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TOWARDS A PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE: A COOPERATIVE INQUIRY RESEARCH APPROACH

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DECLARATION

I, Pricilla Matholo Jiyane,

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declare that:

"TOWARDS A PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE: A COOPERATIVE INQUIRY RESEARCH APPROACH"

is my own unaided work and has not been previously submitted by me or anyone at any other university. All efforts to acknowledge sources used in this study were taken.

_____ _____

Signed **Date**

DEDICATION

In loving memory of:

- My grandmother, Emely Nkepile Thathane, you raised me up with love.
- My mother Mable Mphoko Thathane and my only sister Monica Mmatseleng Bogopa.
- My uncle, Zacharia “Lekgowelammasetlhage” Thatane and my brother Henry Seromo Puna Moroko your memories will be for ever cherished.

I further dedicate this work to the people whose inspiration I felt in my quest to pursue the dream:

- My husband, Motswaledi George Jiyane
- My elder son, Tshepo Solomon Jiyane and my daughter in-law Lesego Cecilia Jiyane
- My younger son, Modige Jacob Jiyane and my daughter in-law Mavis Jiyane
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ABSTRACT

TITLE:

TOWARDS A PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE: A COOPERATIVE INQUIRY RESEARCH APPROACH

Towards a professional value-driven midwifery: A co-operative inquiry research

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Introduction: Midwifery is a highly ethical profession and often referred to as one of the oldest professions. Midwives are at all times expected to observe and apply professional care in their interaction with women during childbirth. Despite this, there is a growing belief that there is generally low ethics and care is deteriorating in midwifery around the globe. Midwifery is a highly specialised value-driven clinical field performed by skilful individuals, the midwives. It is a unique science (Jiménez-Lopez, Roales-Nieto, Seco and Preciado, 2014:79) and the art of nurturing which is composed of scientific acts or procedures which relate to the care of the woman and the expected baby in the course of pregnancy, labour and the postnatal period (International Confederation of midwives, 2011).

Objective: The objective of the study was to develop strategies to empower midwives regarding professional value-driven midwifery care and to engage, enhance and equip midwives with necessary skills to implement the value-driven care during childbirth.

Methodology: A Cooperative Inquiry (CI) approach was conducted in a maternity ward of one public hospital in Mpumalanga province. The CI intended to promote collaboration, democratic

participation, partnerships, mutualism, joint-decision making and sharing among the participants. Purposive sampling was used to recruit the midwives and to encourage their participation. Midwives played a dual role as participants-researchers of an existing problem that required their active participation to solve a problem in order to improve service delivery in their own setting. Midwives became the only category which was actively involved in the Planning, Action, Observation and the post-cycle Reflection of the phases except for the pre-cycle Introductory phase of the study only.
The study was conducted in four phases namely the Introductory, Creation, Implementation and the

Evaluation phases which were further subdivided as follows:

Phase 1: The Introductory phase

This phase was threefold and was subdivided into: The Preparatory phase, stage 1, which involved gatekeeping into the setting, the Reflection phase, stage 2, wherein the 1st Reflection took place as the Hand Diagram image exercise and the Reflection phase, stage 3, which occurred as the 2nd Reflection phase in which a Nominal group technique (NGT) was conducted

Phase 2: The Creation phase which comprised of the Planning phase was achieved by conducting three focus group discussions. Phase 3: The Implementation phase took place as the Action phase and that is where the actual strategies were developed. The final phase was Phase 4: The Observation phase which led to the development of an audit tool for respectful midwifery care towards the admitted women.

Findings: Five themes emerged from the study as: 'providing quality midwifery care to the women during childbirth', 'preserving the holistic well-being of the women who undergo childbirth', 'upholding professional practice to improve midwifery care', 'maintaining ethical midwifery care and 'outlining barriers towards professional value-driven midwifery care'. The integration of these themes was used as a source of information to develop strategies which promote value-driven midwifery care.

Conclusion: The study gave the midwives an opportunity to become change agents, develop new skills and tools which they will continue to use post the study to ensure that value-driven midwifery care is implemented and sustained. The study will also benefit the women and the expected babies, their families and the community at large as care will improve. The study will also extend the notion of value-driven care in health care with specific attention to midwifery. Recommendations for service delivery improvement and the implications for midwifery practice, DoH and Nursing Education were brought forward.

LIST OF ABBREVIATIONS

ABBREVIATION	MEANING
CI	Cooperative Inquiry
DoH	Department of Health
CIG	Cooperative Inquiry Group
OPM	Operational Manager
CDP	Continuous Development Programmes
WHO	World Health Organization
PPE	Positive practice environment
DENOSA	Democratic Nursing Organization of South Africa
NCS	National Core Standards
QIPs	Quality Improvement Plans
SANC	South African Nursing Council's
VC	Values Clarification
NGT	Nominal Group Technique
FGD	Focus group discussion
TA	Thematic analysis
EXCO	Executive Committee
QIP	Quality Improvement Plan

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CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

The choice of the study topic emanates from a belief that care is deteriorating in midwifery around the globe. This study intends to highlight what led to the belief that midwifery care is declining and that there is generally low work ethics in midwifery care. This assertion is supported by a Cooperative Inquiry (CI) research conducted in one maternity ward, in one hospital based in the Mpumalanga province of South Africa. At the selected hospital a number of sub-standard care complaints arose, the midwives-women relationship became intolerable and repeated reporting of negative and/or unpleasant experiences increased. As a result, the first principle of the midwives' continuous efforts to "be with the woman" is sometimes forgotten (Royal College of Midwives, 2014:22) and therefore caring and responsive attitude is lost during childbirth.

Midwifery is a highly specialised clinical field performed by skilful individuals, the midwives. Midwifery practice is a priority service (Department of Health, 2007:2). It is also recognised as a pivotal service according to Renfrew, Homer, Downe, Mc Fadden and Muir (2014:2). It is a unique science (Jiménez-Lopez, Roales-Nieto, Seco & Preciado, 2014:79) and the art of nurturing which entails scientific acts or procedures which relate to the care of women and expected babies in the course of pregnancy, labour and the postnatal period (International Confederation of Midwives, 2011).

Midwives possess personal and professional values, which are a strong source of their individual and professional existence. Midwives belong to families, communities and societies who form a strong base for the socialisation of individuals with regard to personal values. Midwives inherently possess personal values, which are familial, inherited and/or influenced by their interactions with their environment, societies, communities, families and culture over a lifetime (Ozcan, Akpinar & Ergin, 2012:399).

Personal values entail family security, happiness and a sense of accomplishment (Rassin, 2008:626). In general, a midwife who is guided by the above-mentioned values may easily pass them unto the women she is caring for during childbirth. De Jong, Worsley, Wang, Sarmugam, Pham, Februhartanty and Ridly (2017:2) define personal values as principles that direct individual actions (De Jong, Worsley, Wand, Sarmugam, Pham, Februartanty & Ridley (2017:2). Debbarma

(2014:182) adds that these values may determine what is positive or good and negative or bad. Generally, personal values are passed during the individual's socialisation, become a central educative role player during their upbringing, and depend wholly on the societal values. These values are directed by salient normative standards approved by a particular society. Values carry more weight since they are determined by parental values and the context within which one is being socialised (Barni, Ranieri, Donato, Tagliabue & Scabini, 2017:11). The author adds that societal values become standards for evaluating human behaviour. In the same note, personal values are determinants of moral values in midwifery care. Debbarma (2014:186) asserts that they are a basis on which to make care decisions about what is right or wrong. These values channel midwives to take morally justified decisions and apply positive moral judgements. Midwifery personal values go hand-in-hand with professional values. Professional values are ultimately agreed-upon standards of care, which should be upheld when rendering care. In nursing, these values are achieved through formal education and professional socialisation), examples of professional values are: the Code of Ethics for Nursing, the scope of practice, codes of conduct and more (Lachman, O'Connor Swanson & Winland-Brown, 2015). Furthermore, these values are considered desirable, preferred acceptable professional behaviour and act as a 'lens' to view oneself and others to either be '*good*' or *'bad*' or '*normal*' or '*abnormal'* while at work (Jiménez-Lopez, Roales-Nieto, Seco & Preciado, 2014:79). Applied to midwifery these values serve as standards and/or yardsticks to judge, praise, condemn or rationalise the behaviour of individual midwives when rendering care (Rassin, 2008:615).

Instead, the decline in care in maternity and obstetric is experienced globally. In turn, this leads to negative experiences during labour and delivery. The claim is proven to be real in a study conducted by Goer (2010:36) in the United States of America where for example some women experienced forceful manipulation of their bodies and suturing of their perineum without anaesthesia. These acts resulted in dehumanising practice, which caused unnecessary pain and suffering towards the birthing women. In addition, Hodges (2009:8) states similar treatments where women reported that they were scolded, slapped and unnecessarily yelled at by midwives.

Similar ill-treatment and disgraceful conduct were reported in studies conducted in other Sub-Saharan countries such as Malawi and Nigeria where episodes of non-consented, non-dignified, non-confidential, abandonment and denial to care were evident (Sethi, Gupta, Oseni, Mtimuni, Rashidi & Kachale: 2017:5, 6, 7). In Nigeria the midwives' unfriendliness, rudeness, harshness, aggression, abuse and disrespect led women to consult with traditional birth attendants (TBAs)

Ishola, Owolabi and Filippi (2017). Women view TBAs as more caring and supportive than midwives (Kumbane, Bjune, Chirwa, Malata & Odland, 2013:8 & Choguya, 2014:7).

A study conducted in one province in South Africa by Jewkes, and Penn-Kekana (2015:2) revealed that some women who were admitted in maternity wards experience substandard and dehumanising that lead to declined quality of care during childbirth. The declined care ranged from disrespect, verbal abuse and more. Additionally, another study conducted in South Africa by Kruger & Schoombie (2010: 78) revealed that women admitted in maternity and obstetric wards experience dehumanizing care from nurses that range from assault, verbal abuse, suffering, disrespect, lack of confidentiality and privacy. Instead, high quality midwifery should promote safe, effective, woman-centred, timely and equitable care that maximises values that lead to the attainment of professional value-driven midwifery care throughout childbirth.

Value-driven midwifery care can only be realised when midwives result in improved professional values of those who render the caring role. Professional values lead to midwife's responsibility towards the patient (Rassin, 2008:625). These values are portrayed through the midwife's ability to promote good professional behaviour expected in the nursing profession (Poorchangizi, Farokhzadian, Abbaszadeh, Mirzaee & Borhani, 2017:1). Therefore, these values will strengthen the midwives professional performance through the portrayal of a sense of responsibility, security, human autonomy and more (Cetinkaya-Uslusoy, Pasli-Gurdogan & Ayidili, 2017:494). In midwifery, the application of ethical values as a source for ethical reasoning should be continuously reinforced to direct midwives towards the right decision in order to safeguard the lives of women during childbirth (SANC: 2013:4). Dehghani, Mosalanej and Dehghan-Nayeri (2015:1) refer to ethical values as the nursing ethics. Nursing ethics is a source of ethical values, which form the foundation for decision-making to protect women from unnecessary harm during labour and delivery. Dehghani, Mosalanej and Dehghan-Nayeri (2015:1) further refer to ethical values as the competency of nurses, which does have a direct impact and cannot be separated from clinical duties. The researcher maintains that these values serve to inform midwives of their ethical responsibilities when performing their daily duties. These include respect, confidentiality, human dignity, integrity, advocacy, accountability and more (Lachman, O'Connor Swanson & Winland-Brown, 2015). Values serve as standards of actions that are expected to promote professional behaviour in midwifery (Poorchangizi, Farokhzadian, Abbaszadeh, Mirzaee & Borhani, 2017:1).

