then like you know like for my unit specifically I am that side of the maternity admissions and we teach about wound care and perineum care. Teaching is mainly for patient. Patient also is our main focus in teaching. That is why we are to be knowledgeable in order to improve standards. That is why we are going for training...” (F3, P5).*
- *“So most of the decisions will be the advanced midwife’s decisions because sometimes they [doctors] make wrong diagnosis and you are there to guide them.” (F1, P2).*

The findings indicated most of the non-booked maternity patients needed to be admitted to the tertiary hospital because of complications. But, as one participant explained, the occurrence of low risk self-referrals has a huge impact on both patients who need to be admitted due to complications as well as on the advanced midwife when additional beds are needed. This participant voiced the following:

- *“... let me say we have got the patient who needs admission in one of the wards even if she is a medical patient or surgical patient. The ward she is supposed to go to its full and we have got beds so they send that patient to us to manage.” (F2, P5).*

*As the quote below verifies, when a situation arose where patients from other sections were moved into the maternity/neonatal section, the participants used their knowledge and skills to advocate for their babies.*



- “... but at least gynae [gynaecology] and obstetrics is related but sometimes we admit [other patients to maternity unit]. Last time I refused [a] meningitis patient saying the meningitis cannot come with new babies. In reality it can't be ... last time we had a lupus patient, the abscess [or] whatever.” (F2, P5).

**Discussion:** *The term advocacy originates from the legal profession. It is the Latin word ‘advocatus’ which means ‘one summoned’ or ‘called in’ to plead the cause of another in court. Hence, the idea of the advanced midwife as the defender of their patients’ rights (Hyland 2002:473) came into being. Advanced midwives are medically educated and they are the professional members of the multidisciplinary team who spend most of their time with patients (Schwartz 2002:40). As such, they have the responsibility to speak on behalf of patients who cannot speak for themselves such as neonates, babies and young children. According to the SANC’s Generic Competency Framework for Advanced Nurse Practitioners of South Africa (SANC 2014), advanced midwives are expected to act in an advocacy role to protect the patient and assess health education needs specific to the area of practice. Current participants said if an advanced midwife, who has more knowledge and skills than other healthcare professionals in midwifery, encounters a situation like when a “wrong diagnosis” is made, the advanced midwife is “there to guide them” and to “rectify if the information is not sound”.*

*The advanced midwife must also develop plans and implement needs-based findings from follow-up systems to ensure healthcare users receive appropriate services (SANC 2014). In the current study advanced midwives, for example, protected neonates by not allowing babies with, for example, meningitis or lupus to be in the same ward as the neonates.*

In the study they conducted in Cyprus, Greece, Hadjigeorgio and Coxon (2013:1) obviously found evidence to make the statement that “midwifery is dying”. Their qualitative exploration of how midwives perceived their role as advocates for normal childbirth revealed that “a lack of professional recognition and deficiency in basic or continuing education presented barriers to midwives’ adoption of an advocacy role”. The findings indicated that physician dominance, medication of childbirth and lack of institutional support hindered advocacy by midwives. However, in the current study participants asserted the situation in South Africa is more positive because advanced midwives are highly trained and experienced healthcare professionals; they are knowledgeable and skilled in patient advocacy as affirmed by a participant who said it was also her “responsibility to advocate for the patient”. The participants were determined to do the best for their patients even if it meant teaching other healthcare personnel like doctors and basic midwives in practice. Their informal teaching strategies included sharing their knowledge and skills with other healthcare providers for the benefit of the patient as the patients are “our main focus in teaching. That is why we are to be knowledgeable in order to improve standards. That is why we are going for training”.

In the opinion of Hewitt (2001:439), once people enter hospitals and other healthcare institutions and become patients, they become immensely vulnerable because they feel lost and not in control of their own lives and bodies. According to these authors, it seems that when patients find themselves surrounded by nurses and doctors with scientific expertise and amid technological equipment and instruments they do not understand, it restricts or disables their autonomy. Therefore, there is a strong need for patient advocacy so that patients can make informed decisions because they have the right to “informed health care” (Hewitt 2001:439). According to O’Connor and Kelley (2005:454,458), patient vulnerability and lack of autonomy is a trigger for advanced midwives’ advocacy as illness or incapacity leads patients to find themselves in a compromised physical condition. Advanced midwives empower patients in their care with more knowledge (one participating midwife said they taught “mothers as well on how to take care of their children”); they contribute to positive patient outcomes by assuring their patients can make informed decisions about their care (Spilsbury & Meyer 2001:6).

Advanced midwives express their patient advocacy role by creating an atmosphere that is supportive and open for the individual patient’s decision concerning the care provided (Hyland 2002:5). This was confirmed by a participant in the current study who shared the advanced midwives do courtesy rounds “to check on the well-being of the patient in the therapeutic environment where they are at the moment”. In addition to their educational role and being advocates for their patients, advanced midwives have several additional responsibilities in maternity care which include participating in research.

- Participating in research

The advanced midwives showed different views on their involvement in research in tertiary hospitals. In different focus groups the researcher managed to obtain their understanding of the importance of research, their role in research and knowledge acquired from conducted researches. The advanced midwives acknowledged their understanding of the importance of conducting research as specialists. The following quote from a participant provides evidence:

- *“I also think our hospital is also taking part in research and conducting research ourselves. Remember sister said we are to keep updated as specialist in midwifery field you are to do it through research.” (F3, P4).*

Another participant responded on a probing question: “Are you doing research as individual or are you involved in any research?” as follows:

- *“Not really per se but as an advanced midwife you are expected [to be involved in research].” (F3, P4).*

According to a participating advanced midwife, the university involves them in research:

- *“The university research like the doctors like the [deleted university name] they are the ones using this labour ward so when they have research they involve the advance midwives like the they were doing trial, mead pie trial, like on magnesium sulphate trial, trial on something whether it can be used, the advanced midwives they are involved ... So they [advanced midwives] are first one to be called in such researches.” (F1, P1).*

Although it was stated that participants were involved in research, it was explained that no dissemination of information upon completion of the research studies was done as confirmed by the following quote:

- *“Last time they conducted research on this septic issue [high rate of caesarean section sepsis] because it was too much I don’t know ... they [doctors or management] never came back to us on the conclusion what they concluded on what was causing because we started giving antibiotics one hour before patient going to theatre ... they were doing whatever that needs to prevent the patient from being ... so I don’t know what was the conclusion.” (F2, P5).*

On a positive note, the importance of conducting research as part of enhancing their knowledge and because it was expected of advanced midwives to initiate research for continuous professional development (CPD), a participant stated:

- *“But on that again we are doing this CPD portfolio that is also helping which you cannot miss much because it have everything ... you have to attend and accumulate points and that is also helping. We focus more on ethics and area of practice. The institution that has staff development they give us yearly programme with all the topics and it is up to the individual to attend. We have got also clinical facilitators in different disciplines, so [it] is well planned and well conducted ... as academic we are dwelling much in teaching because that very critical part ... if we lack knowledge we cannot be able to do intervention.” (F3, P5).*

**Discussion:** The study by Lesia and Roets (2011:159) shows that advanced midwives do not facilitate or initiate research in the clinical area. It elaborates that the lack of initiating research studies might be from being disinterested in doing research. This study confirms among advanced midwives there is a lack of initiating research studies as participants stated they only participated in research studies done by the universities but nothing was said that pointed to them (the participating advanced midwives) as initiating research studies. Advanced midwives are aware that they are expected to initiate research in the clinical area. A good platform for the advanced midwives in research is to embrace the Continuous Professional Development (CPD) campaign which is presently run by the SANC and leads the midwifery research as it is one of the areas where CPD points can be accumulated. However, this still lacks actual action-taking.

International barriers to research are highlighted as the failure of researchers to communicate findings, a lack of expertise in the appraising of research reports, limited relevant research studies and a lack of supportive organisational context together with insufficient time to read research (Nolan & Cooke (2002) and Markussen (2007) as cited by Gerrish et al. 2010:305), insufficient time for nurses to implement new ideas and also lack of time to read research (McDonnell et al. 2012:369). The importance of strengthening nursing and midwifery practice is consistently endorsed by the WHO.

Dissemination of information is important to people who participate in research. The advanced midwives wanted to receive feedback of the research studies they participated in. The researchers never went back to advanced midwives on the conclusion of the research study. One participant said, “they never came back to us on the conclusion what they concluded on”. The participant felt if there was work which they had done such as collecting statistics, they should be acknowledged. When publishing research results it is considered dishonest and misconduct if claiming work done by others by attaching your name as stated by (Botma et al. 2010:27). The author further explains that acknowledgement of people who assisted you in the research is not a prerequisite, but courtesy to thank those who assisted.

Getting reports of the research studies which the advanced midwives were involved with from universities might stimulate their interest in conducting research. According to Polit and Beck (2012:697), oral reports at meetings which are usually followed by formal reports that take 10 to 15 minutes and highlighting only important aspects, can be done. The audience is also then to be given about 5 minutes to ask questions. An important aspect of a research study is that it must include the dissemination of the results.

The advanced midwives in this study acknowledged that research assists them to keep updated as specialists, but they do not conduct research as individuals. Nursing research is defined as scientific investigations conducted to generate knowledge that will directly influence or facilitate improvement in clinical practice (Burns & Grove 2009:2). A good platform for the advanced midwives in research is to embrace the continuous professional development (CPD) campaign which is run by the SANC and leads the midwifery research as it is one of the areas where CPD points can be accumulated. However, from the study it seemed as if the advanced midwives showed understanding of the CPD but lacked the motivation to take action and enrol in the CPD campaign. The advanced midwives understanding of CPD will strengthen their teaching role.

### **3.5.2.2. Category 2: Contribution through teaching**

Under this category, two subcategories emerged, namely teaching medical and nursing students, and teaching colleagues (including registrars and midwives).

- Teaching medical and nursing students

The educational role is one of the four main functions of a professional nurse; however, most of the education is so informal it may even pass unnoticed by the knowledge recipient. In this study participants mentioned their involvement in education of the medical and nursing students as evidenced in the quote below:

- *“As tertiary hospital we do have students. Here we have got nursing students and medical students they are there all the time. We usually find ourselves teaching doctors ourselves because doctors they are busy with patient and medical students come to you as an advanced midwife to teach them everything. The only thing we are deprived from is the practising the thing [skill] but we only teach them theoretical skills.” (F1, P 2).*

A participant shared one teaching strategy advanced midwives used was role modelling:

*“The advanced midwife is there to be a role model, eh where she has to teach the students and even some interns or doctors about conditions eh with the knowledge that she has.” (F3, P3).*

Another verbalised they also used education as a means to stimulate their own intellect:

- *“Oh with a teaching responsibility, we just grab a page, I mean the students when they are there that’s when you stimulate your mind teaching them ... Or our subordinates to update them with something to manage cases.” (F2, P4).*

**Discussion:** According to Gilmour, Huntington, Bogossian, Leadbitter and Turner (2014:174-175), advanced midwives work closely with medical doctors in healthcare delivery and that obligates the substantial role of being clinical facilitators for junior doctors in clinical areas. This was confirmed by a current participant’s statement that she “has to teach the students and even some interns or doctors” because she was highly knowledgeable and specialised in her field of knowledge. The education role of advanced midwives in medical education is acknowledged and is fully documented in the study by Gilmour et al. (2014:173). Among others, it indicates a need exists for advanced midwives to assist with developing the clinical skills of interns as they have knowledge gaps regarding standards, patient safety, protocols and procedures in maternity care. Because education takes place informally in clinical areas, it is situational and does not have educational preparations. Therefore, the educator must be a professional equipped with knowledge and skills (Gerrish et al. 2012:31) such as an advanced midwife who, as voiced by a participant in the current study, continuously stimulates her own mind as she teaches “subordinates to update them with something to manage cases”.

A study conducted in Botswana on the roles of nurses and midwives in the country highlights the educational role of midwives to nursing students and junior doctors (Magowe et al. 2016:112). The focus is on mentoring and teaching of routine care in maternity. It is significant that advanced midwives play a major role in grooming both nursing and medical students. They not only assist with facilitating clinical practice for students, their assistance in clinical facilitation roles are extended to teaching of colleagues.

- Teaching colleagues (including registrars and midwives).

Registrars and basic midwives are also part of the multidisciplinary team. The majority of healthcare providers are still on junior level in tertiary hospitals in Gauteng. However, the categories of patients in the clinical area expose the junior staff to new learning opportunities on a daily basis thus also paving the way for the advanced midwife to give informal education in clinical practice (Magowe et al. 2016:112). A participant mentioned how the advanced midwives became involved in the following quote:

- *“The doctors sometimes you find that they don’t know the way forward about the patient. The advanced midwife will indicate that ‘let’s continue with the inductions ...’ (F1, P4).*

Participants sometimes shared knowledge and skills with the doctors:

- *“Sometimes registrars doctors who are studying for gynae [gynaecological] and obstetric specialisation with lack of knowledge we end up teaching them and showing them the skills.” (F3, P2).*
- *“But not on regular basis but even the reg [registrar] who is not skilled you end up showing skills to him.” (F3, P3).*

Informal education in the clinical area does not only involve doctors, it also involves the basic midwives. This was confirmed by participants who said the following:

- *“Through teachable moments, maybe you taking rounds ... BP is 160 over 110 then we gave Adalat ... after two or three hours you give Adalat again then you ... it’s a teachable moment then at [the] same time you discuss the PET, the management that’s supposed to be done.” (F1, P4).*
- *“I can say the advanced midwife ... have difficult to practice you know in the ward they help ... other midwives interpreted problem, they read CTG, and they indicate progress of patient...” (F1, P3).*

Orientation plays a major role as they use it for educating and also rectifying wrong practices. This is evidenced in the following statement:



- *“Orientation, yes its orientating how to do things in the ward, the routine because some don’t even know [how] to prescribe, dose for the medications, the patient will need to rectify something.” (F2, P2).*

A further comment made by one of the participants was:

- *“As advance midwife [advanced midwives] we are experts or we like or we want to or we have to be leaders and teachers to teach our subordinates, to teach our juniors how to manoeuvre some of the difficult situations, how to handle them.” (F2, P2).*

**Discussion:** A study by Kilminster and Folly (2000:827) found effective clinical supervision augmented the post-graduate medical doctors’ role. Proper supervision involves administrative tasks, education and support. The emphasis is on professional development and patient safety. The informal education of other staff members, medical students and junior doctors by advanced midwives was highly praised by the majority policy makers in the Ireland when they viewed their speciality role (Begley et al. 2012:6-7).

Education of doctors and basic midwives occur most of the time simultaneously with dealing with managerial issues.

### **3.5.2.3. Category 3: Dealing with managerial issues**

Under this category two subcategories emerged, namely deal with staff shortages and deal with none human resources.

- Deal with staff shortages

According to the participants, they were regarded as being responsible to manage the ward which included human resources management. They admitted staff provision was a vital problem in this study setting. Due to extreme staff shortages on all care levels together with the high volume of patients in the study setting, additional supervision was required from advanced midwives in various situations which further compromised clarity of their role as advanced midwives. This was confirmed by a participant as follows: “You know the staffing, what I have observed as a clinical specialist, [is that] there is great shortage of staff that result in ... increasing the role of the advanced midwife, especially were you find that she has to work with more, many patients than required.” (F1, P1).

In this regard, two participants suggested agency staff and retired midwives could relieve human resource shortages:

- *“Taking us back to years back we use to have shortage of staff but it was complemented by agency staff but now it was stopped, but is it for budget or what? But should consider [it should be considered] if it can step in [help in meantime] while advertising the posts.” (F3, P4)*

- *“The other thing it is happening in level 1 and 2 hospitals, the retired nurses even if they can do seven to four [work 7 o’clock to 4 o’clock shift] but they are experienced with the delivery. Maybe if they can assist in the labour ward.” (F3, P3).*

Participants added the shortage of paediatricians and ward staff forced advanced midwives to take on additional responsibilities and be cast in various roles. When, for example, complications during or after giving birth arose the advanced midwife was expected to take the lead and remedy the situation either alone or with limited help from available staff members. Neonatal resuscitation and taking on supervision of staff members’ work were mentioned as examples by participants:

- *“...to do neonatal resuscitation now the paediatrician is not there who is also supposed to work with you. Do you see that? Lack of manpower ...” (F1, P1).*

In the next example, the participant described how the advanced midwives’ knowledge and skills can promote and ensure safe and quality patient care albeit in a supervisory role:

- *“There’s a lot of supervision. Let’s say somebody has been allocated to do dressings but you identify that she’s a level 2 student [basic student] [and] there’s a with a septic wound [the wound being dressed is septic]. Then you can intervene even if somebody has written that delegation [for student to do dressings] but that one [patient with septic wound] needs, yah a more experience[d] person managing that wound ...” (F1, P4).*

The next verbatim quote directly addresses the fact that in the tertiary hospital there was a total lack of clarity on the role of the advanced midwife. It highlights that it was the general perception and expectation among management, doctors and the maternity ward staff that advanced midwives had no designated role; they were expected to do everything everywhere and at any given time:

- *“And misinterpretation of ... an advanced midwife taking her [assuming she is] as paediatrician like sometimes it’s as if the hospital had got that ... that perception that as long as the advanced midwife is there they [hospital management] don’t care. Isn’t it about calling the paediatrician the law is that all caesareans [Caesarean section] must be attended by the paediatrician but you find that the hospital is not having strict rules that there must be a paediatrician, the advanced midwife is left to take care of the [baby], of such things ... it’s too much it becomes too much on the advanced midwife.” (F1, P1).*

Confirming these human resource problems experienced in the specific tertiary hospital, a participant expressed her concern on the staff attrition rates that, according to her, could have been caused by the lack of management support:

- *“The shortage of staff ... they are trying in-service on staff attitude so that maybe they can work on what is sending people[staff] away – sometimes is not the fear of losing your profession but is what you get in to the system which is pushing*



*you away. Sense of not being recognised even if you are even doing an extra mile ... there is no way or nobody sees it. ... but to have managers that could support us maybe we could have less people [staff] leaving maybe to do exit interview.” (F3, P3).*

**Discussion:** In the current study the participating advanced midwives agreed that multiple tasks such as taking responsibility for safe patient care and managing human resources “becomes too much on the advanced midwife”. They felt the shortage of staff (which in this case included nurses, basic midwives, and vital specialists such as obstetricians and paediatricians) was a major concern which was ignored by the hospital management. The participants were unhappy about this state of affairs because it not only added to their workload and responsibility but essentially made it more difficult to determine what exactly their role was. One felt “the advanced midwife is left to take care” of everything. Confirming this, another participant stated the hospital management automatically assumed that the advanced midwives’ role included doing the work of obstetricians and paediatricians. However, according to the Royal Australian College of Physicians (2005:1), the policy on attendance at Caesarean section indicates that obstetricians do the triaging on whether the mother or baby is high risk and decides whether a Caesarean section needs to be done. He or she then plans for it and a multidisciplinary team is assembled. Because South Africa has no documented guidelines on the presence of paediatric doctors during a Caesarean section (whether elective or emergency), therefore it is often the case in public or tertiary hospitals that advanced midwives attend to babies being born by Caesarean section in the theatre and not a paediatrician. Pattison (2015a:263) only recommend for caesarean section to be performed 24hours, 2 doctors to be always there in district hospital (one for anaesthesia and one for surgery) and nothing mentioned about paediatric doctor. This was confirmed in the current study by a participant who stated advanced midwives were expected to attend Caesarean sections and manage the care of the newborn if a paediatrician was not available. Importantly, this participant queried the legality of such events. Literature reveals the shortage of staff in hospitals and healthcare facilities has been a challenge for a long time. Ameh and van den Broek (2015:1078) refer to the WHO (2012) which revealed that Africa is suffering a critical shortage of healthcare providers, including doctors nursing and midwives. Also in the current study a participant stated she “have observed as a clinical specialist, [is that] there is great shortage of staff that result in ... increasing the role of the advanced midwife, especially were you find that she has to work with more, many patients than required”.