Members of the midwifery profession should possess an increased understanding of their responsibility, which is to protect the welfare of women during childbirth. It is therefore believed that the realisation of ethical values may improve midwifery care (Goethals, Gastmans & de Casterle, 2009) examples of ethical values are beneficence, non-maleficence and justice (SANC, 2013:4). Ethical values are inseparable from moral values. Morality refers to the essential elements of the collective lives of any community, which form a basis for decision- making. Morals are the social boundaries of a specified social group used to evaluate what is good or bad. Midwives are expected to act ethically and morally in order not to harm others, especially women during childbirth.

1.2 PROBLEM STATEMENT

Midwives are at all times expected to observe and apply value-driven midwifery care in their interaction with women during childbirth. Notably, a decrease in value-driven midwifery care was observed in one maternity ward in one hospital in Mpumalanga. The hospital's maternity ward was reported negatively by the community during an Imbizo (a community service delivery mass meeting with political leaders). Usually, during these meetings community members are given a platform to raise concerns about service delivery expectations and/or dissatisfactions. However, during this particular meeting community members diverted from the usual topics such as water, electricity and roads and raised their dissatisfaction about the care received by the women admitted for childbirth. The complainants alluded to the fact that despite numerous complaints lodged, treatment and/or care does not improve. Notably, the operational manager's quarterly reports continuously reflected repeated complaints regarding unacceptable treatment experienced by women; sadly nothing seemed to be done to improve the situation. The inability of the facility/institution to self-correct led to the study.

Bimray and Jooste (2014:198) wrote that the decreased value-driven care in some South African hospitals might be due to lack of professionalism in those who render care to patients. This statement is supported by a quarterly quality report of the maternity ward (quality report number 2 and number 3, 2010 kmh) which revealed a decreased professional value-driven maternity care characterised by unacceptable behaviour of midwives. In the manager's report, eighteen discharge comments revealed unacceptable treatment by midwives. The complaint profile revealed issues of lack of information, clinical issues, hospitality and staff attitudes which ranged from scolding, abuse, neglect and delays to care during the needy moments. The latter indicated lack of delivery of the expected care by midwives who care for women during childbirth.

In South Africa, failure to render the expected care may constitute misconduct. Misconducts are taken as serious offence punishable under law. The South African Nursing Council (SANC) is a

professional body that plays a role to uphold the professional and ethical practice of nurses to ensure the safety of the patients who are cared for (Mathibe-Neke, 2015) by the nursing categories in hospitals. The SANC (2012-2013) statistical report shows an increased number of cases reported and it is sad to note that some are of a serious nature. The report reflects on evidence of misconduct among midwives from different provinces. The table below shows cases of misconducts ranging from maternity related, poor basic nursing care including fraud and physical assault of patients. According to the report, maternity misconducts are among the leading causes in nursing in the country.

TABLE 1.1: SOUTH AFRICAN STATISTIC REPORT OF MISCONDUCT BY SANC (2012)

PERIOD									
CLASSIFICATION	2003	2004	2005	2006	2007	2008	2012	2013	Total
Maternity related	5	28	34	26	33	0	2	6	134
Poor basic care	28	142	90	49	72	22	7	4	414
Sexual assault	-	4	15	7	3	2	-	-	31
Physical assault	-	8	5	3	2	1	-	-	19
Total:				601					

Table 1.1 reflects the classification of the cases in the South African Nursing Council report. In general, the report portrays unethical conduct, and the declined of professional value-driven care.

1.3 RATIONALE OF THE STUDY

The increased numbers on the SANC's statistical report on misconduct (2012) bothered the researcher and eventually decided to embark on a Cooperative Inquiry Research to facilitate an improvement of quality care in midwifery, which, therefore, will lead to professional value-driven care. Vedam, Stoll, Rubashkin, Martin, Miller-Vedam, Hayes-Klein and Jolicoeur (2017:201) report that some African maternity settings still show episodes of physical abuse, non-consented care, discrimination, abandonment and more. The researcher concludes that the setting of this study fell within the aforementioned category and chose to use a Cooperative Inquiry (CI) approach for this

study with the expectation that CI will produce positive results, as it is collaborative and inclusive. Midwives taking part in the study are not treated as melanoma but are included in the process of finding solutions to the improvement of care in midwifery.

1.4 SIGNIFICANCE OF THE STUDY

The study will benefit the Department of Health (DoH), Nursing Education and clinical practices.

1.4.1 The Department of Health

The researcher believes the findings of the study will add to the body of knowledge of the DoH. The findings can also be used by the department to improve care and minimise clients' dissatisfaction. The researcher hopes that the findings of this inquiry will highlight the need for the inclusion of professional value-driven midwifery care as the base for quality midwifery care in the country.

1.4.2 Nursing Education

The findings of this study will benefit nursing education. It is the desire of the researcher that healthcare professional educators' reinforce value-driven care in nursing education, as this may lead to the realisation of quality care in all clinical areas.

1.4.3 Midwifery practice

The researcher believed that the midwives' acknowledgement that there is a decline in midwifery care warrants their interest to attend to the problem. Indeed, the midwives who formed the Cooperative Inquiry Group (CIG) were eager and willing to attend to the problem. The researcher also believed that the study would give the midwives an opportunity to become change agents, develop new skills and tools which they will continue to use the study to ensure that value-driven midwifery care is implemented and sustained.

1.4.4 Policy makers

The study may benefit the SANC to influence nursing policy making regarding measures that might improve midwifery care in the country.

1.5 AIM OF THE STUDY

The aim of the study was to "*develop strategies to empower midwives regarding professional value-driven midwifery care to improve childbirth using a Cooperative Inquiry Research Approach".* The study also aims to engage, enhance and equip midwives with necessary skills to implement the value-driven care.

1.6 OBJECTIVES OF THE STUDY

The objectives of the study were aligned with the phases of the Cooperative Inquiry research and are outlined in table 1.2 below:

TABLE 1.2: LIST OF OBJECTIVES

Objective 1	*To establish a supportive and trusting relationship in the chosen setting.*
Objective 2	*To identify the CIG' values that contribute to teamwork.*
Objective 3	*To prioritize specific values that contribute to midwives' knowledge of professional values applicable to childbirth.*
Objective 4	To explore and describe midwives' views regarding professional value-driven midwifery care
Objective 5	*To develop strategies to empower midwives to promote professional value-driven midwifery care to improve childbirth".*
Objective 6	*To develop tools to improve and enhance the delivery of professional value-driven care.*

1.7 DEFINITION OF KEY CONCEPTS

Important terms are defined and clarified below in order to enhance the reader's understanding of the context under scrutiny.

1.7.1 Cooperative or a Cooperative inquiry group

A cooperative or a Cooperative Inquiry Group (CIG) is an autonomous association of persons united voluntarily to meet a common economic, social and/or cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise (Prakash 2003:4, Mash 2014:3). In this study, a cooperative meant a group comprised of the researcher and midwives who participated in this Cooperative Inquiry research. In addition, the term 'the CIG' was used exchangeably with 'cooperative'. The CIG refer to midwives with the involvement of the researcher. The term Cooperative was used in instances of joint decision making by the whole group. Members of the group entered into a professional relationship, which was characterised, by democratic participation, self-responsibility and accountability, equity and solidarity throughout.

1.7.2 Cooperative Inquiry

Cooperative Inquiry is participatory action research which involves a group of people who voluntarily form a '*do it yourself*' inquiry group into their own experiences, using a series of actions, while moving between the experiences in a collegial environment (Peden, 2004:9). All the CIG engage in the research endeavour as co-researchers who have a say in the decision making regarding the study (Reason, 2002:169). For the purpose of this study, CI refers to the collegial, collaborative, equal and democratic participation of members of the GIG.

1.7.3 Ethics

Ethics refers to standards of behaviour for performance, which are used as a base for appraising beliefs and attitudes to influence one's behaviour (Paradeh, Khaghanizade, Mohammadi & Nouri, 2015:284). Applied to this study the concept referred to a particular body of knowledge that forms the cornerstone for midwifery practice, which points out what is '*good*' or '*bad*' and 'right' or 'wrong' during the provision of care.

1.7.4 Midwifery care

According to the International Confederation of Midwives (2017:1), the term midwifery care refers to the care given by nurses who had successfully completed a Midwifery Education Programme. The programme should be based on the ICM Essential Competencies for Basic Midwifery Practice and the Framework of the ICM Global Standards for Midwifery Education and is recognised in the country where it is located. Midwives are professionals demonstrating competencies and have acquired the requisite qualifications and are registered and legally licensed to practice midwifery and use the title 'midwife'. Specific to the study, the term referred to all the CIG with the researcher inclusive as they all had specialised education, skills, competencies and abilities to care for women admitted for childbirth.

1.7.5 Value

The term value related to standards for activities that are acceptable to a professional group or individual to evaluate the integrity of a group or individuals within that particular group (Poorchangizi, Farokhzadian, Abbaszahdeh, Mirzaee & Borhani (2017:2). In this study, the term meant actions, which are seen as socially acceptable and desirable by midwives.

1.7.6 Value-driven care

The term value-driven care in health relates to the quality of healthcare and facilities. This aspect is measured based on productivity towards healthcare than the provision of healthcare. It is mainly used by healthcare entrepreneurs. Conway (2009) asserts that value-driven healthcare is measured by the achievement of quality care with specific concentration on the dollar spent; therefore, value-driven care is the care outcomes achieved in relation to the money spent. Most healthcare organisations prioritise benefits for shareholders, therefore, the value is determined by the volume of service rendered, profit and cost reduction as opposed to the satisfaction of customers (Porter, 2010). Applicable to this study value-driven care is not financially orientated. It is a social encounter related to the total satisfaction of the customers, who in this case are women admitted for childbirth. Value-driven care requires the provision of care that maximises the patient's individuality with their needs put to the fore. In order to provide professional value-driven midwifery care, midwives should be respectful and responsive to the admitted women's needs. In addition, midwives as healthcare professionals are expected to uplift the safety of the women throughout.

1.8 RESEARCH PARADIGM

The word paradigm refers to a worldview, a general perspective on the complexities of the world. Human research is usually characterised by the answering of questions like 'what is the nature of reality?' (Polit & Beck, 2017:9). It is a philosophical position of the researcher to provide a basic set of beliefs that guide action. It defines the nature of the world to its holder, the place of the individual within it and diverse possible relationships to that world (Creswell & Poth, 2018:325). A critical theory perspective assumes that truth exists as realities, which are 'taken for granted' (Weaver & Olsons, 2005:461). These truths are shaped by individual conflicting underlying structures, for example social, political, cultural, economic, ethnic and gender factors, which develop into reality overtime (Botma, Greeff, Mulaudzi & Wright, 2010:44). Unlike traditional researchers, the researcher in a Cooperative Inquiry became a critical theorist who sought explanations to alter a social situation through the co-researchers' views to improve the care rendered. The co-researcher's role took a beneficial role since they were not regarded as mere data collection tools who were used for the benefit of the researcher alone. CI holds a belief that knowledge is constituted by the lived experiences as well as the social relationships among the co-researchers (Botma, Greeff, Mulaudzi & Wright, 2010:45). In order to provide an understanding of the above paradigm, the researcher included a discussion based on the origin of the critical paradigm and major assumptions of critical theory as applied to the study.

1.8.1 The origin of the critical theory paradigm

Critical theory is a school of thought whose primary objective is the improvement of the human condition. It was founded at the German Frankfurt School by theorists like Horkheimer around 1937 and was later brought to the fore by Habermas around 1960 (Ngwenyama, 2002:1). In this study, critical theory paradigm is aimed at creating new knowledge by transforming midwives in the environment wherein the research was done. The application of the paradigm attempts to assist midwives to close the gap between evidence and practice, as learning would be put into practice immediately. The acquired knowledge would be used further even after the study is completed. In this critical theory, the CIG are not used as objects or subjects but are the CIG in both action and research (Mash, 2014:1). The researcher in this study acted as a the CIG and not a passive observer of the research process. New knowledge was generated as a consensus of the CIG' learning. The generated knowledge was highly contextualised and could not automatically be generalised to other settings. As indicated by Tekin and Kotaman (2013:82) the values contained in critical theory namely democracy and humanitarian values are applied to serve the best interest of the society, and that is applicable to the intended study. In this case, the researcher and the CIG co-jointly participated in deliberations and observations and collectively relooked into the values expected in midwifery care.