The influence of staff shortages on the role of the advanced midwife was seen by participants as profoundly negative. They listed many reasons for the resignation of advanced midwives of which a total lack of support from management was prominent. Participants felt management was misinformed and not aware of what the role of the advanced midwife is and is not. They also felt their varied contributions in

*their job because “sometimes is not the fear of losing your profession but is what you get in to the system which is pushing you away. Sense of not being recognised even if you the clinical area were not appreciated. One of the participants summarised advanced midwives leave are even doing an extra mile ... there is no way or nobody sees it.”*

Added and required different responsibilities resulted in the “misinterpretation of ... an advanced midwife” and made fulfilling her role as an advanced midwife even more difficult to establish as well as to be understood by the management, colleagues and multidisciplinary team in the study setting. This is unfortunate, because as Bryant-Lukosius and DiCenso (2004:530) state, the practice of advanced midwives in healthcare services is a dynamic and complex process. This process is complemented by skill mix and staff support and therefore an understanding and collaborative relationship among trained and knowledgeable healthcare providers is essential for the advanced midwife to execute her role (Bryant-Lukosius & DiCenso 2004:530).

It is obvious from the findings that extreme staff shortages on all levels of care required from the advanced midwife participants to “assume responsibility for tasks that are increasingly complex and complicated” (O’Shea 2013:47). Magowe et al. (2016:104-105) confirm that taking on tasks and a workload “compounded by the scarcity of other health human resources” can lead to confusion because those receiving care and the multidisciplinary team working with the midwives can view it as the “key functions of the nurse/midwife. ... The consequence of this is a blurred and confused role clarity and piling of tasks, which can lead to the risks of inadequate haphazard care, increased practice errors and litigation” (Magowe et al. 2016:105).

There was not enough trained staff in the current study for monitoring patients before, during and after birth. Velaphi and Rhoda (2012:69) state because it cannot always be predicted when there will be the need for neonatal resuscitation at birth, all nurses and doctors involved in caring for newborns should be trained in immediate care of a newborn and basic neonatal resuscitation. However, in the current study the advanced midwives found they were responsible for neonatal resuscitation – which is a major contributing factor towards high mortality rates among newborns according to Ersdal and Singhal (2013:375) – without assistance from trained staff. According to Pattison (2015a:265), in South Africa a woman in active labour requires frequent monitoring on all levels of care. Not fulfilling all the required tasks in maternity care (before, during and after birth) would render maternity care in any hospital unsafe.

Pattison (2015a:262-263) reveals staffing norms in South African community health centres and district hospitals falls somewhere between the WHO staffing norm (each midwife to conduct 175 deliveries per year) which is the minimum number of the professional nurses who are required to render maternity services and the

Greenfield's staffing norm (the formula of 16 midwives per 100 deliveries per month which is 16 midwives for 1200 births per year or 75 births per midwife per year). In South Africa the same midwives will look after babies in the nursery, and antenatal and any postnatal patient.

For the provision of high quality of care and close the gap between the shortage of trained birth attendants that would ensure good safe and quality care outcomes versus poor patient quality care due to staff shortages (Parker & Giles 2012:6), the participants suggested retired midwives could be utilised on a temporary basis. In a study by Marangozov, Williams and Buchan (2016:63), a campaign known as 'Returners – back to workforce' was launched in the UK where the posts of nurses who resigned were filled with retired nurses. The campaign was funded and implemented from February 1999 to March 2004 and resulted in 18 500 former midwives and nurses returning to work.

Caring for patients (to women and newborns before, during and after birth), leadership management, supervision, mentoring and teaching are roles ascribed to advanced midwives by Magowe et al. (2016:111-112). In their capacity as ward managers, the current participants were also responsible to ensure material resources were available and accessible to ensure safe quality care.

- Deal with none human resources

Participants identified themselves as administrators of non-human resources in the maternity units. However, they came across numerous challenges. This was confirmed by the participants who stated shortage of material resource was impinging on patient care in the tertiary hospital:

- *“Ok, you know what the resources ... I have seen it really impinging on the knowledge, the skills and ability of the midwife. When they give the report the advance midwife will know that this patient on misoprostol induction ... this induction will result in causing ripening of the cervix and also result in some uterine retractions which may affect the foetal heart and advance midwife will recommend that the patient be on CTG [a cardiotocograph machine]. You find that there is no CTG. There are many things that advanced midwife want to do but the equipment may imping on such a care, it's just a minor example that I am giving.” (F1, P1).*
- *“To add on the equipment, like when we have to fetch the patient from the theatre, sometimes there are no beds, usually we take bed from the ward and fetch the patient. The patient is supposed to be on the bed, we have to take the other patient out of the bed and let her sit on a bench and take the bed or they will bring the patient with a stretcher, and we didn't want to fidget with this patient with a Caesar to transfer her to the bed.” (F1, P3).*

Another participant elaborated on negligence and how it affects patient care as follows:

- *“... we as staff both medical and nurses mishandle the equipment, we cannot push the machine with cord hanging on the floor. People get paid to come and in-service. Worse with the obstetric assets you know they are very sensitive. For example, if you drop the transducer they detach easily which is about nine thousands [cost of transducer is R9000]. If it starts ragging it is out, it is both doctors and nurses. Doctors I don't know but if you find them pushing the sonar machine around ... I don't know how many times it is sent for repair. With us in maternity admission like we are working like casualty if one cardiotocograph machine is none functional the waiting time is already affected. You can imagine for a day if you have got 50 patients and you have got 2[NST] not working, you will have, will have to see quality assurance to explain why patients was delaying, patients will complain that they were in the unit for 6hours. It is frustrating as midwives.” (F3, P5).*
- *“... is our equipment, so we end up having unused equipments [equipment] that could be used [still have been used] for ... some years to come, but because of negligence machines are just standing [packed in stock rooms].” (F3, P3).*

A participant also indicated shortage of medications in the following statement:

- *“You cannot run the unit without Celestone because what are you going to do with all preterm labours that are coming?” (F3, P5).*

It was also shared that the lack of equipment was wrongly seen as reflecting advanced midwives' skill and knowledge. This is confirmed in the following statement:

- *“Proper care ... enhancing the quality as advanced midwife know how it must be, you find that there are no[not] enough machines, this and that or maybe the advanced midwife want to put the patient in a position like a cardiac patient. She doesn't want to put the cardiac patient flat she want to put her on a 45 degree there are no pillows even the bed is not moving. You know it's*

*making the care, resulting in now pointing to the advance midwife as if she is not practicing her skills....” (F1, P1).*

A further issue voiced by a participant was that some of the shortages in material resources was caused by the lack of assertiveness in shift leader and negligence on the part of both nursing and medical staff:

- *“I am having a different one is about control. We control budget and suppliers in so much now of late even so is questionable we are always out of stock and then look at what courses that is mismanagement, or misuse of resources, for example, in the hospital we do not have... you see one-one doctor or nursing personnel having to do PV [Per Vaginal examination] opening this glove, throwing it away, opening this glove throwing it away and you are just standing there as a leader and not saying anything. If you are maybe a shift leader you are to say, ‘let’s minimise cost’.” (F3, P3).*

Another participant stated that the hospital purchases equipment yearly and the equipment are mishandled:

- *“Though is a big challenge were the hospital having equipment every financial year is trying is buying equipments, more advanced equipments, so if there is no one to come for in-servicing even if we go for in-service people tend to have that attitude of negligence so no one takes the ownership of saying this allow eh maybe change their buying system allow the, no this is management that I am talking [about] they must change their buying system maybe have flexible buying patterns.” (F1, P1).*

**Discussion:** Tertiary hospitals are specialised hospitals with specialised equipment for the management of very ill patients or complicated obstetrics patients (Guidelines for Maternity Care in South Africa 2015:22).

Participants raised the point that the hospital management needs to increase its budget as resource shortages were preventing the execution of quality care. Part of the administrative role of advanced midwives involves the provision of equipment for

clinical practice to ensure the health care providers can execute their safely and competently. As early as 2004, according to Bryant-Lukosius and DiCenso (2004:536), the equipment in the clinical area included sufficient offices, examination space, communication and computer technology, and audio-visual equipment. Participants also stated that the lack of resources like CTG machines resulted in patients complaining about the services advanced midwives rendered because the waiting time at the hospital became very long. The way queues are managed and patients waiting in the queues are attended to impact on their perception of the maternity ward. Queue management should ensure fairness and demonstrate to the waiting patients that they are waiting in a planned environment; they must be reassured that they will be attended to timeously (Sokhela, Makhanya, Sibiya & Nokes 2013:n.p.).

In their investigation on comprehensive emergency obstetric and neonatal care in 12 South African health districts, Pattison, Makin, Pillay, van den Broek and Moody (2015:259) assert the total lack of appropriate gloves used for performing manual removal of the placenta was an indication that the healthcare providers did not have the skill to perform a manual removal of the placenta to save a woman with postpartum bleeding. In the current study, it was also stated that patients attributed the unavailability of material resources to advanced midwives' lack of knowledge and skills.

Patient satisfaction is one of the key factors in quality assurance. A lack or shortage of material resource was not the only challenge advanced midwife participants in the current study encountered. The study about maternal satisfaction with care during labour in the Mampong-Ashanti district hospital maternity unit in Ghana indicated that the non-availability of human and material resources in the maternity setting was highlighted by patients as sources of dissatisfaction (Dzomeku 2011:33).

Advanced midwives also formed part of the team managing the financial resources in the tertiary hospital in the study setting in Gauteng. Advanced midwives do not have the opportunity to give input on the management of the financial resources at ward level. Participants reflected their understanding of the hospital financial budget which they were not directly involved in. A participant shared the advanced midwives' understanding as follows:



- *“... that one [finance] is the management [hospital management]; they must increase the budget of the labour ward then also of the maternity setting. Especially labour ward when managing those resources. Most of the identified challenges they see them as adding to the optimal utilisation of their knowledge and skills. The advanced midwives administrate non-human [material] resources which, according to them, sometimes they are not available, not enough and sometimes not functioning properly.” (F2,P3).*

Kekana, Blaauw and Schneider (2004:171) did a study in South Africa on management and implementation challenges for public financing reforms from a maternity ward perspective. The findings revealed that “the Public Financing Management Act, that aimed to improve the efficiency accountability of the public finance management, had the unintended consequence of causing the quality of maternal health services [to] deteriorate in the hospital wards studied”.

In tertiary hospitals in Gauteng advanced midwives also deal with challenges related to the admissions of patients.

#### **3.5.2.4. Category 4: Dealing with challenges related to admissions of patients**

The following two subcategories emerged under dealing with challenges related to admissions of patients: Admissions of un-booked patients and self-referrals, and collaborations with MOUs and district hospitals.

- Admission of un-booked patients and self-referrals

In this subcategory, the focus was on the patients who went to tertiary hospitals without booking and who did not have a maternity card as well as self-referrals (patients who arrived at the maternity ward without any referral letter from a doctor or clinic). Advanced midwives perceive patients who are not booked or who does not have a referral letter from a registered doctor or clinic as a hindrance preventing the advanced midwives from attending to complicated patients who meet the tertiary hospital admission criteria. Many of these non-booked and self-referrals are low risk patients.

The following quotes signify the participants' dissatisfaction with non-booked or self-referred patients:

- *“The other problem is [in] our hospital is a tertiary hospital but it caters for everybody, self-referrals, everybody if she feel that she wants to go to hospital she comes here so you end up attending to low risk patients not having enough time to cater to those patients that need you[advanced midwife].”* (F1, F1).
- *“There are so many low risk patients that are flocking taking deliveries [giving birth]. The patient at the corner who needs you, who needs total patient care, you don’t have enough time to give her; the care you’re supposed to give to that patient [the one you are attending to].”* (F1, P4).

In the opinion of the participants, the high number of self-referrals who were, in fact, low risk patients could be reduced by down-referrals to lower levels of care as evidenced in one quote:

- *“I don’t know if it is practical ... there is chance the patients can be rechanneled; those who are not referred back [down-referral] those who are not complicated [referred to a lower level of care] to reduce the work load.”* (F3, P3).

**Discussion:** In South Africa, maternal and child healthcare services are free (Guideline for Maternity Care in South Africa 2015:2). The participants in this study unanimously agreed the high number of self-referrals and low risk patients deprived patients who had booked from time and tertiary care. This was supported by participants who commented on the high number of low risk patients who prevented them from having time *“to give her; the care you’re supposed to give to that patient [the booked one you are attending to].”* and *“so you end up attending to low risk patients not having enough time to cater to those patients that need you.”*

Being a tertiary hospital it means that *“it caters for everybody, self-referrals, everybody if she feel that she wants to go to hospital she comes here”*. In general, self-referred patients are women who frequently change doctors or live in areas far from hospitals; they do not attend the maternity ward for antenatal care. Patients who constantly change from doctor to doctor have no referral letters. Self-referral patients do not want to wait long for doctors as they usually come with a diagnosis; they are also usually dissatisfied with whatever advice the advanced midwives and



doctors provide (Guo, Kuroki, Yamashiro & Koizumi 2002:326-330). Obviously, self-referrals are not booked but they usually present with complications and subsequently end up having an emergency Caesarean section (Ugwu, Obioha, Okenzie & Ugwu 2011:81). In the view of Agida, Adeka and Jibril (2010:394), many women who arrive at tertiary hospitals present with eclampsia which is counted as one of the major causes of the high mortality and morbidity maternal rates in developing countries, which includes South Africa. The problem is that often, whether referred from clinics or self-referred, they generally arrive at tertiary hospitals in the late stage of pregnancy, are in a critical condition and need immediate attention to save their lives as well as that of their babies. Murthy, Murthy and Prabhu (2013:108) state most of these maternal deaths are preventable if patients are managed on time. In fact, some self-referred patients arrive when they are already in the second stage of labour which means advanced midwives must leave whichever patient they are providing care for to attend to these self-referred women immediately.

Igberase, Ebeigbe and Andrew (2009:295) found in a tertiary hospital in Nigeria there was poor utilisation of antenatal care in rural areas with most women presenting in tertiary hospitals only when there was a complication. The authors found ignorance, illiteracy and a combination of traditional and religious beliefs as well as poor socioeconomic status were the main reasons for not making use of antenatal care provided by the tertiary hospital which would ensure them bookings and safe antenatal care, delivery as well as post-natal care for mothers and babies by knowledgeable and skilled healthcare teams. Aboyegi, Ijaiya and Fawole (2007:83) found women who do not book but arrive only when problems or complications force them to seek help, are more likely to die than booked patients. The reason is clear – a woman who is pregnant and is taken care of by a team of expert, knowledgeable and skilled doctors, nurses and midwives on a regular basis throughout her pregnancy is less likely to have complications, lose her baby or her life or both than one without professional maternity care provision.

Non-booked patients and self-referrals increase the number of Caesarean sections in tertiary hospitals. The number of patients who undergo a Caesarean section in tertiary hospitals is too high. The following quotes provide evidence from participants:

- *"We have very high rate of C [Caesarean] sections. Maybe because patients are complicating [have complications]." (F2, P4).*
- *"Most of our patients go for C [Caesarean] section. Our Caesarean rate is high." (F2, P1).*

A participant added the Caesarean section rate is high because of the doctors' decisions. The following statement signifies this:

- *"Even delivery of breech presenting because you observe the patient and assess that this baby can come out, but the doctors will come and say patient is going for C [Caesarean] section, doctors do not want to take risks. The doctor is [has the] final decision." (F3, P2).*

The shortage of registrars makes him or her performing Caesarean sections in theatre most of the time leaving advanced midwives to manage the many patients waiting to go to theatre also for a Caesarean section. This is confirmed in the following statements:

- *"And other thing because of overcrowding, there are many patients booked for Caesar [Caesarean sections] but one theatre is working and only one registrar is in the theatre. That's frustrating for a midwife because you know this patient should be in theatre, but there is still another patient in theatre; you have to see how to manage ..." (F1, P2).*

**Discussion:** Caesarean section delivery has been a source of concern to obstetricians globally. On the one hand it is believed to be riskier than a normal vaginal delivery. Ugwu et al. (2010:77) support the stance of Aboyeni et al. (2007:83) that a Caesarean section is 2.5% riskier than normal vaginal delivery by arguing that although there is significant and constant improvement in safe surgical techniques and anaesthesia, compared to a normal vaginal delivery a Caesarean section has higher maternal deaths due to complications such as excessive bleeding, infections, haemorrhage and thrombosis which increases maternal mortality (Marshall, Spiby & McCormick 2014:2). On the other hand, various studies acknowledge that Caesarean sections can have complications, but they highlight that this rarely occurs if Caesarean sections are performed on time (Marshall et al. 2014:2). Moreover,

Begum, Khan, Khan and Begum (2004:1) note mortality can be reduced if an emergency Caesarean section is performed in appropriate time and in selected cases. Betran, Moller, Zhang, Gulmezoglu and Torloni (2016:2) state:

“A caesarean section (CS) is a life-saving surgical procedure when certain complications arise during pregnancy and labour. However, it is a major surgery and is associated with immediate maternal and perinatal risks and may have implications for future pregnancies as well as long-term effects that are still being investigated. The use of CS has increased dramatically worldwide in the last decades particularly in middle- and high-income countries, despite the lack of evidence supporting substantial maternal and perinatal benefits with CS rates higher than a certain threshold, and some studies showing a link between increasing CS rates and poorer outcomes. The reasons for this increase are multifactorial and not well-understood.”

The increase in the rate of Caesarean sections was not only commented on by participants in the present study. The current participants commented on the “*high rates*” or “*very high rate*” of patients booked for Caesarean sections by order of doctors who “*do not want to take risks*”. However, studies done in Nigeria and India reflect the majority of Caesarean sections are performed on non-booked patients who present with complications. In a tertiary hospital in Nigeria, 59.5% of the emergency Caesarean sections were non-booked for antenatal care and were due to repeat Caesarean section deliveries and Caesarean deliveries due to preeclampsia or eclampsia (Igberase et al. 2009:294). In India a study done in a tertiary hospital in Pakistan reflected from the total number of patients who had an emergency hysterectomy during delivery, 52.4% had had Caesarean sections while only 14.2% of the patients who had normal vaginal deliveries had to have hysterectomies. Thirty-three per cent (33.3%) had a laparotomy due to uterine rupture (Nisar & Sohoo 2009:49).

In South Africa, the rate of Caesarean sections in Gauteng regional and tertiary hospitals is increasing as evidenced in the findings of the study which was conducted in one of the tertiary hospitals in Gauteng. Nathan and Rautenbach (2014:147) suggest an investigation to evaluate and monitor the Caesarean section rate may indicate the factors that influence this change. These authors mention a change in the complexity of maternal cases, the burden of diseases profile, and

access to maternal healthcare as possible causes of the increase in Caesarean sections in the province's regional and tertiary hospitals.

The current study participants shared the same opinion with regard to the high Caesarean section rate. They all felt the rate and admission of low risk patients in tertiary hospitals can be reduced if a 24-hour MOU and district hospital was nearby....(Tertiary hospitals).

- Collaboration with MOUs and district hospitals

The participants were of the opinion that a 24-hour MOU or district hospital reduced the admission of low risk patients to the tertiary hospital as the following quotes verified:

- *“The secondary hospital is [deleted name of level 2 hospital] but it's far, so for you [advanced midwife] to say go to [deleted name of level 2 hospital] it won't work, you have to attend to them [low risk patients].”* (F1, P2).

Participants suggested for MOU and district hospital advanced midwives to receive in-service training so that they do not have to refer low risk patients to the tertiary hospital but deliver the services themselves at the MOU or level 2 hospital:

- *“... for instance patient is post-date in the [lower level hospitals] and the patient is 6 cm dilated, why must the patient be referred [the tertiary hospital] because the patient is in labour, keep that patient [deleted name in the lower level hospital] and progress labour [there in lower level hospital]...”* (F3, P5).
- *“The MOUs are not taking decisions; they just refer the patients to tertiary hospital. Even us we do not have much to do because the doctors are around and the patient is taken over by them.”* (F3, P1).

Another participant indicated if screening in the labour ward showed low risk patients, they were transferred to a level 2 hospital. The following quote verifies this finding:

- *“... in labour wards, we screen all of them and then we down refer to [deleted name of level 2 hospital] the low risk [patients], but the others [tertiary hospitals] if its full the hospital will have to close [not receive any more low risk*

patients], *they don't transfer the complicated, only the low risk are the ones to [be transferred]*" (F2, P1).

**Discussion:** Some of the participants shared that midwifery obstetric units (MOUs) staff in level 2 hospitals refer maternity cases to tertiary hospitals without properly screening them first. As for the district hospitals, they are in general situated too far away for patients with no money for transport and such patients will go to the nearest hospital which is often a tertiary hospital. Many among such patients are low risk patients. If it was possible for them to go to the district hospital, the overcrowding in the maternity wards in the tertiary hospital would be significantly less.

The Guidelines of Maternity Care in South Africa (2015) are available in all clinics, district hospitals and community health centres in South Africa. Because specialists are not always available at these healthcare institutions, all midwives (basic as well as advanced) must familiarise themselves with the Guideline of Maternity Care in South Africa (2015), especially on the diagnosis and management of common and serious pregnancy problems (Guidelines of Maternity Care in South Africa 2015:16). Proper utilisation and following of the guidelines in a lower level hospital will reduce incorrect management of maternity patients; complications such as pre-eclampsia or excessive haemorrhage – if diagnosed in time – can be managed timeously and the patient can be stabilised in a lower level hospital before being referred to a tertiary hospital for further treatment. In a study conducted in an Indian tertiary hospital, of the 120 maternal deaths detected, 83.3% were un-booked and most of the causes of maternal deaths were eclampsia, haemorrhage and sepsis (Murthy et al. 2013:105).

When patients are referred from MOUs or district hospitals to tertiary hospitals, telephonic discussions have to take place between the midwife at the referral hospital and a doctor from the tertiary hospital. Sharing this information is vital so that the receiving (tertiary) hospital can prepare for the patient. According to Manning, Magann, Rhoads, Ivey and Williams (2012:810-811), telephonic triaging is an important component of triage in obstetrics. Participants stated sometimes the MOUs simply refer patients without proper triaging; hence, patients that can be managed in the MOU are referred to tertiary hospitals unnecessarily.

According to Harding, Taylor and Shaw-Stuart (2009:153-154), the triage system is used to decide which patient should be seen first; thus, it is categorising patients according to whom services should be provided first. The term triage is also used to assess individual patients needs to determine when, how or if resources should be allocated.

Telephonic triaging is becoming an increasingly easier way of communication in developing countries (Manning et al. 2012:810-811) as nearly every patient own a telephone/cell phone. In the UK and Canada, computer-driven protocols are used

where patients contact the midwife telephonically (during working hours or after hours); the midwife then telephonically discusses the patient's condition with the doctor at the receiving hospital and together they decide where the patient needs to be taken to receive the best possible care for both her and the baby. Telephonic triage includes patient education but is more specifically successful in determining whether the patient needs more extensive evaluation. Manning et al. (2012:11) further assert midwives need 3 to 6 months' training to do transferrals via the computer-driven system. In South Africa, telephonic triaging can work as the mom-connect which is a National Department of Health initiative system has already been initiated and is functioning well (Department of Health South Africa 2015)

In tertiary hospitals the triage system is essential as it helps the receiving hospital to decide where to assign priority patients to. Priority assignment is done according to the degree of risk and urgency of referral patients because addressing and managing the patient's immediate needs are paramount. Quick management may include the immediate administering of magnesium sulphate to women with eclampsia and severe pre-eclampsia, which in turn can reduce unnecessary death of the mother and/or baby (Pattison et al. 2015:259). The challenge faced by the triaging team is limited resources like appropriate gloves for the procedures. This raises the question of whether only those who are most likely to benefit from the services receive the highest priority. Patients have the right to expect fair and transparent decision about who gets seen first in the hospital.

According to the Guidelines for Maternity Care in South (2015:19), a district is the basic unit of a healthcare region, served by a district hospital and a number of health centres, MOU's and clinics. A well-coordinated referral system, with access to transport and facilities, is essential for the provision of optional care to all pregnant women in the district. In this study, participants showed concern on the way midwives refer patients to tertiary hospitals without proper triaging. One participant was upset and mentioned the example when a patient is post-date and 6 cm dilated, she is obviously in labour so she should not be referred at this stage, but give birth in the lower level (district) hospital. Findings from a global consultation on providing quality midwifery care recommended the rotation of the placements of advanced midwives from community settings to hospital settings so that they can maintain their skills and experience of what is taking place in hospital settings (WHO 2016:65). The rotation of staff or exposure of MOU advanced midwives in Gauteng will also improve the relationship and knowledge gap between hospital and MOU staff. The Guidelines for Maternity Care in South Africa (2015:20) further explain an MOU is a community health centre with comprehensive care; it functions on a 24-hour basis

and has obstetric services which are run by midwives and the staffing includes advanced midwives. When it renders only maternity services, it might be called a midwifery obstetric unit (MOU). The maternity section is often situated next to, but still apart, from other services such as minor ailments, emergency care, chronic diseases and the promotion of health services. The Guidelines for Maternity Care in South Africa (2015:20-22) further explains “the package of services provided at district hospitals includes trauma and emergency care, in-patient and outpatient visits, paediatric and obstetric care”. Specialists, family physicians, obstetricians, gynaecologists and paediatricians can be employed. In both facilities advanced midwives are included in the staffing.

### **3.6 CONCLUSION**

The outline of the study findings was presented and analysed in this chapter. To answer the research question: “What is the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng?”, the data collected from the three focus group discussions as well as the field notes was merged to form themes, categories and subcategories. The findings were then presented and discussed according to the emergent themes, categories and subcategories and supported with relevant literature to contextualise the findings.

The next chapter discusses the final conclusions. The limitations are acknowledged, the implications of the study are discussed and recommendations are made based on the findings.



## CHAPTER 4

### CONCLUSION, RECOMMENDATIONS, IMPLICATIONS AND LIMITATIONS OF THE STUDY

#### 4.1 INTRODUCTION

The researcher discussed the findings of the study in the previous chapter and also supported the findings with literature. In this chapter the researcher focuses on the conclusion of the study, makes recommendations and informs on the study limitations. The discussion is guided by the two themes identified in Chapter 3.

#### 4.2 CONCLUSIONS

The purpose of the study was to explore and describe the advanced midwives' role regarding their involvement in maternity care in tertiary hospitals in Gauteng. Based on the findings two themes were identified. The conclusion is presented in accordance with the two themes.

##### 4.2.1 Theme 1: Position of advanced midwife

The study findings revealed the following roles of advanced midwives in maternity care in tertiary hospitals in Gauteng.

##### 4.2.1.1 Category 1.1: Perceived positioning of advanced midwives

From the study findings it was clear that perceived positioning of the advanced midwives included that they were in possession of extensive knowledge and skills which they acquired during their training. The fact that they considered themselves as knowledgeable and skilled made them feel confident when working in maternity care. Advanced midwives identified themselves as specialists and consultants in midwifery as their speciality. The additional knowledge they possess included vacuum delivery, breech delivery and resuscitation of newborns. Possession of such knowledge filled them with enthusiasm and they were prepared and ready to engage in any emergency practice and situation that could arise in maternity.

Most of their knowledge and skills were demonstrated in procedures such as a normal vaginal delivery, suturing of an episiotomy and delivering preterm babies that they performed with confidence. On the other hand, the advanced midwives felt that they mostly observed and monitored patients during the first stage of labour, which is the practice of any basic midwife. They experienced that most of the patients were complicated cases which necessitated the presence of doctors during the delivery.

Participants revealed challenges in tertiary hospitals included the lack of opportunities to practice their skills such as vacuum delivery, commencing tocolysis



and steroids in preterm labours. The structure of a tertiary hospital is apparently such that there are a lot of doctors, interns and consultants. This structuring made the participants feel unclear about their roles as advanced midwives in the multidisciplinary team. The staffing norms in tertiary hospitals expected from them to perform routine care when doctors were present, but in reality, doctors were not there all the time. The advanced midwives were willing and ready to practice to assist when doctors were busy in theatre or in the other wards because most of the time there was one registrar for maternity, especially during the night and over weekends.

In this study the researcher discovered that most of the advanced midwives, who were more worried about losing their skills and knowledge, were more experienced and had been practicing for many years before being employed at the tertiary hospitals. The newly qualified and those who had never practiced their skills mentioned that in tertiary hospitals only the application of knowledge was required and not skills application because doctors were always there. The only challenge faced by advanced midwives was that in order to maintain one's skills in the clinical area, one has to practice. If skills are not practiced they are lost. A study Lesia and Roets (2011:168) did on the description of the practice of advanced midwives, confirms the loss of skills by advanced midwives allocated in urban areas in South Africa where there are many doctors.

Participants stated another challenge was that, when they applied their knowledge during an emergency and the outcome was not good, they were blamed. An advanced midwife gave an example of delivering a patient who came in fully dilated. It was then discovered it was a breech presentation and the registrar was busy in the theatre. Her dilemma was that, if the baby was fresh stillborn, the first question that would be asked was, 'why did you not call the doctor?' and not asking the advanced midwife, 'how was the situation in the ward?' or 'what was the circumstance which led you to deliver the breech?' Globally, advanced midwives are deeply committed to provide quality care to newborns, mothers and their families but they are frustrated by the experiences that constraint their efforts (WHO 2016:2).

The dire shortage of doctors prolonged the waiting times for patients. According to the advanced midwife participants, the prolonged waiting period was one of the factors which most of the patients complained about. Prolonged waiting creates circumstances for advanced midwives to practice their skills such as initiating most of the procedures, but they discovered they could not because their role was not clearly defined in the tertiary hospital. The only people allowed to apply their own knowledge during the waiting period was the intern doctor who had to use the time as a learning opportunity and the registrars who were acquiring consultant knowledge and skills. Therefore, the patient had to wait. Advanced midwives are the first to have contact with the patient and the intern doctor is the second contact. Hence, the advanced midwife with her knowledge and skills can reduce most of the waiting period, prevent complications and save lives because patients wait long

periods for the registrar to make decisions as stated by Smith et al. (2009:118). The participants stated they experienced that, when the registrar was in theatre, patients in preterm labour had to wait for long periods of time before their labour could be stopped. The reason being that the advanced midwives were prohibited from assisting the patients since the registrar was the one who had to make the decisions. The participants gave examples of patients who were found during the night progressing with preterm labour when the patient arrival time in hospital was 08h00 or 09h00. There were several circumstances in which the advanced midwives could practice their skills, but they felt unprotected and unsafe in tertiary hospitals as their role was not clear. As confirmed by Atsalos et al. (2014:2875), in cases where the advanced midwives' role is not clear – such as in tertiary hospitals – it contributes to their knowledge and skills not being optimally utilised and a loss of knowledge can occur.

#### **4.2.2. Theme 2. Responsibilities of advanced midwives**

The findings of the study revealed that advanced midwives have responsibilities in tertiary hospitals. The four categories are discussed next.

##### **4.2.2.1. Category 2.1: Contribute to quality care**

Participants viewed themselves as contributing to the improvement of maternal and neonatal/foetal outcomes in tertiary hospitals. Their presence in tertiary hospitals contributed to positive maternal and neonatal/foetal outcomes. In some tertiary hospitals advanced midwives indicated observable interventions which they applied to meet those monitoring and evaluation of quality care like unit-based maternal and neonatal meetings and auditing of records as stated by Th van Diem, Timmer, Bergman, Bouman, van Egmond, Stant, Ulkeman, Veen and Erwich (2012:1). The identified positives needed to be started in other tertiary hospitals which did not show they were implementing them. The input of advanced midwives is recognised by the Department of Health in Gauteng; hence, they are to be placed in large numbers in tertiary hospitals according to the Guidelines for Maternity Care in South Africa (2015). The advanced midwives are utilised nationally to review, assess and audit maternal death files, identify preventable or avoidable causes of death, and make recommendations of the practice for future reference.

Unit-based audits in all levels of care are one of the requirements in South Africa. This study revealed that in other tertiary hospitals there were only doctor's audits and meetings for reviewing the progress of care with no nurses involved. For the benefit of the patients and for quality assurance, advanced midwives are to initiate and lead the nurse's meeting audits to identify the avoidable causes of complications.

This study revealed that the advanced midwives took part in preparing other staff members by leading the practice of emergency obstetrics skill drills. Participants stated they were the ones teaching the Essential Steps of Managing Emergency (ESMOE) to upgrade staff members so that they could be effective and work as a

team during obstetric emergencies. Regular training in skills drills has been proven to be effective in improving knowledge, confidence, skills and practice as confirmed by Ameh and van de Broek (2015:1081). The team training model is perceived as applicable to the training of obstetric emergencies as it makes changes to the team members. The observed changes from staff who attended obstetric emergency drills are; positive changes in the perception of individuals, attitude, team performance, and self-assessment leading to observable change in team performance as stated by Robertson, Schumacher, Gosman, Kanfer, Kelley and DeVita (2009:77).

Tertiary hospitals are referral hospitals for both district hospitals and midwifery obstetric units (MOUs). The other main function of a tertiary hospital is teaching for different categories of professionals like doctors and nurses. Participants stated that they even invited the local clinics to attend the maternal and mortality meetings run by advanced midwives for learning purposes. The study identified involvement of referring lower levels of care as good outreach practices for midwives at the local clinics, MOUs and district hospitals. One of the advanced midwives' responsibilities is to share their knowledge with other healthcare professionals at different levels of care.

It became clear in this study that universities involve advanced midwives when they wanted to conduct studies in tertiary hospitals as they assisted with data collection. The challenges stated by participants were that they participated in research, but there was no dissemination of information on completion of research as confirmed by Botma et al. (2010:27). Lack or no dissemination of information does not stimulate advanced midwives to participate in the subsequent research studies being conducted in clinical areas. Participants stated that they were not initiating research studies in clinical areas. Planning of patient care by professional staff must be evidence-based, but without research there will not be any scientific progress in the maternity department.

The advanced midwives are to incorporate their research knowledge in the implementation of the CPD points unfolded by the South African Nursing Council (SANC) in order to encourage sustainability of knowledge and skills at the workplace. They are to initiate and facilitate research studies in the maternity section so that they can accumulate teaching points and in return simplify or open access to the accumulation of points to themselves and to all categories of staff in maternity. Research will strengthen and facilitate the advanced midwives' practice as advanced midwives will apply their knowledge on evidence-based research when facilitating improvement in care as endorsed by WHO (McDonnell et al. 2012:369; Gerrish et al. 2012:31).

#### **4.2.2.2. Category 2.2: Contribution through teaching**

Participants said they facilitated patient care by taking part in the education of medical and nursing students. Numerous numbers of medical and nursing students

are allocated in the maternity section to acquire their clinical skills. Most of the clinical skills in maternity are observed in the first practice. Advanced midwives demonstrate skills such as abdominal examinations which include palpation, per vaginal examinations, normal vaginal delivery and suturing of episiotomies. The advanced midwives stated that they also assisted colleges and the universities with the formative and summative assessment of nursing students. Advanced midwives are to mentor students by portraying good mutual relationships and ensuring that adequate and useful resources are in place for students to practice as confirmed by Jokelainen, Turunen, Tossavainen, Jamookeeah and Coco (2011:2854).