1.8.1.1 Major assumptions of critical theory as applicable to the study

The major assumptions of this Cooperative Inquiry Research Approach are reflected as follows:

- **Ontology**

Ontology involves the form and nature of reality and its characteristics (Creswell & Poth, 2018:20). It attempts to indicate what was there to be known about the reality of the situation under investigation (Polit & Beck, 2012:13). It is further described as part of philosophy that deals with reality and its nature (Botma, Greeff, Mulaudzi & Wright, 2010:40). Reality, in this study, would be brought up as subjective-objective data derived from daily encounters of midwives with women admitted for childbirth. Reality is derived from the tell-tales of midwives interactions with women who visit the Maternity ward. The CIG agreed that professional value-driven care should be rendered at times. Their understanding of the CI methods instilled hope that their efforts might assist them to deal with the problem by themselves. The researcher and the midwives formed an Inquiry Group (CIG). The CIG engaged in thoughtful deliberations for the sake of midwifery care delivery. The Cooperative Inquiry approach provided the CIG with a platform to reflect on the status of care in their own ward. The process followed led to meaningful constructions referred to as 'effective intellectual arguments' (Brydon-Miller, Greenwood & Maguire, 2003:15) aimed at changing the declined of midwifery care at the selected hospital. The CIG then planned, acted and also evaluated their own actions with intentions to finally turn-around the existed situation into a professional value-driven environment with increased midwife-woman satisfaction.

- **Epistemology**

Epistemology involved the nature of knowledge in relation to knowing and to be known. It entailed an interactive link between the researcher and the CIG. The researcher worked 'with' but not 'on' the CIG and this led to personal empowerment for both the researcher as the CIG. Epistemology is subjective-objective in nature, it comprised the experiential knowing which stemmed from the lived experiences of midwives. The experimental knowing comprised the tacit knowledge of the specific cultural origin, which was not easily talked about and was known only to the midwives. Knowledge acquired from the midwifery theoretical perspective became useful to the study as propositional knowledge. Eventually, the midwives' presentational knowing (Reason, 2006:195) was enhanced through the repeated cycles of action and reflection (Armstrong & Banks, 2011:16).

- **Methodological assumptions of the study**

Methodological assumptions of this study referred to the rules and procedures that were followed in order to bring forward what was to be revealed regarding the chosen topic (Botma, Greeff, Mulaudzi & Wright, 2010:41). The methodological assumptions of the study involved collaborative forms of CI, the involvement of all the CIG as co-researchers, assigned roles to the CIG and the CIG' engagement in the faction-reflection inquiry cycles. For the success of the CI, the CIG were engaged in collaborative discussions, and every member got an equal chance. Reason (2002:173) asserted that the CIG members are usually bonded together through a series of exploratory conversations and meetings. The meetings remained closed to new members for the duration of the inquiry, thus the notion of 'now we know who *we* are' symbolised that group members ended up knowing each other well, and were open and accepted each other. (Reason 2002:173) added that the group should remain typically closed to new members for the duration of the inquiry and that was adapted by this study.

1.9 RESEARCH DESIGN AND METHODS

The research approaches followed in this study have its foundations in the social sciences. Cooperative Inquiry (CI) is a social research methodology carried out by a team comprising of a professional action researcher and the members of a specific organisation and or community, who seek to improve their workplace situation (Greenwood & Levin, 2007:3).

1.9.1 The origins of Cooperative Inquiry

Cooperative Inquiry (CI) is a collaborative inquiry which was founded by John Heron around 1968, and was later taken further by Peter Reason in 1971. It is a collaborative inquiry which had its foundation in the social sciences. Heron referred to CI as "*research into the human condition"*.

1.9.2 The development of a research group in a Cooperative Inquiry

CI is a research method that encourages active participation by two or more people who research a particular topic using own ideas and experience (Heron, 2006). In this CI, as from the onset of the study, the researcher and the participants became a Cooperative Inquiry Group (CIG) (Mash 2014: 3), whose members maintained the same status throughout their participation. The group engaged in a research endeavour to become co-researchers and co-subjects who together possessed a joint responsibility to manage the research project and also engage in active participation in the study (Reason, 2002:169). Applicable to this study, CI led to a process with the repeated cycle of actions

and reflections, which helped the CIG to answer all the questions of concern. The inquiry resulted in a systematic process of action and reflection among co-researchers who together confront a provocative question of common interest (Ospina, Hadidy & Hofmann-Pinilla, 2008:2). In addition, this CI became a way of working with people with similar concerns in order to understand the problem, while developing new and creative ways of dealing with the concerns. It involved learning how to transform a situation with the intention to make it better (Davies, Lambert, Turner, Jenkin, Aston & Rolfe, 2014:6).

In this study, the CIG did not resist and/or decline the adaptation of professional value-driven midwifery care since they were aware of numerous evidence of community dissatisfaction with the care provided. Participating midwives volunteered to form part of the study. During the focus group interviews they most openly admitted to the decline of professional care in midwifery. The midwives contributed solutions to improve care and came up with tools and plans to uplift professional value-driven midwifery care. They continuously implemented and evaluated the success of the plans and constantly monitored and evaluated the plans to ensure that good practices are sustained.

1.9.2.1 The application of Cooperative Inquiry Approach in the study

Cooperative Inquiry as a systematic process was embraced by the co-researchers who participated in the study. The midwives organised themselves into manageable groups to conduct a radical form of inquiry and attend to the issues which led to the decline of professional values in their workplace. The intention of the CIGs was to explore the issue of interest that is, decreased value-driven midwifery care, which they felt was causing a lot of distress, and thus needed attention. The midwives openly indicated their wish to participate in order to regain and maintain their status as professionals in society, to improve midwives-women relations and reverse the negative reputation of themselves and the hospital (Reason, 1999:2, Ospina, Hadidy & Hofmann-Pinilla, 2008:131 and Kasl & Yorks, 2010:316). Although the midwives were never involved and/or participated in any research, they were enthusiastic and contributed their unique knowledge and experiences. Their commitment to democratic activities and procedures, contribution to social change and their commitment was portrayed throughout the inquiry. The above-mentioned modes resulted in a democratic, collaborative, active participatory and socially-committing context for the participating midwives. Consequentially, the democratic rights of the women were fostered during childbirth (Brydon-miller, Greenwood & Maguire 2003). In particular, the midwives systematically attended to the identified problem by following a series of action-reflection cycles.

1.9.2.2 Principles of a Cooperative Inquiry

Critical collaborative inquiry

The relationship that existed within the CIG brought members closer to each other. As a result, the midwives cherished this relationship, and members started to refer to themselves as 'critical colleagues' or 'learning partners' since they worked as a collective (Ferguson, 2011:30). The CIG believed in teamwork and cohesion, which was strengthened by increased participation and mutual decision-making and problem-solving. Consequentially, '*authentic collaboration'* was portrayed throughout the study, and this led to the attainment of the set goals. Additionally, the inquiry influenced the CIG to act accountably in order to build mutual relationships with women during midwifery care (Graham & Mollenhauer*, 2013:1)*.

Van Lith (2014:258) asserts that Cooperative Inquiry Group relationships require continuous negotiation, no collegial domination, non-hierarchical, interactive and active participation. Applied to the study, a collaborative dialogue took place and involved midwives who jointly addressed a common but unique area of interest in their context and came up with ways to solve the problem (Mubuuke & Leibowitz, 2013:30). Roles were assigned according to the CIG members' individual expertise, and leadership activities were rotated.

Reflective practice by the midwives

Ferguson (2011:8) describes the Cooperative Inquiry as an enquiry conducted by the '*self into the self*', and thus, it is obvious that self-reflection is important for the CIG. Self-reflection in a CI involved the CIG's ability to identify an area of practice to be improved where people think of a solution for an existing problem, implement and evaluate it in order to change own practice. Through repeated cycles of reflection and action, the midwives arrived at solutions for the research questions of the study. Mubuuke and Leibowitz (2013:30) assert that reflective practice instil awareness about a need to change own practices and that was applicable to the members of the CIG who participated in this study.

Accountability and making the results of their inquiry public

The researcher actively involved the CIG in the formulation of the research questions of the study. They further were involved in the research processes of the study, and thus, they finally owned the

study since they were responsible for its production. Mash (2014:1109) maintains that Cooperative Inquiry teaches the CIG to be accountable. This was applicable to the study as the members of the CIG became responsible for the issues and as a result on their own decided to be accountable and agreed to make the results of the study public. The CIG as co-researchers conducted workshops and raised awareness with different stakeholders.

Self-evaluation of own practice and engagement

Ferguson (2011:34) mentions that CI helps the CIG to develop an understanding of the issue under investigation. In this study, understanding of the problem under discussion benefited the midwives during self-evaluation of their own work as they managed to come to a realisation that there is a decline of care in midwifery. And collectively they agreed on measures to address the problem. Audit tools were created for consistent and continuous monitoring.

Participative problem solving and continuing professional development

The Operational Manager (OPM) realised that this study would not only assist the midwives to improve their values effectively but will also empower them professionally. The South African Government identified the lack of compulsory Continuous Professional Development (CPD) in healthcare organisations (Department of Health, 2011:28). Consequentially the OPM became very supportive after realising the dual role of the study. Not only was the hospital to benefit from the participation of midwives but their participation was to contribute CPD points for the hospital. The dual role to simultaneously became an added advantage and as a result, each CIG midwife kept a record of their participation and presentations in their individual files as evidence for CPD points accreditation.

1.10 ETHICAL CONSIDERATIONS IN THIS STUDY

General rules applicable to research are applicable to this study and are addressed as follows:

1.10.1 Ethical approval

The study received ethics clearance number 232/2015 from the Research Ethics Committee of the University of Pretoria. The Department of Health Mpumalanga Province and the chosen setting also granted the researcher permission to conduct the study.

1.10.2 Ethical principles of research

The study used and adhered to the three broad principles of research advocated for by Polit and Beck (2017:139). These principles of ethical conduct include beneficence, respect for human dignity and justice are reflected below:

1.10.2.1 Principle of beneficence

Botma, Greeff, Mulaudzi and Wright, (2010:20) indicate that beneficence has to do with protecting the CIG's welfare and rights at all times. The researcher ensured that at all times during this study the CIG were protected from any form of harm, discomfort and exploitation.

- ***Right to freedom from harm and discomfort***

The researcher had a responsibility to ensure that the CIG were not harmed in any way. In this case, the research could result in emotional harm since the study involved midwives who were reported by the community to the leadership of the hospital and province. The researcher reassured the midwives that the study's intentions were not tohumiliate them but to help them address the issues at hand. Understanding the sensitivity of the subject; pre-arranged intervention by the psychologist was always available on a stand-by basis.

- ***Right to protection from exploitation***

The researcher made it a point to communicate to the midwives that in no uncertain terms is the study intended to be used against them. Their participation was intended to gather information that answers the research question, and since they were the most knowledgeable individuals, their participation was highly encouraged and valued. The CIG were reassured that the study's intention was not to use them as the mere data source and possible benefits for them were communicated (see table 3.9 on the benefits of participating in a Cooperative Inquiry).