The education role which advanced midwives perform is both formal and informal. Formal education follows a planned programme and the topics given must be prepared, typed and filed in the ward to be used as reference sources. Informal education is situational and does not need preparation. Both formal and informal education includes signing of the workbooks for both medical and nursing students after demonstrating any procedure to them. The advanced midwives are obliged to supervise the students in order for the patients to receive quality care and to show good supervision relationship with students. Participants also stated that they assisted with the education of registrars, learnt from registrars and also involved basic midwives in the process of knowledge sharing.

The advanced midwives were involved in protocol formulation and also in supervision of the implementation of such protocols. This research revealed that there are hospitals which do not involve advanced midwives in the formulation of maternity or hospital policies and protocols. Students, intern doctors, registrars and basic midwives have to be orientated by the advanced midwives on how the maternity unit function is based on the set standards and protocols of the hospitals. Hence, the involvement of advanced midwives in protocol formulation is crucial as protocols will also elaborate how the maternity unit is prepared for obstetric emergencies. It is also a priority to show the registrars and midwives the location of emergency equipment such as the emergency trolley, eclampsia box including the emergency post-mortem Caesarean section pack during orientation to enhance their emergency preparedness skills and knowledge. During the orientation on location of obstetric emergency equipment, greater emphasis must be on teamwork as maternity is an unpredictable emergency area in which teamwork is a necessity. The advanced midwife has to apply knowledge and skills in leadership skills in order to gain the cooperation of the students, doctors and the midwives. Effective leadership is crucial in the healthcare system and leaders must be knowledgeable and supportive to students, doctors and midwives in order to promote and enhance professional development as confirmed by Knoche and Meucci (2015:98). All types of education and orientations must be patient-centred.

The participants stated that their main focus in education was patient education. Patients need to be educated in order to make informed decisions about the multidisciplinary care that they receive. Advanced midwives must embrace patient

advocacy in their teaching to bridge the gap between the patient and the complex culture that is the healthcare environment (O'Connor & Kelly 2005:265). The patients' identified lack of knowledge needs to be addressed to prevent further occurrence. Patient stay in the hospital must be of benefit as knowledge and skills should be transferred to prevent further non-booking with a next pregnancy, avoid seeking medical help and child rearing late. Tertiary hospitals cater for very sick and complicated obstetric conditions and therefore more teaching of patients to better their understanding of their own condition is needed. Advanced midwives' educational approach must be individualised and holistic and include the family members and the community. The family and community must be involved in the development and the maintenance of the continuum of care as stated by the WHO, ICM and FIGO (2014:9).

When educating students, doctors and midwives, advanced midwives are to stress individualisation of patient care which must be visible on patients' records. Education in maternity care is informal and situational and does not need preparation but must be documented in the patient records. The emphasis on education and recordings must be on patients' experiences of their care; it should not be from a health worker's perspective describing their tasks as stated by Karkkanen, Bondas and Eriksson (2005:123). Patient involvement in their care must be encouraged and documented in the patient files. The overall supervision of documentation must be based on the legality of the records and ethical considerations.

#### **4.2.2.3 Category 2.3: Dealing with managerial issues**

It emerged clearly from the findings that the advanced midwives had enormous responsibilities in tertiary hospitals. Participants stated ward management as one of the responsibilities. Ward management included the management of human and material resources as well as financial resources for the benefit of the patient. In management, the advanced midwives are the leaders as they delegate and supervise patient care. Participants mentioned the constraints caused by the high resignation of staff without replacement. However, they emphasised it was critical to find out what causes the resignations by proper exit interview in order to retain staff. It was indicated that exit interviews were done, but it is very difficult to find out the intention of the person leaving a job. Marangozov, Williams and Buchan (2016:20) state that stress and burnout is strongly linked with intention to leave healthcare services. Naicker, Plange-Rule, Roger and Eastwood (2009:60) add migration to English-speaking countries as a reason for leaving health services. It is very difficult to orientate new staff in a very busy environment with a high acuity of patients. Tertiary hospitals have a high number of different categories of students resulting in

increased pressure to advanced midwives as team leaders. Shortages of human resources were identified to be prevalent in both medical and nursing staff. Participants said sometimes they found themselves in theatre receiving babies without paediatricians and they did not feel comfortable as most of the patients were not booked, had a complicated pregnancy and there was no protocol which provided them with guidelines. Even if the advanced midwives were skilful, the fact that their skills were not utilised most of the time limited their confidence in the clinical area where they had to cope with shortages of both human and material resources.

Shortage and mishandling of material resources were identified as great challenges. Tertiary hospitals buy sophisticated and expensive equipment suitable for managing complicated patients. However, participants stated that both medical and the nursing staff were mishandling the equipment. Participants highlighted that many machines were packed in storerooms as the staff did not know how to use them or they were used without proper in-service training and were therefore not functioning properly. It clearly came out that the staff did not take ownership of the equipment in such a way that even if the machines were broken, they were not reported and nobody took responsibility for breaking it. Breakage of equipment affects the finances of the hospital. Participants also stated a shortage of medicine such as Celestone, which is given during preterm labour to enhance lung maturity, was a problem. Prioritising of medications which can lower the maternal and neonatal morbidity is important. Hence, advanced midwives should be involved in financial management.

#### **4.2.2.4. Category 2.4: Dealing with challenges related to patient admissions**

Participants highlighted that tertiary hospitals had many low risk patients despite the fact that the requirements of tertiary hospitals are to cater for high risk patients. Many of such low risk patients were not booked and/or were self-referrals. South Africa has free and accessible health services for maternal and child health, but many patients who go into labour go to tertiary hospitals without prior booking. Non-booked patients mostly have an increased risk of complications because they do not attend the antenatal care and they thus miss out on the management of their pregnancy. Screening care is not done where complications can be identified and referral to a hospital can be done on time (Pattinson 2015 b:261).

The participants shared the non-booked patients were not referred to tertiary hospitals or referred late from the clinics or private practitioners. The self-referred patients were those patients who moved from one private doctor to another either because they were not happy about the diagnosis they were given or not happy



about the waiting period at the facilities they came from. Self-referred patients are not easy to handle by both advanced midwives and doctors as they are already unhappy and consider themselves as emergency cases due to the diagnosis they are unhappy with. As stated above, because they are not booked, they also increase the rate of Caesarean sections as they arrive in tertiary hospitals with non-stabilised complications such as eclampsia, uncontrolled diabetic mellitus and antepartum haemorrhages. Such complications affected most of the skills of the advanced midwives when the registrar, who had to take decisions about the management, was in theatre or busy in the other ward. These patients complicate when still waiting in the tertiary hospital, hence the advanced midwives stated in the study that there should be a nearby 24-hour MOU or district hospital because in those facilities advanced midwives will stabilise and manage the patient according to the Maternity Guideline of South Africa (2015:19). Caesarean sections expose patients to many complications like haemorrhage which add to the workload of advanced midwives as patients have to get blood transfusion which means more observations. The advanced midwives in the MOU or district hospital can manage the patient and call the registrar and give report about the care rendered to the patient, but in a tertiary hospital there is no teamwork in decision making on patients' management.

It came out clearly in this study that teamwork in decision making on patient management was a challenge. Advanced midwives, due to their knowledge and skills which is acquired through experience, are more competent in maternity care. Medical practitioners are always rotating in maternity care. Even the intern doctor and the registrar go on training to acquire new skills in different departments in maternity; hence, they need orientation on policies and procedures from the experienced professionals in those departments. Participants indicated the negative attitudes they came across when they tried to share their skills with medical officers. It hindered patient management and had a great impact on maternal and neonatal mortality and mobility rates. Advanced midwives and medical officers work together and are to communicate and share and consolidate knowledge as as stated by Xyrichis and Ream (2008:235) and the team is held collectively accountable (Tzenalis & Sotiriadou 2010:51).

### **4.3 RECOMMENDATIONS**

The findings of this study, based on the participants' information during focus group interviews, revealed that the skills of advanced midwives are not optimally utilised in maternity care in tertiary hospitals in Gauteng and the findings need to be taken into consideration. Based on the finding the following recommendations were made:

#### **4.3.1 Support and supervision of utilisation of advanced midwives' knowledge and skills in tertiary hospitals by Gauteng Department of Health as employer**

The democratic government took a great stride to recognise advanced midwives as skilled practitioners who are to be placed in larger number in tertiary hospitals in



accordance with Guidelines of Maternity Care in South Africa (2015:21) staffing norms. There is a dire need for the government to facilitate optimal utilisation of the advanced midwives' skills as it was revealed in this research that only their knowledge is utilised, but their unique skills are not optimally utilised. The acquired skills without practice will fade away. One of the participants said, "*I am regressing*". The skills of the advanced midwives not regularly practiced will affect the neonatal/maternal mortality and morbidity rate negatively in tertiary hospitals in Gauteng as those skills will be of no value when assisting during obstetric emergencies.

Another recommendation is for the government to pay special attention to staffing in maternity as the shortage of staff was identified as the main course of facilities not adequately prepared to perform all the required essential obstetric emergency services in maternity (Pattinson 2015a:261).

The employing body is to facilitate protocols and policies to be put in place in maternity care in Gauteng tertiary hospitals to guide the advanced midwife how to perform or initiate care in the absence of a registrar. It emerged from this study that most of the registrar's time is spent in theatre and the intern doctors remain in the clinical area and have to make decisions. Some tertiary hospitals have no protocols in place; some have protocols in place but they vary from hospital to hospital – a unified protocol policy is urgently needed for all tertiary hospitals in Gauteng.

#### **4.3.2 Support by the registering body – South African Nursing Council (SANC)**

In this study the participants demonstrated an understanding of Continuous Professional Development (CPD) as outrolled by the Gauteng Department of Health and the registering body, the South African Nursing Council (SANC). By attending well-planned and well-developed staff development programmes focusing on ethics and the area of practice, staff members build up a portfolio of evidence as part of their lifelong learning. Individuals can choose which programmes they want to attend. This is important because it promotes knowledge and without knowledge they cannot intervene.

SANC keeps the register and roll of all the categories of professionals in South Africa irrespective of being in practice, as long as the registration fee is paid. In this study it was found that even professionals who are rendering care in tertiary hospitals are losing skills. The registering body is outrolling the CPD points which are being put in place so that professional people who are registered at SANC and on the roll, can stay updated with knowledge and skills including research and ethics. SANC should consider enforcing nursing specialties such as advanced midwives to perform skills specific to their specialty in the area of practice for the sustenance of those skills. SANC should also consider initiating research endeavours as part of the requirements of all specialties of professionals registered with SANC so that points can be easily accumulated in the area of research.

### **4.3.3 Support by training institutions/universities**

The training institutions make use of the maternity care in tertiary hospitals as clinical areas for both basic midwives and the advanced midwives. Follow-up, fully functional programmes need to be designed on the utilisation of the newly qualified advanced midwives' practice to give them support. The training institutions should emphasise collaboration and working together of students of all professionals to perform their duties together in multidisciplinary teams with respect and in a professional manner.

Tertiary hospitals are known to produce large numbers of good research studies from clinical areas. This study found that advanced midwives are involved or told about the research studies taking place in wards, but there is no dissemination at all or no proper dissemination of information at the end of the research study.

Dissemination of research information is one of the requirements and information should be given to participants. The universities should facilitate dissemination of information to the hospital where research has been done.

From this study it was revealed that there is lack of interest in conducting research from the advanced midwives' side. There should be inclusion of individual research projects in the advanced midwives' training because group research, which is done in most training institutions, is not empowering advanced midwives with the skills and interest to initiate clinical research. Based on the study findings, training institutions can incorporate the roles of advanced midwives in different levels of care into their curricula.

### **4.3.4 Support for advanced midwives by nursing management**

There is a need for open communication between the managers, advanced midwives and the resolving of staff challenges without being judgmental. Managers who listen attentively and are supportive, acknowledge good practices and are receptive to learn new practices. Advanced midwives need support from management when they apply innovative skills after appointment and also when coming back from advanced midwife courses. Lack of support and appreciation from the institution and management was identified as one of the reasons why advanced midwives do not continue with midwifery practice as evidenced in a study done in South Africa by Chokwe and Wright (2013:4). The multidisciplinary team in a tertiary hospital is very large for the newly qualified advanced midwife who may find it difficult to adjust. Managers should assist in the process of adjustment of these skilful professionals in the multidisciplinary team. The utilisation of leadership skills and mentoring by managers to pave the way for the advanced midwives in the multidisciplinary team in the tertiary hospitals of Gauteng is very important and recommended.

Advanced midwives are knowledgeable of how maternity units should be run, and it is therefore recommended that they should become involved in policy making in maternity units. Participants recommended for advanced midwives to be included in

the formulation of maternity protocols; which is supported by the WHO (2015:3). Nursing management should facilitate collaborative meetings between the advanced midwives and the medical staff to build teamwork in decision making on patient management as teamwork is needed for the benefit of optimal patient care.

#### **4.3.5 Self-empowerment of advanced midwives through assertiveness**

The advanced midwives are independent practitioners who must be assertive and practice their acquired skills with confidence and within their scope of practice. There is a need for advanced midwives to have a forum in which they can discuss the challenges which hinder their practice, share good practices and support each other. Forums should have clear objectives and should be communicated with the management and the government or employing body for support. Advanced midwives should have opportunities of benchmarking the practice of other tertiary hospitals within Gauteng province, or outside the province.

Advanced midwives should initiate research projects in their clinical area. Participants stated the importance of conducting research as part of enhancing their knowledge. Participants were asked a probing question, “Are you doing research as individuals or are you involved in any research?”, and the response was that they did not really although it was expected from an advanced midwife to become involved in research. Advanced midwives are aware that they are expected to initiate research in the clinical area. A good platform for the advanced midwives in research is to embrace the Continuous Professional Development (CPD) campaign which is presently run by SANC and leads the midwifery research as it is one of the areas where CPD points can be accumulated. However, actual research is still lacking.

#### **4.4 RECOMMENDATIONS FOR FURTHER RESEARCH**

Based on the findings of this study, further research in tertiary hospitals need to be conducted (regarding management and medical staff) on a larger scale to determine the optimal utilisation of knowledge and skills of advanced midwives. In addition, intensive research should be conducted on the type of support needed by advanced midwives in order to close the knowledge gap where necessary. Based on this study findings, research effective programmes need to be put in place which will facilitate mentoring and grooming of newly qualified advanced midwives to strengthen their assertiveness in the multidisciplinary team. It is further recommended that more research should be done on the placement of advanced midwives in tertiary hospitals in order to meet staff and patient satisfaction needs.

#### **4.5 IMPLICATIONS FOR PRACTICE**

It was highlighted in this study that the skills of advanced midwives are not optimally utilised in the tertiary hospitals in Gauteng. Due to this factor, the relevant implications are set out below.

#### **4.5.1 Advanced midwives**

Tertiary hospitals cater for very sick patients with obstetric complications. Obstetric emergencies require high levels of competencies which are the skills and knowledge one applies when managing obstetric patients. Maintenance of skills by advanced midwives necessitates utilisation of the acquired skills. Places like the labour ward require healthcare workers to be skilled and always prepared for unpredictable emergencies. The clinical areas need professionals to develop and plan patient management based on evidenced observations and assessments.

The study revealed that the skills of advanced midwives rendering maternity care in tertiary hospitals are not optimally utilised. Facilitation of optimal utilisation is crucial as they are losing their skills. Optimal utilisation of advanced midwives skills will make the maternity care areas safe.

#### **4.5.2 Tertiary hospitals in Gauteng**

Collaboration of skills in a multidisciplinary team is needed to embrace the advanced midwives' skills into the tertiary hospitals' health system. There has to be role clarification, which is in accordance with the advanced midwives' scope of practice, and there should be conceptualisation of roles. Protocols should be formulated which are in accordance with the tertiary hospitals' set standards which can also give directions to regional hospitals and MOUs as directed by the Guidelines for Maternity care in South Africa. Collaboration among different professions with respect and with dignity should be the highest consideration.

#### **4.5.3 Gauteng Department of Health/employing body**

Tertiary hospitals is one area to which a large part of the budget is channelled for the management of complicated patients, training of medical practitioners and nursing staff including different nursing specialties for many disciplines. For the country to meet the SDGs by 2030, the utilisation of all employees is of utmost importance and it needs a multidisciplinary approach between the government, the Minister of Health and professionals in tertiary hospitals. More emphasis needs to be placed on staffing in tertiary hospitals with more advanced midwives. Advanced midwives will not be recruited and retained in tertiary hospitals when they are not optimally utilised or not utilised at all as they will lose skills. According to Birch et al. (2007:921), risk reduction involves reporting of incidents, analysis and feedback to staff, which involves the implementation of changes to reduce future harm. Hence, the researcher suggests that the employer, the namely the Gauteng Department of Health, analyses the findings of this study and makes some changes in tertiary

hospitals which will be implemented to reduce further and future harm to the advanced midwives.

#### **4.6 LIMITATIONS OF THE STUDY**

The study was done in three tertiary hospitals in Gauteng, one of the nine provinces. Gauteng has four tertiary hospitals but the findings of the study cannot be generalised. Rich and in-depth data was obtained from four to five participants in each focus group, but the departments were not represented due to staff being involved in patient care. Maternity care consist of antenatal, intrapartum and postnatal care.

Preparation of the setting took more time than expected, because to obtain permission in one hospital, the research proposal had to go through the second Ethics Committee of the University of the Witwatersrand who controls all research studies conducted in the specific hospital. Nine to 10 additional months were needed to get approval.

None of the literature on research studies conducted on advanced midwives in South Africa focused on the role of advanced midwives in tertiary hospitals, which limited the contextual comparison of themes in this study.

#### **4.7 FINAL CONCLUSION**

The aim of this study was to explore and describe the role of the advanced midwife regarding maternity care in tertiary hospitals in Gauteng in order to encourage optimal use of this category of advanced nursing. The study explored the utilisation of the advanced midwife regarding maternity care in the multidisciplinary team. When the role of the advanced midwives in tertiary institutions is clarified, their role and place in the multidisciplinary team could be clearer.

A qualitative, exploratory and descriptive research design was followed to answer the research question. Focus group discussions were performed in three tertiary hospitals after the uneventful pilot testing which was done prior to the main study in the fourth tertiary hospital. Two main themes were identified and literature was used to support the findings. The two main themes were used in the development of recommendations to stakeholders.

The identified roles of advanced midwives in maternity care in tertiary hospitals revealed positive attributes of advanced midwives, responsibilities of advanced midwives, and challenges posed by patients who do not adhere to the admission criteria as crucial information, which will be utilised to ensure facilitating optimal utilisation of advanced midwives in maternity care of tertiary hospitals. Positive and negative impact on service delivery was highlighted in all tertiary hospitals of Gauteng which needs to be complimented or rectified.

The researcher made recommendations to different stakeholders on ways of dealing with identified bottlenecks as far as fulfilling the role of the advanced midwife in tertiary hospitals in Gauteng is concerned. It is hoped that the necessary measures will be taken to achieve optimal utilisation of advanced midwives in tertiary hospitals of Gauteng. Study reports will still be disseminated to tertiary hospitals and also be presented at different seminars countrywide.

The objective of this study was achieved and the research question was fully answered.

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## LIST OF ANNEXURES

Annexure A:	Permission letters
Annexure A1:	Letter requesting permission to conduct pilot study in Chris Hani Baragwanath Academic hospital
Annexure A2:	Letter requesting permission to conduct study in Charlotte Maxeke Academic hospital
Annexure A3:	Letter requesting permission to conduct study in Dr George Mukhari Academic hospital
Annexure A4:	Letter requesting permission to conduct study in Steve Biko Academic hospital
Annexure A5:	Application for WITS
Annexure B:	Ethical approval
Annexure B1:	Approval letter from University of Pretoria Research Ethics Committee
Annexure B2:	Approval letter from WITS Ethics Committee
Annexure B3:	Approval letter from Chris Hani Baragwanath Academic hospital
Annexure B4:	Approval letter from George Mukhari Academic hospital
Annexure B5:	Approval letter from Steve Biko Academic hospital
Annexure B6:	Approval letter from Charlotte Maxeke Academic hospital
Annexure C:	Informed consent
Annexure C1:	Information leaflet and interview schedule
Annexure C2:	Interview guide
Annexure C3:	Consent for focus group interview
Annexure C4:	Consent for audio-taping
Annexure D:	Verbatim transcript of one focus group interview
Annexure E:	Editor's letter



**ANNEXURE A1**

**Permission to do pilot study for the Research at Chris Hani  
Baragwanath Academic Hospital**

<b>To:</b> Chief Executive Officer Dr. S. Mfenyana Chris Hani Baragwanath Academic hospital Johannesburg Road 1864	<b>From:</b> The Investigator Mrs Mbulaheni Rhona Luphai 34 Millstone Heuwelsig Estate Heuwelaard 0157
--	--

**Re: Permission to do the following research at Chris Hani Baragwanath Academic Hospital**

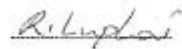
I am working at Rahima Moosa Mother and Child Hospital. I am requesting permission to conduct a study to explore the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng.

The title of the study is: THE ROLE OF ADVANCED MIDWIVES IN MATERNITY CARE WORKING IN TERTIARY HOSPITALS IN GAUTENG

I intend to publish the findings of the study in a professional journal and/ or at professional meeting like symposia, congresses, or other meetings of such a nature.

I undertake not to proceed with the study until I have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

Yours sincerely



Mrs. Mbulaheni Rhona Luphai

**ANNEXURE A2**

Mobile: 0760431166

Email: luphairn@yahoo.co.uk

15 May 2016

The CEO

Charlotte Maxeke Johannesburg Academic hospital

P. O. Box x39

Johannesburg

2000

Ms G. Bogoshi

RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH IN CHARLOTTE  
MAXEKE ACADEMIC HOSPITAL

1. I hereby apply for the permission to conduct the research in Charlotte Maxeke Johannesburg Academic Hospital
2. The title of my study is "The role of Advanced Midwives in Maternity Care working in tertiary hospitals of Gauteng".
3. I am currently registered for MCUR with the University of Pretoria and my student number is 13418387 and I am working in Rahima Moosa Mother and Child Hospital
4. My research proposal has been submitted to the Ethical committee, Faculty of Health Science, University of Pretoria and I am waiting for the approval
5. The findings and recommendations of the study will assist in clarifying the role of an advanced midwife in tertiary hospitals of Gauteng
6. I hope that my request will be taken into consideration

Yours sincerely

Mhulaheni Rhona Luphal

RESEARCHER

*R. Luphal*

**ANNEXURE A3**

**Permission to do Research at Dr George Mukhari Academic Hospital**

To: Chief Executive Officer Dr. F. Kgongwana Dr George Mukhari Academic hospital Setlogele Road Pretoria	From: The Investigator Mrs Mbulaheni Rhona Luthazi 34 Milestone Heuwelsig Estate Heuwelood 0157
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**Re: Permission to do the following research at Dr George Mukhari Academic Hospital**


I am working at Rahima Moosa Mother and Child Hospital. I am requesting permission to conduct a study to explore the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng.

The title of the study is: THE ROLE OF ADVANCED MIDWIVES IN MATERNITY CARE WORKING IN TERTIARY HOSPITALS IN GAUTENG

I intend to publish the findings of the study in a professional journal and/ or at professional meeting like symposia, congresses, or other meetings of such a nature.

I undertake not to proceed with the study until I have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

Yours sincerely



Mrs Mbulaheni Rhona Luthazi

ANNEXURE A4

Permission to do Research at Steve Biko Academic Hospital

To: Chief Executive Officer  
Dr Soe

From: The Investigator  
Mrs Mbulaheni Rhona Luphal

Re: Permission to do the following research at Steve Biko Academic Hospital

I am working at Rahima Moosa Hospital. I am requesting permission to conduct a study to explore the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng.

The title of the study is: THE ROLE OF ADVANCED MIDWIVES REGARDING MATERNITY CARE IN TERTIARY HOSPITALS IN GAUTENG

I intend to publish the findings of the study in a professional journal and/ or at professional meeting like symposia, congresses, or other meetings of such a nature.

I undertake not to proceed with the study until I have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

Yours sincerely

  
Mrs Mbulaheni Rhona Luphal

Permission to do the research study at this hospital and to access the information as requested, is hereby approved.

Chief Executive Officer Steve Biko Hospital

Signature of the CEO

Hospital Official Stamp

ANNEXURE A5

FORM HREC (MEDICAL) Application form for 2015

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

APPLICATION TO THE HUMAN RESEARCH ETHICS COMMITTEE: (MEDICAL) FOR  
CLEARANCE OF RESEARCH

PLEASE read the NOTE section at page 8 before completing this application form.

This application MUST BE TYPED in Capitals & lower case. Handwritten forms are NOT accepted. 25 sets of application form plus attachments and 5 copies of protocol must be submitted.

Please complete ALL sections of this application form; the Committee needs the information to make a decision. If this is not done, clearance is unlikely - you may have to resubmit a fully complete application.

SECTION 1

PRINCIPAL INVESTIGATOR/S PER SITE (graduate or student) STUDENT

FIRST NAME(S): MBULAHENI RHONA SURNAME LUPHAI  
(Prof/Dr/Mr/Miss/MS)

WITS STAFF NUMBER OR WITS STUDENT NUMBER N/A  
(if applicable)

PROFESSIONAL STATUS OR STUDENT YEAR OF STUDY AND DEGREE: MIDWIFE  
2015 STUDENT MCUR

UNIVERSITY DEPARTMENT / DIVISION

UNIVERSITY OF PRETORIA IN FACULTY OF HEALTH SCIENCES

NON-WITS SITE / INSTITUTION (if no association of any type with the University)

DETAILS OF WHERE STUDY WILL BE DONE

WHERE WILL THE RESEARCH BE CARRIED OUT?

(Please furnish name of hospital/institution and department)

THE PILOT STUDY WILL BE DONE AT CHRIS HANI BARAGWANATH AND DATA COLLECTED IN CHARLOTTE MAXEKE JOHANNESBURG, STEVE BIKO AND GEORGE MUKHARI TERTIARY HOSPITALS IN LABOUR WARDS

HOSPITAL/INSTITUTION WHERE EMPLOYED (if applicable)

RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

FULL-TIME OR PART-TIME EMPLOYEE: FULL TIME HPCSA NO: 80304893

SECTION 2

CONTACT PERSON'S DETAILS FOR ALL CORRESPONDENCE:

NAME: MBULAHENI RHONA LUPHAI

TELEPHONE NO: 0114709320 FAX NO: N/A

CELL: 0760431166 EMAIL: luphaimr@yahoo.co.uk

SUPERVISOR'S NAME: DR. M YAZBEK SUPERVISOR'S  
EMAIL: mariatha.yazbek@up.ac.za (if applicable)

CO-INVESTIGATORS' NAMES: DR. S. MATABOGE EMAIL:  
sanah.mataboge.@up.ac.za

ONLY FOR INVESTIGATOR-INITIATED CLINICAL TRIALS – GOOD CLINICAL PRACTICE (GCP) TRAINING: DATE AND NAME of GCP Course attended (dd/mm/year) for all investigators. (Note: investigators' meetings do not qualify as GCP training)

Full Name: \_\_\_\_\_

GCP Course Name: \_\_\_\_\_

Date of GCP course: day/month/year: \_\_\_\_\_

All the following sections must be completed 3. Please tick all relevant boxes.

SECTION 3

3. TITLE OF RESEARCH PROJECT: (Use no abbreviations)

## THE ROLE OF ADVANCED MIDWIVES IN MATERNITY CARE WORKING IN TERTIARY HOSPITALS IN GAUTENG

TIP: To select the check box 1, double click on the box 0, Select checked

### 3.1 PURPOSE OF THE RESEARCH:

Postgraduate: degree/diploma (state which)  1 MCUR

Undergraduate: degree/diploma (state which)  0

Not for degree purposes  0

### 3.2 OBJECTIVES OF THE RESEARCH (please list): (Do not say see attached!)

THE OBJECTIVE OF THE STUDY IS TO EXPLORE AND DESCRIBE THE ROLE OF THE ADVANCED MIDWIFE IN MATERNITY CARE IN TERTIARY HOSPITALS OF GAUTENG

### 3.3 SUMMARY OF THE RESEARCH (give a brief outline of the research plan such that reviewers understand what will be done. (Do not say see attached!)):

QUALITATIVE EXPLORATIVE, DISCRIPIVE STUDY WILL BE CONDUCTED FOCUS GROUP INTERVIEWS WILL BE HELD WITH ADVANCED MIDWIVES WORKING IN THE MATERNITY IN THE THREE IDENTIFIED TERTIARY HOSPITALS OF GAUTENG AND THE MODERATOR WILL BE UTILIZED TO FACILITATE THE FOCUS GROUP INTERVIEWS GUIDED BY THE PREPARED INTERVIEW GUIDE (ANNEXURE C) IN COLLECTING DATA. PERMISSION FROM THE CHIEF EXECUTIVE OFFICERS FROM THE CHOSEN TERTIARY HOSPITALS WILL BE OBTAINED AFTER OBTAINING APPROVAL FROM THE RESEARCH ETHICS COMMITTEE, FACULTY HEALTH SCIENCES OF THE UNIVERSITY OF PRETORIA. PARTICIPATION WILL BE VOLUNTERY AND INFORMED CONSENT FORM WILL BE SIGNED (ANNEXURE B). AUDIO TAPES WILL BE USED AFTER OBTAINING PERMISSION FROM PARTICIPANTS AND FIELD NOTES WILL BE TAKEN BY THE RESEARCHER. TESCH'S METHOD OF CODING WILL BE USED FOR DATA ANALYSIS. ETHICAL CONSIDERATIONS AND TRUSTWORTINESS WILL BE FOLLOWED.

## SECTION 4

### 4. DOCUMENTATION REQUIREMENTS



4.1 Is this project a secondary analysis of data in an established database? Yes 1 No 0

Note: written consent to access a database from the database gatekeeper plus a list of the data to be recorded (see 6.1) must accompany this application.

Is this documentation attached? Yes 1 No 0

4.2 Is this project a retrospective patient record review? Yes 0 No 1

Note: for a retrospective review the date of the ethics committee meeting at which the application is considered

sets the final date for the patient records. If the initial and / or final date is after the meeting date, the study is

prospective. Patient records include ALL DATA collected on patients including blood results and radiographs etc.

What is the initial date for the patient records?

What is the final date for the patient records?

Is this documentation attached? Yes 0 No 1

Note: the following must accompany this application – written proof of application for permission from the hospital or clinic CEO to do the study, written permission from the clinical entity in which the patients in which patients records are based, how the patients will be selected, what type of records will be examined, a list of the variables to be extracted (see 6.1).

Is this documentation attached? Yes 0 No 1

Have patients consented for the anonymous use of their data Yes 0 No 1

4.3 Is this project a prospective patient record review? Yes 0 No 1

Patient records include ALL DATA collected on patients including blood results and radiographs etc.

What is the initial date for the patient records?

What is the final date for the patient records?

Note: the following must accompany this application – written proof of application for permission from the hospital or clinic CEO to do the study, written permission from the

clinical entity in which the patients in which patients records are based, how the patients will be selected, what type of records will be examined, a list of the variables to be extracted (see 6.1).

Is this documentation attached? Yes 0 No 1

4.4 If this project involves prospective studies with drugs at a teaching hospital associated with this University, approval must first be obtained from the Hospital's relevant Committee.

Has application been made? (If not, this application cannot be considered) Yes 0 No 1

4.5 If radiation or isotopes are to be used in prospective studies, written approval must be obtained from the Director, Radiation and Health Physics Unit (james.larkin@wits.ac.za / 011-717 6931). Note: for patients these are radiation dosages over and above those for standard diagnosis / therapy

Is this attached? If not, the application cannot be considered. Yes 0 No 1

4.6 Is a Participant Information Sheet attached? (For written consent)

Yes 1 No 0

Informed Consent Form is attached. (For written consent). Yes 1 No 0

For guidance please refer to the Wits Informed Consent Form Template at [www.wits.ac.za/research/ethics](http://www.wits.ac.za/research/ethics) and adjust this for your needs

If informed consent will be verbal or If informed consent is not considered necessary – a written motivation and justification needs to be attached

4.7 If a questionnaire or interview is to be used in the research, it must be attached.

Is it attached? (If not, this application cannot be considered). Yes 1 No 0

## SECTION 5

### 5.STUDY POPULATION

5.1. If patients/patient records are being studied, state where and how they are selected:

5.2. Where the participants are not patients,

Will they be invited to volunteer? 1 Will they be selected? 0

State who is invited to volunteer or how the participants are selected:

PURPOSIVE SAMPLING WILL BE USED FOR THIS STUDY AS ONLY ADVANCED MIDWIVES IN THE SELECTED TERTIARY HOSPITALS OF TERTIARY HOSPITALS OF GAUTENG WILL BE USED AS PARTICIPANTS IN THE STUDY.

Are the participants subordinate to the person doing the recruiting? Yes 0 No 1

If yes, justify the selection of subordinate participants:

5.3 Will control patients/participants be used? Yes 0 No 1

If yes, explain who they are and how they will be recruited

5.4 What is the age range of participants in the study?

If participants are minors (under 18 years), from whom will consent be obtained?

If participants are minors, is an Assent Document provided? Yes 0 No 0

5.5 Gender: Male 1 Female 1

5.6 Number of patients/participants 5 TO 12 controls

5.7 Will the research benefit the patients/participants in any direct way? Yes 1 No 0

If yes, explain in what way.

-DATA WILL BE USED TO MAKE RECOMMENDATIONS FOR THE PRACTICE OF ADVANCED MIDWIVES IN TERTIARY HOSPITALS

-THERE IS POSSIBILITY THAT THE RECOMMENDATIONS MAY INFLUENCE THE POLICY MAKERS TO RELOOK THE STAFFING NORMS OF THE TERTIARY HOSPITALS AND ALSO IMPROVE THE PRACTICE OF THE PRACTICE OF THE ADVANCED MIDWIVES IN THE MULTIDISCIPLINARY TEAM

5.8 Will participants receive any remuneration? Yes 0 No 1

If yes, explain what the remuneration is for and how much will be paid

5.9 Will participation, non-participation or withdrawal from the study disadvantage patients/participants in any way?

Yes 0 No 1

If yes, explain in what way:

## SECTION 6

### 6. PROCEDURES

6.1 Mark research procedure(s) that will be used and attached what is required:

Record review (attach a list of data to be recorded)

Interview form / questionnaire (must be attached)

Self-administered questionnaire (must be attached)

Focus group (questions to be used must be attached. Note: there is no confidentiality in a focus group, participants must be told this)

Examination (state nature and frequency of examination)

Drug or other substance administration (state name, dose, and frequency of administration)

Radiographs

Isotope administration (state name, dose, and frequency)

Blood sampling; Venous; Arterial

(State amount to be collected and the frequency of sampling.)

Will a biobank be used in the study Yes  No  (See page 7 regarding biobanks)

Biopsy (explain)

Other procedures (explain)

Use this space to elaborate on procedures marked above:

6.2. Is/are procedure/(s) routine for: diagnosis/management? Yes  No

specific to this research? Yes  No

Identify which of the procedures above a routine for diagnosis and management of patients: and identify those procedures specific to the research

6.3. Who will carry out the procedure(s)? if not the PI please indicate who and their qualifications to perform the procedures

6.4. When will the research project commence after obtaining ethics clearance, and over what approximate time period will the research be done?

DATA COLLECTION START DATE: 2 December 2015 ESTIMATED  
STUDY END DATE: 30 December 2015

6.5. For studies being done outside the Gauteng Academic Hospitals, please list the number of studies currently being done by the Principal Investigator, the number of patients per study and where they are being done.

6.6. For applications outside the Gauteng Academic Hospitals: Is the investigator involved in a clinical Part-Time / Full-Time capacity at the study site?