1.10.2.2 Principle of justice

The principle of justice according to Polit and Beck (2017:141) refers to the CIG's rights to fair treatment and privacy and confidentiality while taking part in the study, and these were addressed as discussed below:

- ***The right to fair treatment***

The researcher ensured that the CIG's right to a fair, humane and equitable treatment was respected before, during and after the inquiry. This right included fairness and non-discriminatory selection, non-prejudicial treatment access to professional research personnel, respect for the CIG' beliefs, opinions and judgements. In line with Polit and Beck (2017: 141), the CIG who declined participation were not coerced in any way.

- ***Right to privacy and confidentiality***

The study looked at the sensitive issue regarding declined midwifery care, which according to Dickson-Swift, James, Kippen and Liamputtong (2007:330) involves "*entering into the lives*" of others. Therefore, stricter measures to promote confidentiality and privacy were taken into consideration by the researcher. Three confidentiality clauses (Donald, 2012) were signed by the researcher and the two transcribers to protect the collected data from unauthorised persons.

1.10.2.3 Respect for human dignity

The right to full disclosure and the right to self-determination were also addressed as follows:

- ***Right to full disclosure***

The CI channelled the CIG to disclose matters that are personal and unique to midwives while rendering care. To follow Polit and Beck (2017:140), these matters were treated with utmost respect. As these involved the truths only known to the CIG and the disclosed information was respected.

- ***Right to self-determination***

The CIG volunteered to take part in the study, those who did not wish to could not continue after the first stage of the first phase. Those who volunteered to be part of the study signed a consent form.

1.11 ORGANISATION OF CHAPTERS

The chapters of the study were organised as shown in table 1.3 below:

TABLE 1.3: SUMMARY OF CHAPTER ORGANISATION

CHAPTERS	SUMMARY
Chapter 1	Orientation to the study
Chapter 2	Literature review
Chapter 3	Research methods
CHAPTERS	**SUMMARY**
Chapter 4	The presentation and interpretation of findings for the Introductory phases of the study namely, the Pre-entry, the Reflection phase 1: the Hand diagram exercise (stage 2) and the Nominal group technique (stage 2).
Chapter 5	The presentations and interpretations of the findings of phase 2
Chapter 6	Discussion of findings and literature control of the findings of phase 2
Chapter 7	Development of strategies to empower women regarding professional value-driven midwifery during child
Chapter 8	Conclusions, limitations and recommendations

1.12 CONCLUSION

The choice of the study topic emanates from a belief that care was deteriorated in midwifery around the globe. As such, chapter one highlighted what led to the belief that midwifery care is declining and that there was generally low work ethics in midwifery care. The belief of declined professional value-driven midwifery care was highlighted and backed up with literature. Chapter one also gave an overview of the CI research methodology and processes followed in the study.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

Chapter one gave an overview of the problem at hand, the decline of value-driven care in midwifery and introduced the research methodologies employed. Chapter two reflects on the literature review conducted in relation to the topic "Towards professional value-driven midwifery: Cooperative Inquiry research approach".

2.2 LITERATURE REVIEW

A literature review is a critical summary of research related to the area of interest, which is logically prepared to put a research problem in the context of the existing knowledge (Polit & Beck, 2017:733). Chronin, Ryant and Coughlan (2008:38) view the literature review as a summary of relevant and available literature regarding the topic studied and analysed. The literature review of this study was done prior to the study itself. This was supported by Schryen, Wagner and Benlian (2015:2) who maintain that researchers cannot conduct research without first having knowledge and understanding of the literature in the field of study.

The literature review of this study involved the search for relevant material during the inception stages of the study. This allowed the researcher to concentrate on the literature containing experiential descriptions of the phenomenon being studied. Since the researcher intended to seek financial support for the study, an upfront literature review was necessary to provide funders with an overview of the researched topic. The act of performing the literature review prior to data collection is also posited by Polit and Beck (2017:87) when they argued that conducting full early literature review can be appropriate and relevant depending on the nature of the study. This encourages the review of an overall body of knowledge and involves a critique of specific studies, which meet the criteria. This act differentiated this study from the 'grounded theorists' methods that advocate for the collection of data before the literature is reviewed (Polit & Beck, 2017:87). The process followed during the literature review followed logical steps as shown in 2.2.1.

2.2.1 Creswell's (n.y) steps for conducting literature review

Five steps of literature review were applied as shown in Creswell (n.y) as follows:

Step 1: The identification of key terms

The keywords used were care, midwifery, professional, professionalism, values and value-driven care. Bolderston (2008:79) further stated that keywords are important for literature search in any study since they are 'a cornerstone for effective search'.

Step 2: Locating literature about the topic

Different search engines were used for tracing literature. A search engine is an information retrieval system designed to assist the researcher in finding stored information from computer systems (Trivedi, 2009:79). These systems include the web, the network and/or the computer itself. The search engines served as programmes which were used to search for documents through specified keywords. Search engines related to nursing, healthcare, mother and baby care, medicine and related life sciences were visited. The used search engines included CINAHL, Scopus, Science direct, MEDLINE, Cochrane Library, MedInd, maternity and Infant care and Google Scholar, Open Med, Pub Med, Health in India, Relemed, Google and MDchoice. Different databases were also used. The local librarian was also consulted as an information specialist in literature and relevant database searches.

As suggested by Bolderston (2008:79) words related to the study topic were considered during the search as keywords. Both primary and secondary sources were used. Primary sources originated from the literature by specific individuals who produced specific publishable research in a form of published articles and books. E-books were also included. Gray literature such as conference papers, academic papers like dissertations and theses, reports and other official government policies, guidelines, newsletters and bulletins (Creswell, n.y,:5. & Paez, 2017: 233) were also considered. The inclusion criteria included only literature written in English, period of the reviewed literature ranged from 2012 to 2016. But in instances of usage of primary sources and the scarcity of literature, 2004-2011 literature were used but backed-up with more current ones. The search results yielded 93 searches, and 75 of these were used in the study.

Step 3: Critical evaluation and selection of literature for the review

The step involved the researcher's own judgement about the quality and the relevance of the searched literature. In order to promote access to quality sources the researcher created a priority list for searching. PICO method was used to create a question that directed the search (Leen, Bell & McDullen; 2018:4). The relevance of the search was based on the topic, individual and setting, problem and question and accessibility of the literature.

Step 4: Organising the literature

The obtained literature was organised in readiness for the literature review writing and different folders were created for storage of qualitative and quantitative literature. Abstracting was done for quantitative and qualitative literature. Abstracting for qualitative research included topics on the research problem, research questions, data collection procedure and findings and that of a qualitative nature included aspects like research problem or hypothesis, data collection procedures and study results.

Step 5: Writing of a literature review

The researcher constructed a written summary of literature which consisted of research articles as well as reports. The literature review had headings, discussions which were supported with literature which was verified with in-text references and list of sources.

2.3 THE PURPOSE OF THE LITERATURE REVIEW

The purpose of the literature review according to Hofstee (2006:91) is to raise awareness of the focus of the study. It provides the researcher with the knowledge and understanding of where and how the study fits in with what has already been done. Randolph (2009:2) concurs that the literature review intends to bring forward the context of the researched area. In this case, the review proved the significance of the study to midwifery practice and the potential to contribute new knowledge to the existing scholarly literature. The review also showed that the research was necessary thus encouraging the researcher to continue conducting the research without fear that similar studies already exist in the chosen field. In other words, the researcher does not reinvent the wheel (Schryen, Wagner & Benlian, 2015:2). Munhall (2012:155) maintains that a literature review brings the

researcher's experience into contact with those of other authors thus resulting in a better understanding of the research area.

Purposes of literature review according to Randolph (2009:2) are as discussed below:

- Rationalisation of the significance of the problem researched upon might be achieved through the literature on the subject matter, which reflects the intensity of the issue under discussion or where further research was recommended by prior studies.
- Seeking new lines of inquiry, which will be achieved through how previous studies were approached and alternative methods, sought for the chosen topic.

Schryen, Wagner and Benlian (2015:3) viewed the literature review as a contribution that exceeds the mere summary of the existing materials regarding the chosen topic. In addition, they viewed the literature review as a tool that enhances the researcher's vocabulary related to the chosen topic.

2.4 THE FOCUS OF THE LITERATURE REVIEW OF THE STUDY

The context of the literature review addressed professional of care aspects with specific reference to the generic professionalism in nursing and in particular midwifery with the hope that this might enhance the reader's understanding of the subject under discussion.

2.4.1 The generic professionalism in nursing and midwifery

Professionalism is a process through which members of a specific profession, for example, nurses become socialised into a profession to become professionals (Alidina, 2013:128). The concept 'professionals' is defined as '*a disciplined group of individuals who adhere to high ethical standards and uphold themselves to, and are accepted by the public as possessing special knowledge and skills in a widely recognised, organised body of learning derived from education and training at a high level, and who are prepared to exercise this knowledge and skills in the interest of others*' (Halldorsdottir & Karlsdottir, 2011:807). Through professionalism, the professional growth of an individual nurse and midwife takes place. Alidina (2013:130) concurs that in midwifery, professionalism as a multidimensional concept provides midwives with opportunities to grow personally and professionally.

The professional growth of midwives improves their level of knowledge and allows them to increase their level of personal autonomy, their ability to think critically and to reflect on the midwifery care rendered. Consequentially, professionalism uplifts the knowledge status of members thus encouraging them to become more empowered to handle complex issues arising during the delivery of service. Knowledge of professionalism usually contributes to individuals' job satisfaction, and that might be applicable to midwifery (Alidina, 2013:130). The researcher first discussed professionalism in nursing in order to promote the understanding of the origins of professional values in midwifery. Further discussions on the characteristics of midwifery and the enhancement of professionalism in midwifery practices are reflected below.

2.4.1.1 Characteristics of a profession

Every profession has its own characteristics, which render it different from the others. These characteristics influence members of a particular group, in this case, midwives, to identify and commit to their profession (Black, 2014:53). Several characteristics of midwifery as a profession are documented and described in Black (2014:53) and, these are service oriented, with a prolonged period of training, self-regulation, increased autonomy and more.

Midwifery is a unique profession characterised by prolonged specialised training (International Confederation of Midwives, 2011:2). The midwives' training equips trainees with a set of skills that are unique, which consequentially allow them to perform special techniques applicable to women during childbirth (Nursing and Midwifery Board of Australia, 2008:1). On completion of the midwifery training, members openly pledge their faith-based nature, which is directed by an ethical behaviour that is binding on them. For midwives; course completion leads to the formal authority granted by a legal body in the form of a certificate and/or licence/licensure to practice. The International Confederation of Midwives (2011:1) refers to the licensure as a state registration that forms a legal right for a midwife to practice and use the title 'midwife'. For midwifery to take place, midwives should practice under a recognised setting aimed at benefiting the community. Throughout midwifery care, midwives work towards a common goal of practising their profession with dignity and respect.

2.4.2 The enhancement of professionalism in midwifery practice

Midwives should promote good practices; they must strive to uplift the image of the profession at all times. This notion is supported by Meiring and van Wyk (2013:3) who emphasised that the image of nursing is an important scale to measure nursing and midwifery in particular. Applied to midwifery

settings, midwives are expected to act in a manner that will enhance the image of the profession. Meiring and van Wyk (2013:3) maintain that nurses and midwives must show pride in their profession as they belong to the knowledge-based and status-imposing profession, which is different from others. Discussions to provide clarity regarding the professional nature of midwifery are found in Alidina (2013:133). Five attributes of professionalism namely, the midwife as a continuous inquirer; accountable professionals; an inter-professional collaborator and a competent practitioner.

2.4.2.1 The midwife as a continuous inquirer

The spirit of inquiry is a good attribute and should be portrayed by all midwives during their continuous rendering of midwifery services. In order for the midwives to render value-driven service to women during childbirth, they should remain alert throughout. Alidina (2013:133) supports that midwives should have an ability to make accurate observations, formulate questions depending on the situation, gather relevant information and interpret data in order to provide proper care to women during childbirth.

Alidina (2013:133) further indicates that midwives as independent practitioners should actually 'think out of the box' in matters that involve midwifery care. Gaither, Remedios, Sanchez and Sommers (2015:1) concur that the results of 'thinking out of the box' increase creativity and innovation and if applied prudently may overcome procedural monotony which is referred to as functional fixedness. In midwifery, thinking out of the box requires individual midwives' creativity. Gomez (2007:1) also argues that creativity may allow flexibility, tolerance to ambiguity and willingness to act in a responsible manner.

In Midwifery, responsible midwives may utilise the scientific and technological creativity which according to Gomez (2007) may assist them to deal with problems which emerge during childbirth. In addition, midwives are responsible for their own actions, and thus they should be held accountable for their clinical decision-making (International Confederation of midwives, 2014:1).

2.4.2.2 The midwife as an accountable professional

Professional value-driven midwifery requires midwives to behave responsibly and accountable. Accountability in midwifery refers to the ability of midwives to assume responsibility for their own conduct, and this forms a fundamental part of the midwifery profession (Alidina, 2013:133). As a

result, they should be guided by dominant values applicable to midwifery practice (International Confederation of Midwives, 2011:10).

In midwifery, accountability may be achieved through the midwives' obedience to the profession as well as the adherence to best practices portrayed through professional values. The Canadian Nurses Association (2008:18) asserts that rules, regulations and professional standards determine the ethical responsibilities of members of a particular profession and in this case, midwifery.

The South African Nursing Council's professional value statement (2013:6) guides the activities of midwives in executing their duties. These include respect for human life and the acknowledgement of the uniqueness of every individual woman admitted in the maternity ward. The SANC (2013:5) professional value statements, for example, respect, dignity, kindness are meant to remind midwives of the care they are expected to provide. Applicable to the study, the midwives' adherence to professional values might attract more women to give birth in the maternity ward of the chosen hospital. Access might enhance recognition of the women's right to expected service, and consequently, value-driven midwifery care might be achieved.

In order to achieve professional value-driven midwifery practice, midwives should apply their scope of practice and professional competencies (SANC, 1991 & SANC, 2014) in a mutually, interrelated and interchangeable manner. For midwives to achieve independence, they should have knowledge of the professional values, which guide them to render the expected midwifery services as effective as possible autonomously (Shahriari et al. 2013). The knowledge of the professional values promotes the independent functioning of the midwife to render care with confidence. Shahriari and Baloochestani (2014:1) contend that knowledge alone is not sufficient. The application of values is also very important. Any midwife who renders value-driven midwifery care should be trusted by the employer, colleagues and patients/clients. In addition, Isfahani, Hosseini, Khoshknab, Peyrovi and Khanke, (2015) argue that self-confidence leads to increased creativity, innovation and accountability.

However, self-confidence is not viewed the same by various scholars. Tilley and Watson (2004:6) argue that some midwives' self-confidence might make them take accountability for granted. Mirzakhani & Shorab (2015: 1285) concur that self-confidence instil feelings of being competent and capable and may allay their fears of being held responsible and they may engage in wrongdoings. Applicable to this study, midwives in the selected hospital were expected to uphold the practice of

joint accountability as this might enhance professional value-driven midwifery care with the increased satisfaction of women during childbirth.

2.4.2.3 The midwife as an autonomous practitioner

Autonomy as defined by Kramer and Schmalenberg (2008:60) and Johnson (2013:241) means the freedom to act in the best interest of the patient. Skår (2008:2226) and Black (2014:56) maintain that during professional autonomy, the midwife act in accordance to the acquired knowledge base that allows them to act independently and control their own actions. Undoubtedly, midwives are self-sufficient and therefore, are capable of using their own judgement while bearing in mind that they are responsible for the decisions, actions and omissions at all times (International Confederation of Midwives, 2014:1).

In Midwifery, professional autonomy permit midwives to do reflective thinking when rendering service. In return, reflective thinking promotes the midwives' rational actions taken out of free will without being intimidated (Skår, 2008: 2226). Reflective thinking promote autonomy which might allow midwives to function as stand-alone practitioners who show determination to make choices based on their professional values (Nursing and Midwifery Board of Ireland, 2014:2). In general, midwives as autonomous practitioners are the only ones who own the sense of power to control their own actions (Bedwell, McGowan & Lavender, 2015:173).

Although midwives possess the autonomous decision-making powers, they are still open to harmonious collaboration with other members of the healthcare team (Maillefer, Labrusse, Cardia-Coneéche, Hohlfeld & Stoll, 2015). Harmonious collaboration assists midwives to be capable of making independent clinical decisions. Harmonious collaboration prepares midwives to take responsibility for their own practice area at all times. Collaboration finally equips midwives to effectively co-ordinate and apply correct decision-making skills throughout (Solomon, 2009:47 and Maillefer, Labrusse, Cardia-Coneéche, Hohlfeld & Stoll, 2015). Indeed, the inter-professional relationships allow midwives to consider the independent role they play within the multi-disciplinary professional relationship. The International Confederation of Midwives (2011) concurs with the author that professional autonomy does not mean working alone or in isolation.

Contrary to the above debate, midwives sometimes depend on other healthcare professionals in making decisions regarding the care rendered to women during childbirth. A comparison study

regarding professional accountability in midwifery practice, as conducted by Kruske, Young, Jenkinson and Catchlove (2013) revealed that doctors publicly undermined midwives' competency with regards to decision-making. Additionally, Hastings-Tolsma and Nolte (2014:589) confirmed that midwives have a tendency to depend on stereotypical protocols, which may negatively influence the management of their patients. In midwifery, the multi-disciplinary team should aim at a collegial and collaborated relationship. This collaborative relationship is glued together by the woman during childbirth hence the notion of 'collaborative woman-centred relationships' as described in Macdonald, Campbell-Yeo, Snelgrove-Clarke, Aston, Helwig and Baker (2014:1).

2.4.2.4 The midwife as an inter-professional collaborator

Professionalism is promotable in environments, which embrace the 'working togetherness' of healthcare practitioners which is crucial when rendering service. The Midwifery and Nursing Board of Ireland (2014:26) refers to inter-professional collaboration as the professional, collegial relationship that exists between health practitioners and is based on mutual respect and trust. Peu, Mataboge, Chinouya, Jiyane, Rikhotso, Ngwenya and Mulaudzi (2014:14) view inter-professional collaboration as a pivotal learning process. Usually, the collaborative relationship in midwifery comprises the midwives and other members of the multi-disciplinary healthcare teams. In Midwifery, the effectiveness of the collaboration depends on the togetherness of the multi-disciplinary team which is referred to as inter-professional collaboration (WHO, 2013:5). Consequentially, the outcomes of the collaborative relationships should be equal among members. Johnson (2013:241) indicates that during the collaboration members of the multi-disciplinary team share a common goal that is patient or woman. Actually, the collaborative relationship should be characterised by open and honest communication, mutual respect and competency of healthcare professionals.

In midwifery, teamwork within the midwifery workgroup may be beneficial for women during childbirth. Manser (2009:143) states that teamwork among the healthcare providers contributes to quality clinical practice with resultant positive clinical healthcare outcomes. Therefore, collaborative midwifery does not require the professional silo mentality, which may encourage midwives to work alone or in isolation (Dorn, 2013:10). The professional silo mentality in midwifery usually triggers different emotions, which may disturb the normal functioning of the multi-disciplinary team. Professional silos in healthcare organisations often originate from authoritative power and hierarchies as well as competition among members of the multi-disciplinary team. Margalit, Thompson, Visnovsky, Ceske, Collier, Birk and Paulman (2009:166) agree that professional silos usually contribute to inefficient teamwork within health settings and thus should be discouraged.

2.4.2.5 The midwife as a competent practitioner

A competent practitioner possesses the skills necessary to perform in practice. Competence is the ability to possess a combination of expected skills, knowledge, attitudes, values and abilities that guide safe, effective and superior performance within a specific profession (WHO, 2013:6). SANC (2005:2) affirms that the competencies acquired in midwifery practice are made up of a combination of knowledge, skills, judgement, attitudes, values, capacity and abilities. SANC (2005) further documents that competencies are meant to pronounce the cornerstone of the whole nursing practice. These competencies denote the building blocks that shape nursing midwifery work in all clinical and practice settings. Furthermore, these competencies are described as dynamic attributes, which comprise context-specific skills and are applicable throughout the professional life of midwives (SANC, 2005:2).

In relation to the competencies, the World Health Organization (WHO, 2011:8) formulated core components, which indicate the key concepts that determine the unique role played by midwives.

These competencies include among others:

- Working with women to promote self-care
- Working with women to promote good health of infants and their families
- Respect for human dignity and treating women with respect
- Advocacy for women whose voices are silenced
- Empowerment of women to seek and obtain better healthcare
- Working with women to overcome cultural practices that are harmful
- Health promotion and disease prevention.

Even though specific competencies are outlined by organisations like the SANC and the WHO, midwives at times ignore these guidelines, and this leads to poor maternity outcomes. The decreased competency is confirmed by the DoH (2012:23) which states that in general there is a drastic decline in the image and status of the nursing profession.

2.4.3 Incompetence in midwifery practice

In South Africa, there has been a general decrease in the nursing standards, which in turn may have affected the maternity practice in the selected hospital. The decreased status of maternity care is labelled as ‘shocking and appalling’ by the DoH (2012:23), and this constitutes pure incompetence. In South Africa, incompetent practice take place despite various competencies which are stipulated

by the Nursing regulatory bodies and that led to the state of care which is regarded as “appalling”. Alspach’s (2009:12) efforts to identify forms of incompetence which be avoided as much as possible was intended assist the nurses, with midwives inclusive to play safer throughout their caring. See the tables reflected hereunder as follows:

TABLE 2.1 FORMS OF INCOMPETENT PRACTICES WHICH SHOULD BE AVOIDED BY MIDWIVES DURING CHILDBIRTH

CATEGORIES OF COMPETENCIES	HOW COMPETENCIES MAY RESULT TO INCOMPETENT PRACTICES.
Caring practices	Failure to create or maintain a therapeutic environment for the patient or family.
Clinical judgement	Faulty and/or poor clinical judgement.
Collaboration	Interactions with others discourage mutual contributions towards patients’ goals.
Systems thinking	Actions failed to recognise inter-relationships among elements in the healthcare system.
Response diversity	Failure to incorporate diversity in care provided.
Clinical inquiry	Neglected questioning or evaluating aspects of practice when warranted.

TABLE 2.2 TYPES AND DESCRIPTIONS OF INCOMPETENCE APPLICABLE TO MIDWIFERY PRACTICE

AREAS THAT MAY CONTRIBUTE TO INCOMPETENCE	TYPES OF INCOMPETENCE THAT MAY BE COMMITTED BY MIDWIVES
Skillset	Inability to provide basic nursing and/or patient care.
Omissions	Failure to render the care that was ordered and/or warranted.
Commission	The provision of care that was not ordered or warranted.
Self-knowledge	Failure to recognise the limits of one’s competencies.

Quality	Rendering of care that is inconsistent with policies, procedures and/or protocols of the unit or hospital.

Table 2.1 intended to show categories of competencies that may contribute to incompetent practice during the general caring as well as in midwifery practice which should be avoided at all costs. Table 2.2 reflected areas which may contribute to incompetence and type of incompetence that may be committed by midwives when caring for women during childbirth.