## SECTION 7

### 7. RISKS OF THE STUDY PROCEDURE(S):

To patients/participants and all members of the research team

- 1 No risk
- 0 Physical discomfort
- 0 Pain
- 0 Possible complications
- 0 Side effects from agents used
- 0 Breach of confidentiality
- 0 Possible stigmatisation
- 0 Psychological stress

If you have checked any of the above except "No risk" please provide details:

## SECTION 8

### 8. GENERAL



8.1. For any study, has permission from relevant authority/ies been obtained to do the study? Yes1 No0 N/A0

State name of authority/ies and provide written proof of application for permission(s)

8.2 Has this study been submitted to other Ethics Committees? Yes1 No0 N/A0

If yes, what is the status of the application? APPROVED BY FACULTY OF HEALTH SCIENCES RESEARCH ETHICS COMMITTEE UNIVERSITY OF PRETORIA

8.3 How will confidentiality be maintained so that participants are not identifiable to persons not involved in the research? CONFIDENTIALITY CANNOT BE GUARANTEED IN THE FOCUS GROUP DISCUSSION BUT WILL BE ENCOURAGED  
Please answer the questions below:

Will data be anonymous? How? YES, NO NAMES WILL BE USED

Will identifiable data be coded and the 'links' kept separate? How? DATA WILL BE CODED AND NOT LINKED TO ANY NAME

Who will have access to the raw data? ONLY THE RESEARCHER

8.4 To whom will results be made available? – THE ADVANCED MIDWIVES AND POLICY MAKERS

8.4 How will the results be disseminated? - THE RESEARCHER WILL GIVE FEEDBACK TO THE ADVANCED MIDWIVES AND MANAGEMENT OF THE THREE TERTIARY HOSPITAL

-STUDY FINDINGS WILL ALSO BE PRESENTED IN NATIONAL CONFERENCES AND PUBLISHED IN ARTICLE

8.5 Will there be financial costs to:

Participants Yes0 No1

Hospital/Institution Yes0 No1

Other Yes1 No0

Explain any box marked "Yes": THE RESEARCHER WILL PAY FOR TRAVELLING, MODERATOR, CODING, LANGUAGE EDITING AND PRINTING FINAL COPY

8.6 If no protocol is attached please indicate: Budget? How will the research be funded? I

Please give details of the source of funds

8.7 Any other information, which may help the Committee to evaluate this application, may be provided here:

- THE PROTOCOL ALREADY GOT APPROVAL LETTER FROM THE ETHICAL COMMITTEE OF THE UNIVERSITY OF PRETORIA AND IS ATTACHED

Date: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_

---

WHO WILL SUPERVISE THE PROJECT? (Where applicable)

Name \_\_\_\_\_ Department: \_\_\_\_\_

Telephone No: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

---

HEAD / RESEARCH COORDINATOR OF DEPARTMENT / ENTITY IN WHICH STUDY WILL BE CONDUCTED (Where applicable)

Name: \_\_\_\_\_ Department / Entity \_\_\_\_\_

Tel No: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MSWord/lain0015/HERCMedAF

NB: PLEASE NOTE IT IS NOT NECESSARY TO COPY THIS PAGE (For your information ONLY)

PLEASE NOTE:

1 Please note: the application form labelled with the year in which an application is made must be used. If any other year's application form is used, the application will need to be redone.



2. There are guidelines at [www.wits.ac.za](http://www.wits.ac.za) regarding waivers from ethics approval, case reports, and

sub-studies within already approved projects. At the Wits web site choose <research and library> <research resources> <ethics and research integrity> <ethics application forms, guidance....>

3. Please indicate clearly, where correspondence should be sent; failure to do this cause delays. Please provide the supervisor's email address (where applicable) for sending copies of correspondence.

4. This requirement holds even if, to assist the Committee, a protocol detailing the background to the research, the design of the investigation and all procedures, is submitted with the application.

5. If any doubt exists please contact Ms Zanele Ndlovu and Mr Langutani Masingi, Medical School, Parktown, Phillip Tobias Building, 2nd Floor, Cnr York Road and Princess of Wales Terrace, Mon-Fri 08h00-17h00 Tel: 011-717-1234/1252/ 2700 or Room SH1005, 10th Floor Senate House, Emails: [zanele.ndlovu@wits.ac.za](mailto:zanele.ndlovu@wits.ac.za) or [Langutani.Masingi@wits.ac.za](mailto:Langutani.Masingi@wits.ac.za)

6. Please note that written clearances will not be available until approximately 10-14 working days after a Committee meeting – minutes must be checked, clearances printed and signed by a Committee Chair and only then despatched to applicants, this takes time.

7. Whether written or verbal consent is to be obtained, the HREC requires a Participant Information Sheet written in friendly language understandable to lay persons explaining what is required from a potential participant. This should include the following (a template is available to help applicants at [www.wits.ac.za/research/ethics/](http://www.wits.ac.za/research/ethics/)):

(1) Participation is voluntary, and refusal to participate will involve no penalty or loss of benefits to which the participant is otherwise entitled;

(1) The participant may discontinue participation at any time without penalty or loss of benefits:

(2) A brief description of the research, its duration, procedures and what the participant may expect and/or be expected to do:

(3) Any foreseeable risks, discomforts, side effects or benefits, including those for placebo:

(4) Disclosure of alternatives available to the participant. If risks are involved:

- (5) A professional contact name and 24 hour telephone number:
- (6) Explanation whether medical treatment will be provided in the case of a complication developing:
- (7) If required - compensation for clinical trial related injuries will be in accordance with the ABPI guidelines:

Remember to INVITE a person to take part in the study; to include a greeting and to introduce yourself.

## 8 STORAGE OF BLOOD AND/OR TISSUE SAMPLES:

The policy of the ethics committee is:

- If, blood or tissue specimens are to be stored for future analysis and / or it is planned that analysis may be done outside Wits then the specimens must be stored at Wits with release of sub-samples only once projects have been approved by the local Research Ethics Committee applicable to where the research will be done as well as by the Wits Human Research Ethics Committee: (Medical);
  - A separate information sheet and consent form for this is required. Please see the Standard Operating procedure at [www.witshealth.co.za/ethics](http://www.witshealth.co.za/ethics).
  - For information on Biobanks and the Biobank Ethics Committee within the Wits Human Research Ethics Committee (Medical) go to [www.wits.ac.za](http://www.wits.ac.za) then choose <research and library> <research resources> <ethics and research integrity> <ethics application forms>
  - Only approved analyses may be done;
  - Specimens may not be shared with anyone unless approved by the Wits Human Research Ethics Committee (Medical).
9. Evaluation of applications from private sites / institutions without any affiliation to Wits may be done but is at the discretion of the Wits Human Research Ethics Committee (Medical). In such instances a management fee is payable.
  10. Researchers from abroad should obtain ethics clearance BEFORE arriving at Wits, a tight time schedule is not considered a valid reason for departing from Wits Standard Operating Procedure. A Wits collaborator may help obtain the clearance.
  11. Researchers with syndicates in the Wits Health Consortium – please read the home page at [www.witshealth.co.za](http://www.witshealth.co.za) regarding the requirement that the syndicate must be based in a Wits academic department or recognised research entity.

12. Please note: No late applications will be accepted after the submission date listed at [www.wits.ac.za/research](http://www.wits.ac.za/research) resources.

13. No data may be collected before a clearance is issued by the HREC(Medical).

ANNEXURE B1

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal site Assurance.  
• FWA E0002567, Approved 02 Oct 2002 and Expires 25 Oct 2016.  
• IRB 0200 2235 ID#R0001762 Approved 04 22/04/2014 and Expires 22/04/2017.



UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

23/07/2015

Approval Certificate  
New Application

Ethics Reference No.: 307/2015

Title: The role of advanced Midwives in Maternity care working in Tertiary Hospitals in Gauteng

Dear Mbulweni Rhona Luphal

The **New Application** as supported by documents specified in your cover letter dated 29/06/2015 for your research received on the 1/07/2015, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 22/07/2015.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year
- Please remember to use your protocol number (307/2015) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MRChB; MMed (Int); MPharmD.  
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

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 2004 (Department of Health).

☎ 012 354 1677    📠 0960516047    📧 [research.ethics@up.ac.za](mailto:research.ethics@up.ac.za)    🌐 <http://www.healthsciences.up.ac.za>  
📍 Private Bag X323, Arcadia, 0007 - 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Centra, Pretoria

ANNEXURE B2



R1448 Ms Mbulaheni Rona Luphai

**HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)**  
**CLEARANCE CERTIFICATE NO. M150889**

**NAME:** Ms Mbulaheni Rona Luphai  
**(Principal Investigator)**

**DEPARTMENT:** University of Pretoria; Department of Nursing Science  
Charlotte Maxeke Johannesburg Academic Hospital  
George Mukhari Tertiary Hospital  
Steve Biko Academic Hospital

**PROJECT TITLE:** The Role of Advanced Midwives in Maternity Care  
Working in Tertiary Hospitals in Gauteng

**DATE CONSIDERED:** Adhoc

**DECISION:** Approved unconditionally

**CONDITIONS:** -

**SUPERVISOR:** Dr M Yazbek

**APPROVED BY:**   
Professor P. Cleaton-Jones, Chairperson, HREC (Medical)

**DATE OF APPROVAL:** 23/03/2016

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

**DECLARATION OF INVESTIGATORS**

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10034, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.**

R. Luphai  
Principal Investigator Signature

Date 20.04.2016

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

ANNEXURE B3



**GAUTENG PROVINCE**  
HEALTH  
REPUBLIC OF SOUTH AFRICA

MEDICAL ADVISORY COMMITTEE  
CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

**PERMISSION TO CONDUCT RESEARCH**

Date: 8 April 2016

TITLE OF PROJECT: The role of advanced midwives in maternity care working in tertiary hospitals in Gauteng

UNIVERSITY: Pretoria

Principal Investigator: M R Laphai

Department: Nursing services

Supervisor (if relevant): Dr M Yazbek


Permission Head Department (where research conducted): not yet


Date of start of proposed study: April 2016

Date of completion of data collection: Dec 2018

The Medical Advisory Committee recommends that the said research be conducted at Chris Hani Baragwanath Hospital. The CEO /management of Chris Hani Baragwanath Hospital is accordingly informed and the study is subject to:-

- Permission having been granted by the Human Research Ethics Committee of the University of the Witwatersrand.
- the Hospital will not incur extra costs as a result of the research being conducted on its patients within the hospital
- the MAC will be informed of any serious adverse events as soon as they occur
- permission is granted for the duration of the Ethics Committee approval.

  
.....  
Recommended  
(On behalf of the MAC)  
Date: 08 April 2016

  
.....  
Approved/Not Approved  
Hospital Management  
Date: 14/04/16



ANNEXURE B4



**GAUTENG PROVINCE**  
HEALTH  
REPUBLIC OF SOUTH AFRICA

**Dr. George Mukhari Academic Hospital**

Office of the Director Clinical Services  
Enquiries : Dr. PMT. Mabusela  
Tel : (012) 529 3880  
Fax : (012) 560 0099  
Philly.mabusela@gauteng.gov.za  
kedibone.matsimela@gauteng.gov.za

To: Mrs. Mbulaheni Rhona Luthal  
: Department of Nursing Science  
: University of Pretoria  
: Private Bag X 323  
: Arcadia, Pretoria  
: 0007

Date : 20<sup>th</sup> May 2016


**PERMISSION TO CONDUCT RESEARCH**

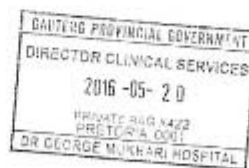
The Dr. George Mukhari Academic Hospital hereby grants you permission to conduct research on "The role of advanced Midwives in Maternity care working in tertiary Hospitals in Gauteng at Dr. George Mukhari Academic Hospital."  
The hospital is aware that you have already obtained Clearance from the University of Pretoria

This permission is granted subject to the following conditions:

- That you obtain Ethical Clearance from the Human Research Ethics Committee of the relevant University
- That the Hospital incurs no cost in the course of your research
- That access to the staff and patients at the Dr George Mukhari Hospital will not interrupt the daily provision of services.
- That prior to conducting the research you will liaise with the supervisors of the relevant sections to introduce yourself (with this letter) and to make arrangements with them in a manner that is convenient to the sections.

Yours sincerely

  
**DR. PMT. MABUSELA**  
DIRECTOR: CLINICAL SERVICES



ANNEXURE B5

Permission to do Research at Steve Biko Academic Hospital

To: Chief Executive Officer  
Dr M.E. Kenosi

From: The Investigator  
Mrs Mbulaheni Rhona Luphal

Re: Permission to do the following research at Steve Biko Academic Hospital

I am working at Rahima Moosa Hospital. I am requesting permission to conduct a study to explore the role of advanced midwives regarding maternity care in tertiary hospitals in Gauteng.

The title of the study is: THE ROLE OF ADVANCED MIDWIVES IN MATERNITY CARE WORKING IN TERTIARY HOSPITALS IN GAUTENG

I intend to publish the findings of the study in a professional journal and/ or at professional meeting like symposia, congresses, or other meetings of such a nature.

I undertake not to proceed with the study until I have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

Yours sincerely

*R. Luphal*

Mrs Mbulaheni Rhona Luphal

Permission to do the research study at the hospital and to access the information as requested, is hereby approved.

Chief Executive Officer Steve Biko Hospital

Signature of the CEO

DR ME KENOSI  
CHIEF EXECUTIVE OFFICER  
STEVE BIKO  
ACADEMIC HOSPITAL

Hospital Official Stamp

2/6/2016  
1 of 1

ANNEXURE B6



## GAUTENG PROVINCE

HEALTH  
REPUBLIC OF SOUTH AFRICA

### CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

Enquiries:  
Ms. G. Ngwenya  
Office of the Nursing Director  
Tell: (011) 488-1558  
Fax: (011) 488-3786  
23 MAY 2016

Sr. Mhulaheni Rhona Luphal  
Department of Nursing Sciences  
University Of Pretoria

Dear, Sr. Mhulaheni Rhona Luphal

RE: **"The Role of advanced Midwives in Maternity Care working in Tertiary Hospitals in Gauteng "**

Permission is granted for you to conduct the above recruitment activities as described in your request provided:

1. Charlotte Maxeke Johannesburg Academic hospital will not in anyway incur or inherit costs as a result of the said study.
2. Your study shall not disrupt services at the study sites.
3. Strict confidentiality shall be observed at all times.
4. Informed consent shall be solicited from patients participating in your study.
- 5.

Please liaise with the Head of Department and Unit Manager or Sister in Charge to agree on the dates and time that would suit all parties.

Kindly forward this office with the results of your study on completion of the research.

Supported / not supported

Ms. M.M Pule  
Nursing Director  
Date:

Approved / not approved

Ms. G. Ngwenya  
Chief Executive Officer

27/05/2016

**ANNEXURE C1**

**PATIENT / PARTICIPANT'S INFORMATION LEAFLET & INFORMED CONSENT FORM FOR A NON-INTERVENTION STUDY**

**STUDY TITLE: THE ROLE OF ADVANCED MIDWIVES IN MATERNITY CARE WORKING IN TERTIARY HOSPITALS IN GAUTENG**

**Principal Investigators:** Mrs Mbulaheni Rhona Luphai

**Institution:** Rahima Moosa Hospital

**DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S):**

**Contact detail:** 0760431166

email:luphaimr@yahoo.co.uk

**DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:**

			:
<b>Dd</b>	<b>mmm</b>	<b>Ivy</b>	<b>Time</b>

**Dear Advanced Midwife**

**1) INTRODUCTION**

You are invited to volunteer for a research study. This 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. In the best interests of your health, it is strongly recommended that you discuss with or inform your personal doctor of your possible participation in this study, wherever possible.

**2) THE NATURE AND PURPOSE OF THIS STUDY**

You are invited to take part in a research study. The aim of this study is to evaluate the role of advanced midwives in maternity care working in tertiary hospitals in Gauteng.

**3) EXPLANATION OF PROCEDURES TO BE FOLLOWED**

You will be invited to participate in a focus group discussion which will take about 45 to 60 minutes in a convenient venue at your work place. Field notes and audio-recording of the interviews will take place.

**4) RISK AND DISCOMFORT INVOLVED.**

There are no risks involved in the study. The information obtained will only be used by the researcher.

**5) POSSIBLE BENEFITS OF THIS STUDY.**

The data will be used to make recommendations for the practice of advanced midwives in tertiary hospitals. There is possibility that the recommendations may influence the policy makers to relook the staffing norms of the tertiary hospitals and also the improvement of the practice of the advanced midwives in the multidisciplinary team.

**6) I understand that if I do not want to participate in this study, I may refuse.**

**7) I may at any time withdraw from this study.**

**8) HAS THE STUDY RECEIVED ETHICAL APPROVAL?**

The study was submitted to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria and University of Witwatersrand and written approvals has been granted by the committees.

**9) INFORMATION**

If I have any questions concerning this study, I should contact:

Researcher: MRS. MR. LUPHAI 0760431166 email: luphaimr@yahoo.co.uk

Supervisor: DR. M.YAZBEK 0825763558 email: mariatha.yazbek@up.ac.za

Co-Supervisor: DR. MATABOGE sanah.mataboge.@up.ac.za

Ethics committee: 0123541677

**10) CONFIDENTIALITY**

All records obtained whilst in this study will be regarded as confidential. Results will be published or presented in such a fashion that participants remain unidentifiable.

**11) CONSENT TO PARTICIPATE IN THIS STUDY.**

I have read or had read to me in a language that I understand the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given opportunity to ask questions and am satisfied that they have been answered satisfactorily. I understand that if I do not participate it will not alter my management in any way. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

.....  
Participant name                                  Date

.....  
Participant signature                                  Date

.....  
Investigator's name                                  Date

.....  
Investigator's signature                                  Date

.....  
Witness name and signature                                  Date



ANNEXURE C2

**INTERVIEW GUIDE**

**Main question:**

"What is the role of advanced midwives in maternity care working in Gauteng tertiary hospitals?"

**Probing questions:**

1. When you hear the word advanced midwife, what is the first thing that comes to your mind?
2. What responsibilities should advanced midwives have in tertiary hospital of Gauteng?
3. What procedures should advanced midwives be allowed to perform in tertiary hospitals of Gauteng?
4. What training role are the advanced midwives having in clinical setting?
5. How are the advanced midwives involved in planning and management of patients care?
6. What good things are identified with the roles of advanced midwives?
7. What are the identified problems on the role of advanced midwives in the multidisciplinary team?
8. What causes those problems in the utilization of the advanced midwives in the multidisciplinary team of the tertiary hospital of Gauteng?
9. How can we resolve the identified problems?



**ANNEXURE C3**

**INFORMED CONSENT FOR THE FOCUS GROUP**

You have been asked to participate in a focus group and the topic is "what should the role of advanced midwife be in the tertiary hospitals of Gauteng".

The purpose of the focus group interview is to try to clarify the role of advanced midwives in tertiary hospitals of Gauteng. The information learned in this focus group will help policy makers to make some evidence based decisions when allocating advanced midwives. You can choose whether or not to participate in the focus group and stop at any time. Although the focus group will be tape recorded, your responses will remain anonymous and no names will be mentioned in the report.

There is no right or wrong answers to the focus group questions. We want to hear many different viewpoints and would like to hear from every one. We hope you can be honest even when your responses may not be in agreement with the rest of the group.

To respect each other, we ask that only one individual speak at a time in the group and that responses made by all participants be kept confidential.

I understand this information and agree to participate fully under the conditions stated above.

Participant's name:.....(Please print)

Participant's signature.....Date:.....

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I Mbulaheni Rhona Luphai, herewith confirm that the participant above has been fully informed about the purpose, benefits, nature and the expectations of the study.

Researcher's name: MBULAHENI RHONA LUPHAI

Researcher's signature:.....Date.....

Witness's name :.....( Please Print)

Witness's signature:.....Date.....

**ANNEXURE C4**

**INFORMED CONSENT FOR THE AUDIO-TAPING**

You have been asked to participate in a focus group and the topic is "what should the role of advanced midwife be in the tertiary hospitals of Gauteng".

The purpose of the focus group interview is to try to clarify the role of advanced midwives in tertiary hospitals of Gauteng. The information learned in this focus group will help policy makers to make some evidence based decisions when allocating advanced midwives. You can choose whether or not to participate in the focus group and stop at any time. Although the focus group will be audio-taped, your responses will remain anonymous and no names will be mentioned in the report.

There is no right or wrong answers to the focus group questions. We want to hear many different viewpoints and would like to hear from every one. We hope you can be honest even when your responses may not be in agreement with the rest of the group.

To respect each other, we ask that only one individual speak at a time in the group and that responses made by all participants be kept confidential.

I understand this information and agree to participate fully under the conditions stated above.

Participant's name:.....(Please print)

Participant's signature.....Date:.....

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I Mbulaheni Rhona Luphai, herewith confirm that the participant above has been fully informed about the purpose, benefits, nature and the expectations of the study.

Researcher's name: MBULAHENI RHONA LUPHAI

Researcher's signature:.....Date:.....

Witness's name :.....( Please Print)

Witness's signature:.....Date:.....

ANNEXURE D

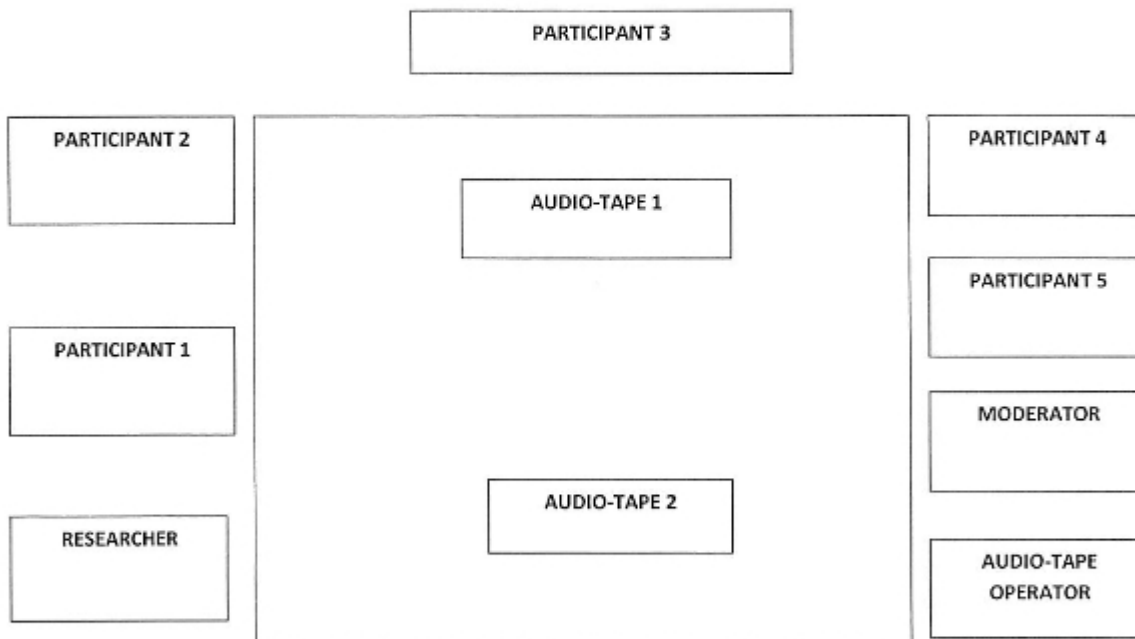
VERBATIM TRANSCRIPT OF ONE FOCUS GROUP INTERVIEW

INTRODUCTION

*The researcher welcomed the participants and introduced self, moderator and the audiotape operator.*

EVERYBODY INTRODUCED THEMSELVES

Sitting position of participants, moderator, audiotape operator, audiotapes and researcher



Moderator: Ok, so the first central question which Rhona want to know is: "What is the role of Advanced Midwife working in maternity care in tertiary hospital of Gauteng". You are working in tertiary institution so when you think of the word 'Advanced Midwife', what comes to your mind? Who is a midwife? What is she all about? Who would like or want to start?

Participant 5: Ok I will like to start, Oh well first thing that comes to my mind is that the word advanced is talking about the high level of expertise, when they say you are advanced it means you are able to perform beyond the normal , so an advanced midwife which means is a person who is a specialist in the midwifery center.who is expected to perform you know a little bit better than a just registered midwife so which means my performance, Oh you know the way I cater for my clints it has to be advanced, you know you also looking at the ESMO which is the essential steps of managing emergency cases for an advanced midwife is more like the same. If I am an advanced midwife I will be performing better, and then a registered midwife will be going for ESMO just to know equal my level but is just that with me I have got a national diploma so which means I expected to work independently and I need to excel.

Moderator: Ok anybody else to add on what( participant 5) has said?

Participant 2: Positively she said it all – (group laughter)

Participant 3: I should also want to add on what she has said it the role of advance midwife in cases in eh like in rural places where there is shortage of doctors she has to step in as a mini doctor so to say because she has to make decisions on how to manage a particular patient and should there be a need in delivering such cases she has to co to-to be there to assist the delivery, and if there is in level1 hospitals she can actual phone there even the other level of care to-to to notify the current situation they are dealing with at that moment and she could also be in a position to-to to-to help co-ordinate or to-to engage the subordinates in research on continuous bases so-so to minimize litigations other problems arising in the institution.

Moderator: So what you finished saying to me is that especially in the rural area that is the independent function. Participant 5 the independent function within the tertiary education system when you find yourself, lets elaborate on how you see your role in this situation.



Part 5: Can I take over? Can I talk to you before I, please can I? Well in being in tertiary institution you know my role as advanced midwife in tertiary hospital I have to act vigilantly reason being that sometimes it happens in our units that there is no doctor around. You know so now the whole responsibility lies with me in terms of-of eh-eh of advocacy okay and then how I disseminate the message to senior people you know. If there is anything with the patient, so in a tertiary institution we are working hand in hand with doctors is something which can be left out like we are working hand in hand with the doctors because we are a central institution so I cannot see and manage patient and make final decision. The final option lies with the doctors in the central institution but during that moment or at that moment when doctor is not there I am able to rescue the patient because subordinates rely on me and my expertise.

Moderator: Anybody else?

Participant 3: In the tertiary with me I see the, the role of advanced midwife limited in the sense that they we-we rely mostly on doctors decision as much that at the end of the day the skill that you are to practice for instance to do vacuum you-you ( it falls off) because there is no practice at all like you cannot stand and say I can do it even if you see the need because now the doctor has to come is, so I per se as an individual I feel if we were given a chance even the number of c/section case will not be there if they can say let the advance handle up to –to this point.

Moderator: Anybody who would like to add on?

Participant 5: Well adding on, I don't know if I to differ with what participant 3 has said. We are still having MOU (Midwifery Obstetric Unit) which are level 2 and 1 that are still operating with Advance Midwife yah but we are having high number high rate of c/section with patient referred by them to us by them. I wonder if really the c/section (caesarean section) rate will reduce, I don't know I am just thinking in one way. Right now we have got MOU may be it will be possible but we still have got MOU but still having lots of patients referred to us and they end up with c/section

Participant 1: The MOU's are not taking decisions they just refer the patients to tertiary hospital. Even us we do not have much to do because the doctors are around and the patient is taken over.

Moderator: In other words the doctors take over the patient so the decision is taken over by doctor, is that what you are saying?

**Participant 5:** Yah actually let me explain the referral system, you know we have got our national guide lines which means what is practiced in (Tertiary hospital name mentioned) is what is practiced in (level 2 hospital name mentioned )or (Other tertiary hospital name mentioned). So now if in level 2 hospital they are seeing a patient and they-they with their findings there are some complications which cannot be managed by level 2 hospital that patient will be discussed eh by the doctors or midwife on the other side from level 2 phoning the level 3 which is central institution talking to the registrar I feel sometimes is a little bit of a dilemma because doctor is not with patient as he cannot say don't bring the patient and on the other side the midwife is uncomfortable, she feels patient must be in the tertiary hospital. We are at locker heads because of that sometimes by the time patient arrive patient already delivering meanwhile it was said it is prolonged second stage so that is the referral. With the referral system there is nothing we can do as Advance Midwife as they are accepted by the doctors.

**Participant 2:** Yah to add on that even those other patients who are being referred from level 2 of MOU when they say come this side there are some doctors who do respect the Advanced Midwife's opinion you can assess and say let us deliver this patient but there are those who feel uncomfortable in to rely on Advanced Midwife and they end up just cutting the patient.

**Moderator:** So lets us move on, what is your responsibilities in this situations here as an advance midwife? **Participant 1** I think you are too quiet (group laughter)

**Partner 4:** (Laughter), mmm I think the biggest thing will be advocate. Yes because during our training our training you are trained some of the things like you are trained to deal with some of the complication that are most of this pregnant mothers become with so you have an idea even if you are not allowed to prescribe the management of the patient but advocating like for instance if you have got a patient that is presenting with a certain problem and you see like doctor come like mismanaging the patients your biggest role basically be advocating for the particular patients.

**Moderator:** So advocacy is your role (participant 1)?

**Participant 1:** Sorry about that, ok concerning the treatment as a midwife I have a responsibility, I have the right to give my patients sedation if in pain so I can give, then doctor will come and prescribe after giving.

**Participant 5:** Yes mmm why because we have a guideline that is covering us that we can administer then doctor will come and prescribe after.

**Moderator:** That is part of your interdependent functions?

**Participant 5:** Yes that is our interdependent function. Assessing because patients you know on arrival from different institutions we are the first people to screen and assess, yes and then you know after documentation and everything then we advocate that doctor here is the patient presenting with one , two, three then doctor takes over. If patient is dire emergency also is my responsibility to advocate for the patient.

**Moderator:** Explain a little bit on that.

**Participant 5:** Leadership you know taking charge you know like for example let's say maybe today I have four on duty maybe two Advanced Midwives, one of them has to take charge-ship so that they should be able to consult. Yes be like juniors should be able to consult to Advanced Midwife there is also delegation with leadership that is delegation of duties. Screening and scrutinising patients individually as you do your courtesy rounds so that you are able to see if there is a patient who will need emergency care, you will delegate let's patient is sweating in labour you will delegate somebody to take care of the patient and you continue with your courtesy rounds.

**Moderator:** Participant 3 can you say something?

**Participant 3:** Teaching

**Moderator:** Can you tell us more about teaching role?

**Participant 3:** The Advanced Midwife is there to be a role model eh where she has to teach the students eh even some intern or doctors about conditions eh with the knowledge that she has

**Moderator:** Is it like teaching on the spot or do you have specified periods for teaching?

**Participant 3:** Like I will give example, every day in the morning when doctors are doing rounds there is one allocated to take rounds with them, the other one will be allocated maybe to be with a nurse allocated maybe to give the topic on breastfeeding or wound care then you are there to rectify if the information is not sound.

**Participant 5:** And also having like we having as Advanced Midwives we need not be allocated we need to take charge to take that responsibility of mentors and then selecting our mentors and then selecting our own mentees and –and to do that follow up for the outcome, that positive outcome. It also help



**Participant 2:** As tertiary hospital we do have students here, we have got nursing students and medical students they are there all the time. We usually find ourselves teaching doctors ourselves because doctors they are busy with patient and medical students come up to you as a midwife to teach them everything. The only thing we are deprived from is the practicing the thing but we only teach them theoretical skills

**Moderator:** And no practical skills?

**Participant 2:** No like in the labour ward we do basic things done by ordinary midwives. The things which need to be done by Advanced Midwives like vacuum or assistant delivery is done by Reg (Registrar)

**Participant 3:** We do teach them to do the basic deliveries

**Participant 2:** Sometimes registrars with lack of knowledge we end up teaching them and showing the skills

**Moderator:** There is also time of teaching those advanced skills?

**Participant 3:** But not on regular basis but even the Reg (Registrar) who are not skilled you end up showing skills to him.

**Participant 5:** There is also facilitation of standards in order to improve the quality care. There for example you know if we got litigations incidences is important to sit and have a nurses m & m, mortality and morbidity infect we do have it on monthly bases, nurses mortality and morbidity meetings, you know just to sit, discuss and explore how best should we have managed this case or handled this case.

**Moderator:** Can you elaborate who is present in this meeting?

**Part 5:** In the meeting is our assistant director, is the one who is co-ordinating and the we have got m & m eh nurses m &.m committee, like with us we are amalgamated mother and child , like is obstetrics and paedics (paediatric doctors)we are together we have got one assistant director, she is the one who is co-ordinating the whole m &.m(mortality and morbidity) . Like we select, like we are presenting, we are to choose the file to be discussed or which case you going to present, sitting in is all different category of nurses.

**Moderator:** Is there other categories like medical staff, social workers that attend?

**Part 5:** No that one, we only do it with the m &.m by the way what is that meeting? O& G is combined meeting we have it on monthly bases meeting and we have it monthly, it is a combined multidisciplinary meeting there everyone is represented

with surgical and support staff. Surgical side infection that One all of us attend, with nurse m & m we invite other hospitals and clinics to attend as reach out but as such they were not attending. There is another m & m which is both medical and nursing meeting which is held every Wednesday. We had one today and sometimes (hospital name) staff join us.

**Moderator:** Facilitation of standards is very important

**Participant 4:** I also think our hospital is taking part in research and conducting research ourselves remember sister said we are to keep updated as specialist in midwifery field you are to do it through research

**Moderator:** Are you doing research as individual or are you involved in any research?

**Part 4:** Not really per se but as an advanced midwife you are expected

**Part 5:** But on that again we are doing this CPD(Continuous Professional Development) portfolio that is also helping which you cannot miss much because it have everything, because it has got everything you have to attend and accumulate points and that is also helping, we focus more on ethics and area of practice the institution that is staff development they give us yearly program with all the topics and it is up to the individual to attend, we have got also clinical facilitators in different discipline, so is well planned and well conducted, because information as academic we are dwelling much in teaching because that very critical part as if we lack knowledge we cannot be able to do intervention. Always say we take study leave but cannot change our attitudes and character it is still something to be re-enforced

**Moderator:** I will also like to probe more, your training role is focus on students, is focus on keeping up standards and

**Participant 5:** It also focus on patient, that is why we do health education and we have got our health education book because we do courtesy rounds you are , is part of teaching as well. When doing courtesy rounds you want to check on the wellbeing of the patient in the therapeutic environment where they are at the moment. Yah but at the same time you know you can teach them about breastfeeding, that is what we are re-enforcing as a mother-baby friendly initiative and then like you know like for my unit specifically I am that side of the maternity admissions and we teach about wound care and perineum care. Teaching is mainly for patient, patient also is our main focus is mainly teaching. That is why we are to be knowledgeable in order to improve standards. That is why we are going for training so that we can provide

Participant 3: I am having a different one is about control, we control budget and supplies in so much now of late even so is questionable we are always out of stock and then look at what courses that is mismanagement, or misuse of resources for example in the hospital we do not have agency staff, but you will find that management of-of-of-of allocating staff on a particular shift is sort of imbalance, you see more staff on the other shift affecting other shift and you see now those who are short staff having a problem of absentism. Now it comes back to how we, we manage mmm what is it staff allocation. Resources you see one-one doctor or personnel having to do PV (per vaginal examination) opening this glove throwing it away, opening this glove throwing it away and you are just standing there as a leader and not saying anything. If you are maybe a shift leader you are to say let's minimize cost.

Moderator: So do you as an advanced midwife you feel you have to act?

Participant 3: Not only advanced midwife is for everybody, but we must have that knowledge to say let us minimize cost.

Participant 5: The saving is a challenge for advanced midwives to say let us to optimizing resources

Participant 3: Though is a big challenge we are the hospital having equipment every year is trying is buying equipment's, more advanced equipment's, so if there is no one to come for in-servicing even if we go for in-service people tend to have that attitude of negligence so no one takes the ownership of saying this is our equipment, so we end up having unused equipment's that could be used for-for-for some years to come, but because of negligence machines are just standing.

Moderator: Now is negligence to the doctors, nurses or who is responsible?

Part 3: We are all trained. the managers will-will organize the what is it, in-service but ultimately it stays with the nurses, people, the users because when we want to know why is the machine not reported there is always the thing of I do not know or it is not me.

Moderator: Are you talking about the break ager? So it is not utilized properly or it is just wear and tear? What are you talking about you?

Participant 5: No exactly she is trying to like explain the way we as staff both medical and nurses handle the equipment we cannot push the machine with cord hanging on the floor. People get paid to come and in-service. Worse with



obstetrics assets you know they are very sensitive for example if you drop transducer they detach easily which is about nine thousand. If it starts regaling it is out, it is both doctors and nurses. Doctors do not but if you find them pushing the sonar machine around oh my God, I don't know how many times it is sent for repair. With us in maternity admission like we are working like casualty if one machine is none functional the waiting time is already affected. You can imagine for a day if you have got 50 patients and you have got 2 not working, you will have will had to see quality assurance to explain why patients was delaying, patients will complain that they were in the unit for 6 hours. It's is frustrating as midwives.