2.5 VALUES IN MIDWIFERY PRACTICE

Midwifery, as a branch of nursing, is discipline rich in values as confirmed by Florence Nightingale (Rassin, 2008: 614). Florence Nightingale, during the nineteenth century, realised that nursing should be a profession founded on specific human values and should not be judged only through scientific knowledge and technical skills (Rassin, 2008: 614). The above statement supports the researcher's intentions to provide detailed discussions on the concept of 'value', and/or 'professional values' as applicable to midwifery practice. The researcher hoped that these discussions may provide a clearer understanding of the study topic.

2.5.1 Description of the concept 'value'

Value refers to attitudes, ideals or beliefs that are held by specific individuals, which are used to guide behaviour (Black, 2014:89). Values, explicit or implicit, play an important role as underlying determinants for behavioural decision making in general (Park & Yang, 2006:25). Values do not happen spontaneously but are acquired from families and communities. Lai and Lim (2012: 271) assert that values are learned and arise during the human development and affect the cognitive domains, which encompass feelings and intellectual aspects of the human mind.

In midwifery, the cost of the services rendered in some settings cannot be equated to the quality of service received. Miller (2009:1418) argues there are discrepancies between the quality of care and the healthcare costs. Furthermore, most healthcare organisations prioritise 'volume-driven care, rather than value-driven care'. In other instances, healthcare providers, for example, doctors, intentionally plan to increase revenues and profits by delivering quantity rather than quality service. Unfortunately, the issue of volume-driven care goes unnoticed by service recipients (Miller (2009:1418).

The above paragraphs indicate that the term “value” may be applied differently depending on the meaning thereof. In this study, the term value denotes the application of measures that may lead to quality improvement modalities with the resultantly increased satisfaction of women receiving care and/or service. To most healthcare organisations, ‘value-driven’ refers to the health outcomes achieved per money spent on the service rendered (Porter, 2010:2477). However, in this study, the term ‘value-driven’ is not used in terms of the financial gains but the healthcare service the user/women experience during childbirth. The intention of the study was to equate the service rendered to the quality experienced by the user. The study does not look at the financial models employed in the healthcare sector.

2.5.2 Professional values applicable to midwifery

Lai and Lim (2012) mention the importance of values in different professions; these may also be applicable to midwifery. In midwifery, professional values are referred to as standards of behaviour that determine and serve as a framework for guiding the individual behaviour of midwives (Paradeh, Khaghanizade, Mohammadi & Nouri, 2015:284). Professional values serve as a motivator, and they instil pride and give a sense of belonging to midwives. They guide midwives on how to care for admitted women. Professional values also guide the nurse, who in this case a midwife, to be a carer who acts in a professional manner. Lai and Lim (2012:32) concur that professional values mould the midwives’ professional behaviour and transform them into caring practitioners who possess special traits necessary when rendering service. Consequentially, the professional values enhance the behaviour of midwives to act professionally continuously (Jonasson, 2011:1). Applicable to this study, professional values may improve the image of the midwifery profession among the communities they serve. In addition, the application of professional values might enhance the image of the midwifery profession in the said community. In support of the above statement, negative media reports might be a drawback towards the recruitment of students into the nursing profession (Meiring & van Wyk, 2013:4).

2.5.3 Professionalism in midwifery practice

The definition of midwifery in this study is two-fold namely, the midwife as a scientist and specialist and the midwife as an ethical professional.

2.5.3.1 Definition of the concept midwifery

The concept 'midwifery' refers to a caring profession, which is practised by persons registered under the Act, who support and assist women, to achieve and maintain optimum health during all stages of labour and afterbirth (SANC**,** 2005:6). During midwifery care, carers should as much as possible, strive to achieve the survival of both the mother and the newborn baby (Pearson, Larsson, Fauveau & Stanley (n.y:64). Midwifery may be practised in diverse settings; for example in homes, community health centres, clinics or health units and hospitals (International Confederation of Midwives, 2011:1). In support of this statement, Irvani, Zarean, Jangorbani, & Bahrami, (2015) indicates that throughout midwifery, midwives should care for women and every new-born baby and share the joyous celebrations that mark the beginning of a new life.

2.5.3.2 The midwife as a scientist and specialist

According to the Nursing and Midwifery Board of Australia (2008:1), a midwife is a person who underwent a full midwifery educational programme duly recognised in the country in which they practise. A qualified midwife should have successfully completed the specified prescribed duration of the course and acquired the necessary qualifications leading to the registration to practise midwifery. Due to its nature, midwifery is considered an art and science since it involves the application of two distinct bodies of knowledge 'nursing' and 'midwifery' (Dole & Nypaver, 2012:206). Midwifery's scientific aspect is specified through its characteristics of offering lifelong woman-specific care. Midwives are a highly disciplined group of individuals who adhere to high ethical standards of care, which allow them to act in the best interest of women (Halldorsdottir & Karlsdottir, 2011:806). Midwifery is a dual-regulated profession, which is certificated by the midwifery boards while regulated by a nursing organisation, in the case of South Africa, the South Africa Nursing Council.

Midwives as specialists enter into a professional relationship with each woman in their care in order to provide the necessary advice, care and support throughout labour and the postpartum (The Nursing and Midwifery Board of Australia (2008:1). The dense body of midwifery knowledge forms the science of nursing that comprise intensified nursing theory and practice, research and science acquired through intensified training within an academic organisation (Black, 2014:220). Black, 2014:222) confirms the scientific origins of midwifery and classify the profession as a natural science, which comprises of life sciences, chemistry, physics and social sciences. The Nursing and Midwifery Board of Australia (2008:3) and WHO (2014:4) suggest that women's dignity should be respected and uplifted at all times. Consequentially, women should not be exposed to any form of harm and indecent treatment and environment (WHO, 2014:4).

Midwifery training is the core of nursing science since it produces practitioners whose professional caring forms the cornerstone of the nursing profession (Halldorsdottir & Karlsdottir, 2011:806). Caring for the women in midwifery denotes 'being with the woman' (Reiger & Lane, 2009:318 and Jefford, 2012:19) and consequently a positive connotation of a 'good midwife' by those who are cared for. Below are characteristics of a good midwife:

- ***Midwives' flexibility***
  Being a good midwife requires a non-judgemental attitude towards woman admitted for childbirth (Reiger & Lane, 2009:318). Midwives deal with diverse women on a continuous basis, as a result, they should treat them as unique individuals with unique needs, and therefore they should be un-comparable.

- ***Safe practice***
  An expectation is that midwives' actions should be safe to all women admitted for childbirth. The Royal College of Midwives (2014:22) concur that apart from physical safety, acts, which are easily ignored such as listening and providing information, are important.

- ***Skilled midwifery practitioner***
  A skilled, caring midwife is competent enough and can be entrusted with the lives of women who require care.

In support, McConville (2014:8) asserts that a midwife is the most best qualified and suitable professional to render full midwifery services than any other health professionals. Therefore, they are rightful specialists in this regard. McConcille (2014) adds that undeniably, other healthcare professionals like doctors only render a portion of midwifery care and that does not automatically acquaint them to the field compared to midwives.

2.5.3.3 Midwives' professional and ethical responsibilities

Ethical values are the backbone of the way people act, behave and deal with different moral situations (Jonassons, 2011:3). Furthermore, ethical values may cause people to feel valued and respected, and provide individuals with feelings of 'being respected' especially in circumstances where one depends on another person for care. Essentially, ethics is concerned with the individual

nature of humanity since acting in an ethical manner promotes humanitarian characteristics (Vyas-Doorgapersad & Ababio, 2010:413). Lachman (2012: 113) identified the three elements of a midwife as a carer, which is attentiveness, responsibility and responsiveness.

2.5.4 Attentiveness of a caring midwife

Attentiveness of the midwives is portrayed when the midwives show their ability to attend to the admitted women's needs on time. The South African People First/Batho-Pele principles require that healthcare providers show attentiveness to recipients of care (DPSA, 2008). As such, the care rendered should be based on the principle of 'woman first'. Lachman (2012:113) asserts that attentive midwives put themselves last and 'step out of their own preference system in order to take up that of the woman in order to fully understand the patient's situation'.

Ball, Murrells, Rafferty, Morrow & Griffiths (2013:4) reveal that the most common lack of attendance is related to failure to talk and/or educate patients due to time constraints and staff shortages. However, other scholars disagree with the statement above; one such scholar is Lachman (2012:114) who alluded that time should not be considered a factor in instances where care is substandard. A midwife who pops up in the woman's room through a short round during busy times might send a 'caring message' to the woman since 'little things' may count a lot during midwifery care. In order to address the lack of attentiveness, Lachman, (2012:113) noted that maternity wards should implement policies like 'no pass zones'. Failure to address the attentiveness in the maternity wards may be interpreted as an obvious lack of care.

2.5.5 Responsibility of a caring midwife

The internationally agreed definition of a caring midwife recognises the midwife as a responsible and accountable professional who works in partnership with women to render the necessary support, care and advice during pregnancy, labour and the postpartum period. Midwives are expected to provide care including preventive measures, detect complications, access of medical care and/or other appropriate assistance, carry out emergencies and conduct births (The Royal College of Midwives, n.y:5). In addition, a midwife must have completed midwifery education program recognised in the country where they practise. The educational program should adhere to the International Code of Midwives. Furthermore, a qualified midwife should have acquired the requisite qualifications for registration and/or legally licensed to practice midwifery and utilise the title 'midwife' (International Confederation of midwives: 2011). Midwives should focus on health promotion and

disease prevention in order to address problems that may divert pregnancy from its normality (International Confederation of Midwives, 2015).

2.6 RESPONSIVENESS OF A CARING MIDWIFE

In addition to the above, South Africa through the DoH (2013:14) mentions the need for professional and ethical practice specific to the midwives. The requirements indicate what is expected of a midwife in each and every midwifery care setting. It reflects that it is imperative for midwives to portray an ability to: demonstrate knowledge and insight into laws and regulations relevant to the practice of midwifery and to practice in accordance thereof. In addition, midwives should continuously protect and promote the rights of women by practising in an ethically safe manner. Lastly, midwives are reminded to assume full responsibility for their actions and omissions while continuing with diverse and dynamic midwifery care. They must continuously use the relevant legislative and competency frameworks, standards and scope of practice (SANC, 2013:8) to ensure that value-driven midwifery care is provided.

On the contrary, Vyas-Doorgapersad and Ababio (2010:413) maintain that midwives may find themselves faced with situations, which require them to make decisions that have no clear-cut resolutions with resultant ethical dilemmas. These dilemmas may arise from situations that necessitate competing principles, values, beliefs, opinions and perspectives (Vyas-Doorgapersad & Ababio, 2010:413).

During childbirth, women should be treated as unique individuals. Midwives should refrain from comparing one woman to the other since their belief systems may be totally different. This may be the reason why the idea to move away from the 'normalcy' was suggested. Davis (2010) advocates that a woman's values may channel her to behave in a certain way while giving birth. Furthermore, 'childbirth screamers' may still scream despite how hard the midwife advice (Davis, 2010:209).

To further the discussion, it is important to reflect on the professional and ethical responsibilities of midwives as advocated for in the Canadian Nursing Association (2008:3). These professional and ethical responsibilities are a global expectation for midwives. Midwives should strive to achieve the professional values and ethical responsibility of ensuring safe and accountable care. This may be achieved through the ability to aim at the maximum benefit, less harm towards admitted women and should respect women as individuals, treat them equally and portray empathy towards them on a

continuous basis (Ergin, Özcan, Ersoy & Acar (2013:24,25). Ethical responsibility refers to the ability of the midwife to provide reasonable foreseeable care based on policies and professional standards (Royal College of Nursing, 2017:1). In addition, the adherence to the professional and ethical responsibility should lead to improved quality of maternity services (Canadian Nurses Association, 2008).

2.7 MIDWIFERY AS A CARING PROFESSION

To clarify the caring aspect of midwifery, the researcher chose subtopics, which steer the discussion towards the understanding of the discussed topic, and these are discussed below.

2.7.1 Caring during midwifery

Caring refers to a human interaction, which is recognisable and structured within societies. It stems from the humanistic caring philosophy, which focuses on the respect of other peoples' identities, the responses to the choices and commitment to societal needs (Salehian, Heydari, Aghebati & Moonaghi, 2017:258). Care or caring extends from birth to death and midwifery is at the core of caring (Cody, n.y:9). Caring in midwifery may be the essence of nursing which may constitute the basic factor that distinguishes nurses from other health professions (Azizi-Fini, Mousavi, Mazroui-Sabdani & Adid-Hajbaghery, 2012:36). Cody (n.y:9) maintains that in various areas of speciality carers constitute professionals who deliver specialised care. Caring should be individualised since no two women are the same, thus midwifery care should not be generalised. Individual preferences differ and midwives' actions may be deemed necessary or unnecessary by those who are cared for, i.e. pain management is reliant solely on the views of the women, some find the necessity for pain relief while for others that maybe useless and unnecessary (Larkin, Begley & Devane, 2017:6). Jonasson, (2011:3) asserts that professionals involved in caring may have different experiences of caring depending on how they think and feel and thus no one meaning can wholly denote what caring is.

The universality of the term 'caring' has led to the emergence of different theories especially in nursing (Black, 2014:268). In order to provide clarity two theories, which concentrated on transpersonal care including culture and universality care were chosen.

2.7.2 Different authors' perspectives on the concept of caring

Specialist nursing theorists developed theories to guide the act of caring by nurses and midwives. For the sake of this study, only two reflected hereunder were found suitable.

2.7.2.1 Watson's theory of care: The caritus factors

Watson's caring theory is well known in nursing. This theory maintains that caring contains humanity and continues throughout the lifespan (Watson, 2009:143). Caring during midwifery depicts the art and science that involves human hands as tools. That may be the reason for Watson (2009) to assume that nursing as a caring science differs from all the other sciences including the medical sciences. The theory comprises the caritus factors of the transpersonal and the caring moment (Lachman, 2012:112).

Four out of the ten caritus factors as referred to by Lachman (2012:112) were chosen by the researcher because they related well to the topic of the study. The four caritus involves the midwives' acknowledgement of the need to develop and sustain an authentic heart-centred relationship with the women they care for. The development of this relationship is aimed at maintaining an authentic caring relationship, which may be termed woman-centred relationship throughout childbirth. In this relationship, the midwife should practice care and kindness to women without limitations (Watson, 2009:144). In order to apply these caritus factors further, midwives should portray qualities of helpfulness and trustworthiness.

The midwife-woman relationship recognises the uniqueness of each situation and preserves the dignity of both the midwife and the woman (Lachman, 2012:112). During the midwife-woman relationship, the midwife should show feelings of concern and empathy towards the women (Lachman, 2012:112). Midwives have a responsibility to uphold the professional values without imposing their own individual and societal values (Jonasson, 2011:9).

The midwives should always 'be there' for the women during childbirth. Watson (2009:144) asserts that the notion of caritus may be uplifted by the midwives' presence. Thus, when the women are left alone, neglected and/or ignored, they may feel completely unsupported and dissatisfied. However, women who are satisfied will not show negative feelings and may, in turn, contribute to the midwives' satisfaction. In support to the latter statement, Lumadi and Buch (2011:14) and Irvani, et al. (2015:3)

assert that the quality and the timeous fulfilment of the women's needs may raise the women's satisfaction with the care they receive.

An environment that fosters the satisfaction of stakeholders within any caring situation and may lead to the attainment of healing as suggested by caritus number eight; Watson (2009:144). The environment suggested by the discussed caritus depicts a Positive Practice Environment (PPE), Democratic Nursing Organization of South Africa (DENOSA) (2013). This suggestion was introduced in order to improve a user-worker-friendly environment for stakeholders within the healthcare sector.

2.7.2.2 Leininger's theory of care: Culturally competent care

Caring should be holistic, and that is the reason that Leininger, the well known and founder of Transcultural Nursing came up with the theory of culture care diversity and universality (CCDU). Transcultural Nursing is believed to be the foundation of quality care especially in instances where diverse populations are serviced. The theory raises the health service providers' awareness as regards the value of patients' culture. The healthcare service providers' own beliefs, sensations and thoughts should be channelled in such a way that they do not negatively influence those of the patients (Tortumluoglu, 2006:1).

The midwives as healthcare service providers are encouraged to demonstrate knowledge and understanding of various cultures. They have to accept and respect cultural differences and adapt in order to offer culturally acceptable care. Midwives should possess cultural awareness, desire, knowledge and skills in order to enhance competent cultural care (Tortumluoglu, 2006:1) and (de Beer and Chipps, 2014). Douglas, Pierce, Rosenkoetter, Pacquiao, Callister, Hattar-Pollara, Lauderdale, Milstead, Nardi and Purnell, (2011) alluded to the fact that healthcare service providers should gain an understanding of the perspectives, traditions, values and practices of diverse individuals, families, communities and populations they care for.

2.8 VALUE-DRIVEN CARE

Value-driven care means care that is guided by professional values as provided for in midwifery practice. The value-driven care is also called value-based care, Cody (n.y:9) mention that during value-based care midwives as practitioners render care to women, as consumers of care.

2.8.1 Value-driven midwifery care and values

In midwifery, value-based care is guided by the values, which are applied during the execution of service. That is the reason Cody (n.y:11) indicates that people live their values because they direct their lives on a continuous basis and are therefore enacted repeatedly. Professional values direct midwives on how to deliver service while the personal-societal values direct women's choice of the type of care they need. Cody (n.y:10) helps to clarify the understanding of care received by women and practices employed by midwife by using the following terms 'caring' and 'practising', and these are clarified in the table below:

TABLE 2.3: THE DIFFERENCE BETWEEN MIDWIFERY CARE AND MIDWIFERY PRACTICE

MIDWIFERY CARE	MIDWIFERY PRACTICE
Midwifery care views women as healthcare consumers.	Midwifery practice belongs to midwives as practitioners.
Midwifery care is highly controlled by consumers, laws, rules and the society at large.	Midwifery practice is controlled by practitioners and by the profession.
The care involves an increased interdisciplinary intervention since it is consumer driven.	It is more discipline-specific because it is practitioner based.
Midwifery care provided is evidence-based.	It is value-based.

Table 2.3 depicts the difference between midwifery care and midwifery practice. In order to provide clarity, the researcher differentiated on the two main concepts so as to provide understanding.

2.8.2 QUALITY AND PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE

Value-driven midwifery care leads to increased quality of care, and midwives are expected to act based on specific professional values. These values form a foundation of their activities, and a scale for determining care priorities and midwives are expected to live by these values (Shahriari, Mohammadi, Abbaszadeh & Bahrami, 2013:4).

2.9 CONCLUSION

Chapter two provided details of the literature reviewed in order to clarify and create the accurate meaning of the concepts used in the study. The chapter orientated the reader on the aspects of literature reviewed for this study. The meaning of midwifery as a profession, values that promote professionalism in midwifery practice and the caring aspects of midwifery were discussed and clarified. The next chapter will discuss the research methodology employed in the study.

CHAPTER 3
RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

Chapter two discussed the literature reviewed for the study and chapter three focused on the research design and methods used. The intention of the study was to conduct practice-based research through a CI. The 'action' in this inquiry research was achieved through the actual activities performed while 'research' aspect involved the ways and methods thereof. Due to the nature of the research problem, this researcher concluded that a CI was the best-suited methodology for the study.

The study is about the decline of professional values, which led to a declined level of midwifery care in a public hospital in the Mpumalanga province of South Africa. Admittedly, the CIG' collaboration became the core aspect of this CI and thus contributed to the ownership of the inquiry. In addition, this CI was collaborative in nature and had the intention to understand, inform and improve midwifery practice at the chosen setting. To ensure that there was transparency the CIG played a dual role as role players and researchers.

3.2 COOPERATIVE INQUIRY RESEARCH APPROACH

Cooperative Inquiry research methodology founded by John Heron is employed by the study. The CI is a methodology that allows the CIG to interact and work as co-researchers and co-manage the inquiry. The CIG have a responsibility to generate research ideas, design and manage the project. Furthermore, decision-making and project conclusions are laid upon their shoulders (Reason, 2002:169). Applicable to this study, CI was adapted by midwives in order to work together while developing new ways of improving the situation. Also called qualitative research, CI is used mostly in community-based research (Mardis & Everhart, 2013:157). This researcher adapted the methodology because the main intention of the study was to improve the quality of service rendered in the maternity ward of the chosen setting. In its nature, CI is cooperative and collaborative;

therefore it was a suitable methodology, which could assist with the attainment of the objectives of the study.

CI is directed by specific principles of understanding of the own role played by its members who automatically attain a role as co-researcher, co-subjects who become fully immersed in resolving issues that involve them. In addition, the members use own experience to participate while they gain capacity to improve it in turn. CI increase their sense of ownership, mutualism and collaboration within the group (Reason 1999:208)

To demonstrate aspects that promote the suitability of the approach to this study refer to table 3.1 below.

TABLE: 3.1 CONTRASTS BETWEEN COOPERATIVE INQUIRY RESEARCH AND TRADITIONAL POSITIVIST RESEARCH

	COOPERATIVE INQUIRY	POSITIVIST SCIENCE
Aim of the research	• Knowledge in action. • Aims at theory building and testing. • Research is conducted 'with' people. • It believes in 'together we explore'.	• Knowledge is universal. • Aims at theory building and testing. • Research is conducted 'on' people. • It believes in 'I ask … you answer'.
Type of knowledge created	• Knowledge created is particular. • It is situational.	• Knowledge created is universal. • It is covered by the law.
The nature of data **Validation**	• It is contextually embedded. • Data is practical. • It is experiential. • It is participatory and democratic.	• It is context-free. • Data is often theoretical. • It is logical. • It is passive and oppressive.

Researcher's role	• Researcher is an actor.	• Researcher is an observer.
Researcher's relationship to the setting	• Researcher is immersed in the research. • Genuine achievement of a sense of 'us', the group.	• Researcher is detached and neutral. • Achievement is attached to a sense of 'me' the researcher

Coughlan & Cochlan (2002:224), Reason (2008)

3.2.1 The type of Cooperative Inquiry of this study

CI researchers usually perform an internal or external, closed or open boundary and an Apollonian or Dionysian inquiry type. This CI was a closed boundary Apollonian, internally initiated but also applied some form of Dionysian approach to the study.

3.2.1.1 Apollonian inquiry research

The descriptions of the above-mentioned forms of inquiry are important and applicable to this study. In this study, an Apollonian inquiry was followed. Oates (2004:32) mentions that an Apollonian inquiry research is rational and undergo a formalised, systematic and sequential approach which is achieved through reflection, planning, action and observation (McNiff, 2013:57). The steps of this CI followed each other in a logic, rational, expressive, clear and detailed actions followed by the second reflection stage which served as a determining factor to or not to proceed to the next phase. Reason & Bradbury (2008:37) refers to the Reflection phase as a systematic approach to review the success of the previous phase. The aforementioned characteristics qualified this inquiry to be of an Apollonian type (Heron, 1996:95) and reflected the difference between the two inquiry approaches.

Oates (2004:6) added that both approaches complement each other and as such, no study can solely apply a single approach. In this study, the Dionysian type was also applied where co-researchers presented topics they knew better which resulted increased presentational knowing which contributed to the CIG's cooperative learning.