**Moderator:** What procedures must the advance midwife allowed to do?

**Participant 1:** Assisted deliveries like vacuum and forceps

**Participant 2:** Even delivery of breech presenting because you observe the patient and assess that this baby can come out, but the doctors will come and say patient is going for c/section, doctors do not want to take risks. The doctor is final decision

**Moderator:** What about forceps and vacuums, you are not doing anything?

**Part 3:** According to my time where I was training we were told by our tutor we are teaching you the skills to have it and to practice, if you are not sure how to do it don't and I am sure people are holding back to say I do not want to be the victim. If you can ask individually you will find some of us know it theoretically, but in practice they cannot do it.

**Moderator:** So you lack skills still?

**Part 3:** Yes I will also want the advanced midwife to have that skill be emphasis of doing the sonar so as to identify these problems because we are having the introduction of doing sonar but practically we do not do it at all.

**Moderator:** So that is the doctor that is doing that?

**Participants 1, 2, 3, 4, 5:** Yes (as a group)

**Part 5:** You know with that it is taking us back to waiting time you know if I know how to do it will be easy I will not say to the patient wait for the registrar who is still busy in theatre.

**Interv:** So that is your need from your training?

**Participants 1, 2, 3, 4, 5:** Yes (as group)

Participant 3: The other one will be to assist, to be an assistant in operating theatre if that is allowed for us to assist because you find that maybe they were doing delivering of breech or transverse because in this hospital the theatre sister are just theatre trained, you as a midwife but standing there, you have the work you are a boundary away. If you were assisting you might say don't turn the baby to this position because the position is already a problem. Mother will end up bleeding

Moderator: In other way what you are saying with your advanced knowledge it will be of benefit for the patient if you assisted in theatre?

Part 1, 2, 3, 4, 5: Yes (as a group)

Part 5: It will minus one doctor who can be needed in the other area. When assisting there they are just holding there.

Part 2: Theatre sisters don't even suction the baby

Part 3: Theatre trained sisters just hand the instrument and they are not vocally active in the procedure and you are just standing there at a boundary waiting for this poor baby who can come out with APGAR of 1.

Moderator: Ok what else? What other procedures are you allowed to perform? Anything else you can think of?

Participant 3: I think we covers

Moderator: lets then move on to how are you involved in the planning of nursing care: the management of your patient care?

Participant 4: whispering- lets sister (participant 5) say

Moderator: participant 5 is doing lots of talking can you talk, let's start with participant 4. She is very quiet

Participant 5: For the sake of the time let me rescue. You know our responsibility we are given full responsibility and I-I am quite satisfied with that is just that something we are under using it or under-utilizing our responsibility, yes because like I will always refer to our set up in our unit when patient, all patients that are arriving we are the first people we are first contacts as midwives to assess you know triage or screen and vital signs and do everything and plan, by the time the doctor comes to see the patient I have done almost everything for the patient, that what sister (part4) was explaining. Even with administration of some medication you know we do everything

**Moderator:** As you assess, you plan, you diagnose according to the nursing plan?

**Participant 5:** mmm-mmm, yes like for example we are seeing a patient with high blood pressure we have got the guide line which says if the blood pressure is this high you know you give, may be adalat stat then you will give and even document, you know given as per protocol you know but doctor still to prescribe. Yes so I feel we are given full responsibility on that. If a mom comes and she is in labour you know I take history, I do everything, I do my assessment, I do my vaginal examination, you know I plot the patient. If the doctor is still busy and caught up somewhere if the patient is in active phase of labour I push the, her straight to the labour ward, I have got the authority to do that, and the doctor will follow the patient up in labour ward but I know the patient is in good safe environment, we are given full responsibility you know especially with us in maternity admission ward, because we are a casualty I am quiet happy with that.

**Moderator:** probing participant3?

**Participant 3:** Hey even with us in the labour ward we are given the responsibility because we do admit you know, when the patient comes I do admit the patient, manage patient progress the whole labour until I discover something that needs the doctor's attention that I can go and call the doctor that I am worried about this thus when the doctor comes in.

**Moderator:** Just to come in there, who does the delivery of normal delivery?

**Participants 2 & 3:** the midwives

**Moderator:** So you don't stand back for the interns?

**Participants 3 & 4:** no we don't.

**Part5:** Even with the suturing of episiotomy we do not wait for the doctor.

**Participant 4:** The only problem that I think is becoming a challenge is when if something can go wrong may be you are faced with fully dilated breech patient and the baby was coming out and get stuck and the baby becomes FSB( Fresh steal birth). There then that is when it becomes a problem because they will say why didn't you call the doctor? And when you look at it the patient was fully dilated and pushing, the doctor may be was in theatre. **Participant 2:** You have just to report to the doctor for accountability that there is a breech delivery. Even if you can deliver the case at least you have told the doctor that there is a breech.

**Moderator:** Who will like to add here on planning and execution of care?



Participant 4: M&M, I think as they have said its its we are given that opportunities, though there are some you know individuals people or certain doctors or yes, that will say let me give an example: a diabetic patient ,why do you continue with the sliding scale when this women was gestational, what you take on this as she was gestational diabetic? Why do you want us to continue giving insulin? I took it from my Reg(Registrar) as she want us to give insulin when the when the hgt is 4. For me the hgt of 4-6 is normal, why do you want to give insulin on my side I won't give but the other nurse as it is prescribed she will give. For me that is the thing which needs clarity and it needs advocacy but treatment per se we are given that responsibility

Moderator: So what good things do you think is there with regard of Advanced Midwives?

Participant 5: The good about it is that mm you are knowledgeable, you are more confident even with your patients or clients you know with the execution of whatever intervention you know you can do it without fear of going to the council or being charged because you know whatever you do or implementing you have knowledge and what else money-wise salary is also is good. I am being honest because if I don't say it they will not say it. You know salary wise we benefit. Ja we benefit because previously midwifery used to be so over-looked, when when you say you are a midwife ah they ah but now they can even pay attention. But this days everybody want to do advanced midwifery but it's not may be about money but at least we are being acknowledged you know when our profession is acknowledged is something else you know eh I some-thing pushing other people to say come come-come with education, come and do it but passion is the most important part, passion, not money thing because when you are passionate with what we are doing then we are able to-to preserve life, you know yes.

Moderator: (participant 4) what is good?

Participant 4: Eh the fact that you are allowed to function independently because you are a specialist in that field i think that is one thing that is good about advanced midwife.

Participant 5: And being a consultant you know local clinics are phoning and consulting with you.

Moderator: Aha is that good? Oh is a nice feeling? (everyone laughed)

Participant 5: Yah you know i know normally they phone when they have got a challenge as they have challenge with Caesar (caesarean section) wounds as



they are not used to Caesar (caesarean section) wounds so they will phone to say you think i can remove the stiches or leave it for some days I was even talking

Moderator: So what I am picking up is that you are enthusiastic?

Participant 5: Yes very much, very much, very much, very much (moderator) they know a ke re le a tseba (group laughter including moderator) very much enthusiastic. That is why even with litigations you just cancel your juniors that they don't condemn themselves it is very said you don't want to lose babies, you don't want to lose mothers, we do not want to see patients complicating when we can prevent it, you know that is how passionate we are.

Moderator: Ok we have touch on a few problems that we have identified with your role, who will like to elaborate on problems still. Basically what you saying is that you can work up to certain place with patient care you stop. The other thing you identified is the misuse of resources and supplies any other problem regarding your role?

Participant 5: Eh shortage of-of human resource, eh shortage of-of human material resource is a huge-huge frustration I am talking from experience. Ya, like right now in terms of staffing norms there is one thing that we have realized that you know with the staff who has resigned it may benefit seven month to get replacement. by that time you are counting so many incidences of shortage of staff. You know its-its a huge frustration to the staff now. So the little that we have they try their best that they end up getting very much strained and they become very much spelled out to an extend that they want staff rotating and if they rotate it means you will be remaining with new people. Is quite frustrating

Moderator: So that is the problem?

Participant 5: yes a big problem and then staff magnet is not so good according to my assessment, you know my or observation ya(yes) that you like we are using training as part of the the magnetic neh, or of to keep staff or staff retention but it does not work so well for the company or the institution, because the very people you are training or who you are training when they come back they just serve three months and they move on you know, is like you always have to get people train them they leave eh you get new ones so it is quite draining, to an extend that you sometimes run out of the innovations you know you can't be innovative any more. Because all the measures you have put in place you still not winning. You know the shortage of material resources as well is-is-is-is-is a serious frustration especially with essential items because if they are essential you need them in the institution. You cannot run the unit without celestone because what are you going to do with all preterm labours that are coming. Are

you saying they are going to end up with early neonatal death or fresh steal births. Equipment as well is a serious problem, gloves as we have said, we are not saying currently they are not them but just picking on them as they are most essential, I am doing vaginal examination continuously you know, k-y jelly as you cannot do vaginal examination without k-y jelly. Ya shortage of human and material resource is a huge frustration

Participant 4: I should also say I *don't know if this is a problem or concern. The replacement of the advanced where should they be placed should they be placed in the labour ward only or what is the maternity mm definition saying? Are we to be spread in all the areas or locally focusing on labour ward and admission placement only?*

Moderator: What is currently the situation?

Participant 5: Currently advanced midwives are placed in fact they are more placed in labour ward and maternity admission. Reason being that the maternity admission is the entry, patients are starting from admission, we manage them, we stabilize them, we bring to labour ward and we send to different unit so i feel the way they are placed for now i feel is fair enough

Moderator: Sufficient?

Participant 5: E-e not really sufficient why because we cannot stop the ones are resigning, so you place them within three months four has already left so you are back to square one. Ya(yes) you know so in-in-in-in antenatal clinic there are more advanced midwives as well you know the way things are done, mm cause patient end up in my unit is like we cannot do anything here because we are a clinic here. Patient is delivering somewhere in the matro bus but i have to be called to come and rescue when I am 15 minutes away, antenatal clinic is within reach, but we have got advanced midwives at the clinic.

Moderator: do you feel they are not optimized?

Participant 5: No I don't know but I am trying to answer what (part4) has said, we can be placed anywhere, but we are going to-to be productive as expected, I feel I should not be running to the care to rescue where there is an antenatal clinic there when they are called, call maternity admissions. I always feel one has to run rescue then call for the wheelchair guys but at least the mom and the baby are all safe, we are all having the experience to do it we are specialists you know.

Moderator: So it is not happening? In other words you are saying that is not happening. Even though we have got advanced midwives it is not happening.

**Participant 3:** Even in the post-natal like you find the nurses who are working there or may be the sutures coming out or patient PPH(post partum haemorrhage) they will call the advanced midwives to come and manage.

**Moderator:** In other words there are no Advanced Midwives in post-natal?

**Participant 5:** No they are there but they will still call the labour ward to come and manage actually what is happening is that we as advanced midwives we are creating our own demarcation that are not necessary, and we end up forgetting that we are there for the patient.

**Moderator:** Basically what you are saying that even though nurses are in antenatal and postnatal they are not utilizing their skills?

**Participants 1, 2, 3, 4, 5 :** yes(same time)

**Participant 5:** Others are holding back, they are there you know now we are talking politics is n't it? Yep(that is right)

**Moderator:** But it is important because it is a problem

**Participant 5:** But it is a problem you know we are placed in areas you know even last year before(dr so and so) left celestone you know we have patients with previous preterm labour, obvious you don't want them to end with preterm labour again. Patients are having prescription and they coming for subsequent visit. There are advanced midwives in that area but they will come and que in admission office to be given celestone, patients will go and get celestone in pharmacy and come and add que in admission unit.it was the big issue even if the doctor was saying how about you guys give first dose and the other dose given in the clinic.it was big issue i think they even wrote petition concerning that.

**Moderator:** But what is causing that problem why are they holding back on those skills?

**Participant 5:** That is what I am saying, when you are in a certain area now you want to be in comfort zone and everything nje you want to block. We need to be flexible, with us we want to get rigid with with protocols in such a way that even if the patient is here I can't say take the patient to (next ward) stabilize the patient, put up the drip before you send the patient to me. That is why there are emergency trolleys in all the wards.

**Moderator:** OK let us have a look at problems in utilization of Advanced Midwives in the multidisciplinary set up. Is there any problem that you are experiencing



because i know that you are part of the team. We have got doctors, social worker, interns and other registrars

Participant 5: No I can't say that there is any as anyone is doing her job, like you find patients with social problems you refer

Participant 2: I don't know because in the antenatal ward some of the doctors are so reluctant to take advice from Advanced Midwives. The doctors are always rotating. I don't know whether they don't that you are an Advanced Midwife like even when you say call the Reg (Registrar) you can see like when you say can't I do it like this they will take a long time, dragging and even delay patient management.

Participant 5: I understand mostly with new interns they are from different disciplines it does not mean because we are double checking PV we are taking their qualifications, I was talking to the other one yesterday that we are as a team you depend on us and I depend on you, let us say I don't check the PV and stay with the patient the whole day, who is 2 cm and the following day the Reg do PV and say the patient is not in labour. Now I sit with the patient who is sobbing and crying, how can I let the patient leave the ward and the following come to quality assurance and lodge a complaint and appear in quality that I allowed patient to leave the institution crying. I am to involve quality assurance I always let us call the consultant to be covered. That is why the head of the department always say let us work as a team to explain that sometimes they are reluctant, Even in m & n today it was emphasized that let us work as a team, both nurses and doctors.

Moderator: How can all the problems that you have identified be resolved. I think you have now mentioned that doctors are reluctant and the best way is top down approach that is it comes from the top. What about the problem with human resources especially with nurses leaving?

Participant 5: With human resources you know it already escalated even with material resources those which are out of stock we need to communicate with area manager so that they can communicate with the assistant director for the stores or different stores you know to see what is the delay. in most of the cases they will be telling you that most of the stock is getting stuck in Auckland park, you the one or the other company is not paid. On the floor with the patient, you cannot say to the patient the hospital is owing money to the company you know ya. All those problems have been escalated to the seniors or top management.

Moderator: And the shortage of staff as well?

Participant 5: Shortage of staff as well you know, even last week we were discussing it. It is like we are depending more on the midwives that are doing midwifery, the diploma midwives. They come back as awaiting results, it is like we are relying on them and when come they are not yet registered so they still have to be under supervision, you still have to be under supervision, you still have to be counter-sign on them. It is too much and it is overwhelming. I do not know if they are taking the 'walk ins'. Last week I saw staff nurse from outside the hospitals asking for directions to the HR. I do not know if they are taking them. Staffing norms is a serious issue, the management is aware and they are dealing with it but midwifery is more affected because of more staff members leaving because of litigations. You feel threatened in your own profession. Even if you do your best you still accountable for the doctor and that is quite demoralizing.

Participant 4: Taking us back to years back we use to ha shortage of staff but it was complemented by agency staff but now it was stopped but is it for the budget or what? But should consider if it can step in while advertising the post.

Participant 5: That was proposed also (participant 4) thank you for raising that ya, we proposed it also. Right now we are depending on hospital OT (over time) now because of none payment. ICU( Intensive Care Unit) is surviving because of the agency. That one really, really is frustrating for the manager. Sometimes I want to go off at four (16hoo), I cannot get someone to work until I get someone and end getting stuck in traffic, tomorrow and find the unit full of patients waiting for 2 days because of shortage of beds. Sometimes extended waiting period as sometimes extended waiting period as sometimes extended waiting period as sometimes patients wait for 3 days waiting to be cut but we still smile.

Participant 3: I don't know if it is practical if-if-if there is chance the patients can be rechanneled those who are not referred back those who are not complicated to reduce the work load.

Participant 5: Well with that one you know last week in our multidisciplinary meeting with the head of department,(dr so-so) was proposing and was even discussed in national level. For instance patient is postdate in the (lower level hospital) and the patient is 6cm dilated, why must the patient be referred because the patient is in labour, keep that patient and progress labour, like he was also referring the patient but, but up to now it is on hold.

Moderator: Anybody who will want to add something?

Participant 3: The shortage of staff if we could have but they are trying in-service on staff attitude so that maybe they can work on what is sending people away. Sometimes is not the fear of losing your profession but is what you get in to the

system which is pushing you away, sense of not being recognized even if you are even doing an extra mile ke ore( it means) there is no way or nobody sees it. I am sorry I am not offending her but to have managers that could support us maybe we could have less people leaving .Maybe to do exit interview.

Participant 5: Exit interview are done at the moment.

Moderator: Maybe to take up whatever has been said in exit interview serious.

Participant 3: The other thing it is happening in level1 and 2 hospitals, the retired nurses even if they can do 7-4 but they are experienced with the delivery. Maybe if they can assist in the labour ward.

Participant 5: Interns of what you know the statement which part3 has just said about managers support i am sorry I was not supposed to be here they were supposed to be on their own but unfortunately we could not get the other person. I will talk the side of the managers the other thing as managers we try managing staff with different characters is very difficult. We have got support system of referring the employee wellness clinic in wellness clinic .she is an experienced old social worker who maintaining confidentiality. I don't remember sending a staff and it is said something was said from that clinic that the only thing is that we as staff remember stigmatized it and we don't want to utilize it. I am just pointing it out for example if I know (Sr so-so) has got a problem of absenteeism I rather refer instead of going to labour relations

Moderator: Thank you so much the information you have made, I think Rhona got a lot of information which she will compile report which will also help us.



**ANNEXURE E**

***Suzette M. Swart***

***FULL MEMBER: Professional Editors' Guild***

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27 January 2017

**TO WHOM IT MAY CONCERN**

I, Suzette Marié Swart (ID 5211190101087), confirm that I have edited the noted Master's thesis. The accuracy of the final work is still the student's own responsibility.

**STUDENT:**

Mbulaheni Rhona Luphai

(Student number: 13418387)

**TITLE:**

THE ROLE OF ADVANCED MIDWIVES REGARDING MATERNITY CARE IN TERTIARY HOSPITALS IN GAUTENG

**The edit included the following:**

- Spelling
- Vocabulary
- Punctuation
- Structure of proposal
- Word choice
- Grammar (tenses; pronoun matches; word choice etc.)
- Consistency in terminology, italics etc.
- Sentence construction
- Suggestions for text with unclear meaning
- Logic, relevance, clarity, consistency
- Checking reference list against in-text sources

Thank you

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