3.2.1.2 Internally initiated inquiry research

Specific to this study, the CIG conducted an internally initiated inquiry (Oates, 2004:6). The internally initiated inquiry was possible since the since the researcher and the midwives formed a team of experienced midwives. The researcher worked as an Operational manager prior to employment by the academic organisation in Gauteng province of South Africa. An Internally initiated inquiry took place easily as the research proceedings were initiated by midwives who all were conversant with

the requirements of the study which was conducted. The CIG spent prolonged periods together and that differentiated the group from those of the others qualitative researches. The researcher obviously operated differently from external researchers who intentionally separate themselves from the participants immediately after collecting data (Iacono, Brown & Holtham, 2009:42).

The criteria mentioned above qualified the researcher as an internal initiator. The researcher as an inquiry initiator understood the role played by professional values in daily activities of nurse-midwives. The knowledge, allowed the researcher to diagnose the problem easily. Heron, 1996:95) agrees that researching from the same angle automatically render the researcher an internal inquirer. Comparatively, 'an external inquirer' who belongs to a different discipline would work differently from an internal researcher and might be detached.

Armstrong and Banks (2011:6) indicate that the researcher as an internal inquirer conduct research 'with' people rather than 'on' people and that was applicable to this study. Also applicable to this study, was that the researcher worked collaboratively with the CIG. The CIG automatically led to a dual role of the CIG as part of the action and co-researchers.

3.2.1.3 Closed system boundary inquiry research

A boundary is determined by an imaginary boundary depicting what is inside or outside a particular system. A research boundary can be either: closed' or 'opened'. Applicable to this inquiry research, a closed boundary was employed. The CIG members were actively involved in the planning and decision-making of the inquiry. The participants decided that the CIG should comprise of maternity ward staff alone. The CIG continuously took decisions as a collective with no imposition from anyone. Following (Heron, 1996:45) data was generated by the CIG as they had a right to make decisions regarding the inquiry.

3.3 THE CONTEXT OF THE STUDY

Coghlan and Shani (2014:528) refer to a research context as the centre for the business, social and academic background of research. They continue that the research context, the operations of the setting should be described clearly. The research context is very important in a research study because its lack might lead to failure in replicating the findings. The interpretation, application and translation of findings might lack support and therefore be missed. Particularly in healthcare related researches, the description of the context is necessary (Tomoaia-Cotisel, Scammon, Waitzman,

Cronholm, Halladay, Driscoll, Solberg, Hsu, Fetters, Wise, Alexander, Hauser, McMullen, Scholle, Tirodkar, Schmid, Donabue, Parchman & Stange (2013:115).

The context of this study comprised of a broad overview or a situational analysis, which included both the geographic and the organisational contexts. In general, the environment, be it geographic or organisational might have a positive or negative influence on the delivery of service (López-Chevallos & Chi, 2010:2). As a result, the geographic and organisational contexts are discussed in relation to the goals of the setting where research is conducted. Of equal importance is the context in relation to specific date and time (McNiff, 2006:193, Coghlan & Shani, 2014:525, Glatthorn & Allan 2005:190, Tomoaia-Cotisel, Scammon, Waitzman, Cronholm, Halladay, Driscoll, Solberg, Hsu, Fetters, Wise, Alexander, Hauser, McMullen, Scholle, Tirodkar, Schmid, Donabue, Parchman, and Stange (2013:115). The context in this study comprised of geographic, the socio-academic and research topic specific.

3.3.1 The geographic context of the study

The inside nature of the context might bear a negative bearing on healthcare within a specified health environment. The research findings of the qualitative research are localised. Despite this realisation, the inclusion of the research setting in a research document is important. The reason thereof is that the findings of this study might be generalisable to others whose problems are comparable to that of the researched setting (Botma, Greef, Mulaudzi & Wright, 2010:95).

The geographic context of every society determines the health outcomes in its vicinity, and therefore, a brief overview has to be provided. The geographical context of the study is Nkangala district, which lies, in the far western aspect of the Mpumalanga province of South Africa. The district has a total of population of 1 226 513 (National Treasury, 2011:6) and consists of seven municipalities.

Nkangala district is demarcated into six districts namely, Dr J.S Moroka, Thembisile Hani, Emakhazeni, Steve Tshwete, Victor Khanyi and Emalahleni which differ vastly in size and population. See the attached map https://manucipalities.co.za/map/133/nkangala-district.municipality.

In order to promote clarity; the geographical context of the described area was shown in the map that follows:

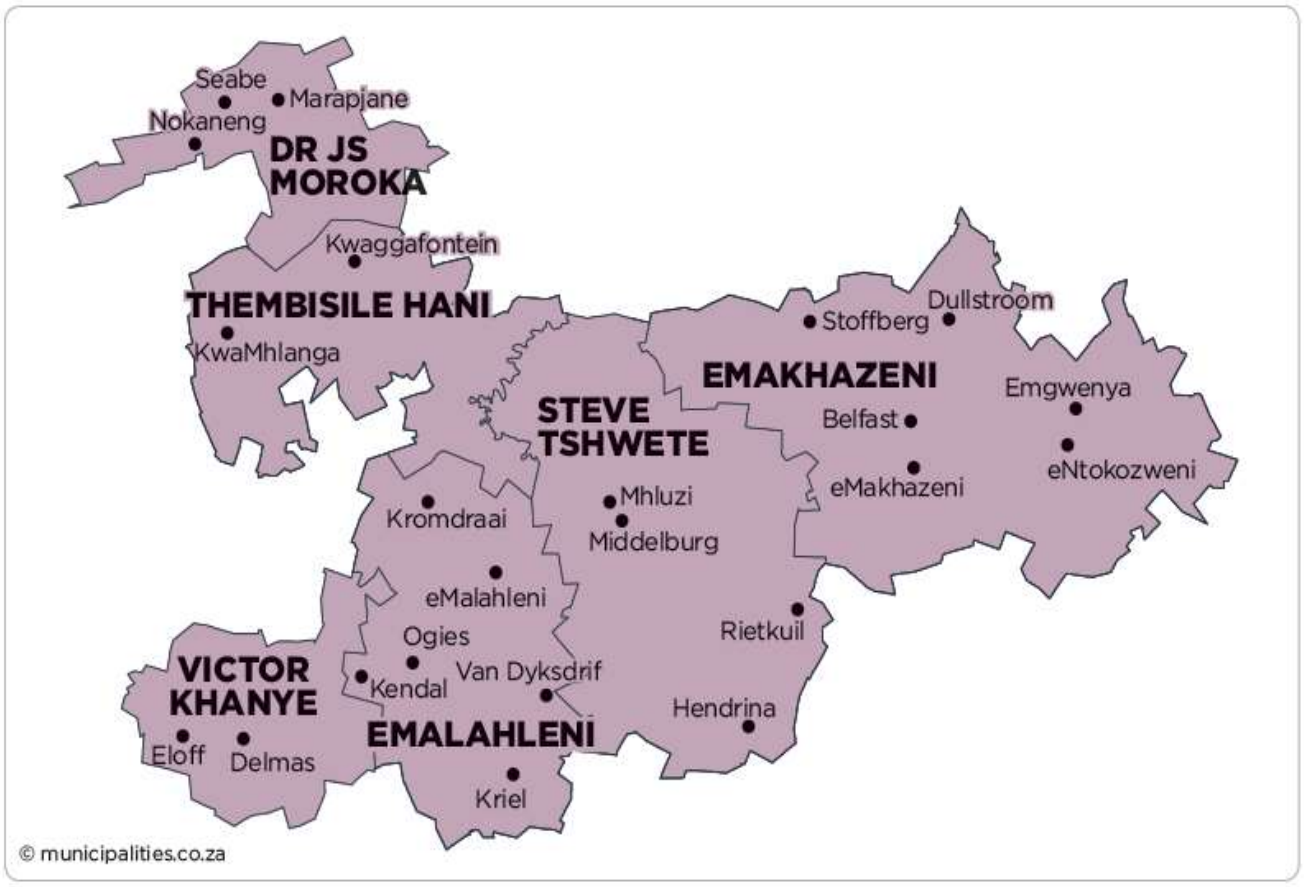


Figure 3.1: Map of Nkangala District municipality (DC31)

The district has eight level one hospitals, three private hospitals, one regional and one specialised hospital, which make a total of thirteen.

The setting is a rural district hospital in one municipality within the above-mentioned district. This remained the only setting throughout the study. The number of usable beds at the hospital is 150. The total number of nurses in the setting is 176, with the number of midwives being 88; while non-midwifery trained nurses were 24. A total of 48 midwives are allocated to the maternity ward on a semi-permanent basis with 12 midwives allocated for day and night duties per shift. The ages of women admitted for childbirth in the maternity ward ranged from 14 to 40. The number of deliveries per month ranged between 280 and 295. A total number of deliveries per quarter ranged from 740-780. This was the only context for conducting this study.

3.3.2 The socio-academic and the researcher's topic-specific context level

The social-academic context was achieved through one informal meeting with two senior nursing managers as 'trusted sources'. The data collection method applied in this phase was informal, conversational interviews based on an unplanned set of questions generated instantaneously at the time of the interview Jamshed (2014:87) and Turner (2010:755). The reason for using the unstructured interview was that the researcher had already developed an understanding of the setting after attending the 'gatekeepers' meeting. The CIG also understood the research topic since it was introduced in the earlier meeting.

The conversation revealed the presence of negative attitudes of community members towards staff in the maternity ward. The researcher's preliminary topic was well suited to the situation. The literature review conducted in chapter two provided awareness of the need for the professionalism of midwifery practice. Therefore, this identified need further rendered the topic to be well fitting. The social context described gave the researcher a chance to enter the maternity with no preconceived ideas but to remain as neutral as possible.

3.3.3 The practice level context

The discussion of the practice level context is divided into two sub-levels namely, the requirement of the Department of Health (DoH) and the maternal-child health workers' level which are elaborated upon in the subsequent discussions.

3.3.3.1 The requirement of the National Department of Health

The DoH generally carries out the assessments for accreditation of hospitals through the National Core Standards; seemingly, the effort did not yield good results at the chosen setting. Episodes of truculent by healthcare providers, in particular, the midwives, were continuously reported. Admittedly, so, it seemed the Government's Batho-Pele initiative was still not adequately taken into consideration. Consequentially, community members conveyed anger towards the midwives. This part of the discussion diagnosed the status of the maternity ward and suited the topic well (Mannava, Durrant, Fisher, Chersich & Luchters, 2015:17).

3.3.3.2 The maternal-child health providers' level

This level comprised of the local issues related to the care provided. Locally, the discipline context involved the individual goals of the researcher and the trusted sources since all parties had a common goal of promoting quality professional value-driven midwifery care. The trusted sources highlighted the existence of repeated unacceptable interpersonal relations between the midwives and the women. In other words, the communities and the hospital had a history of unpleasant interpersonal relations. The involvement of families of admitted women in midwifery issues created a human resources' dilemma.

The repeated negative media reports blew up the issue out of proportion and had a negative impact on the image of the institution and damaged the reputation of the midwives. As such, some professional nurses detested being allocated to the maternity ward and in turn presented emotions of anger, fear and/or worse; frustration (Bick, 2010:147). The point on environmental factors influencing practice was highlighted by Coghlan and Shani (2014: 528) with challenges of overpopulation in the maternity ward. Thereafter the researcher paid an official visit to the maternity ward.

3.4 RESEARCH METHODOLOGY

According to Polit and Beck (2017:11) research methodology refers to methods or techniques utilised to collect data and to analyse the collected data for a particular study. Data were conducted in one phase and was achieved through sequential steps of Reflection, Planning, Action and Observation, where each steps informed the other. The sequence of the CI approach followed was reflected refer to 3.4.1.

3.4.1 An outline of the phases of a Cooperative Inquiry research

This (CI) research revolved around the reflection, planning, action and observation phases which formed a process that eventually led to a full cycle (Reason, 1999:7). McNiff (2002:10) refer to the CI as a series of basic steps, which gave rise to an action plan. Information on the different steps of a CI followed is reflected in the below figure.

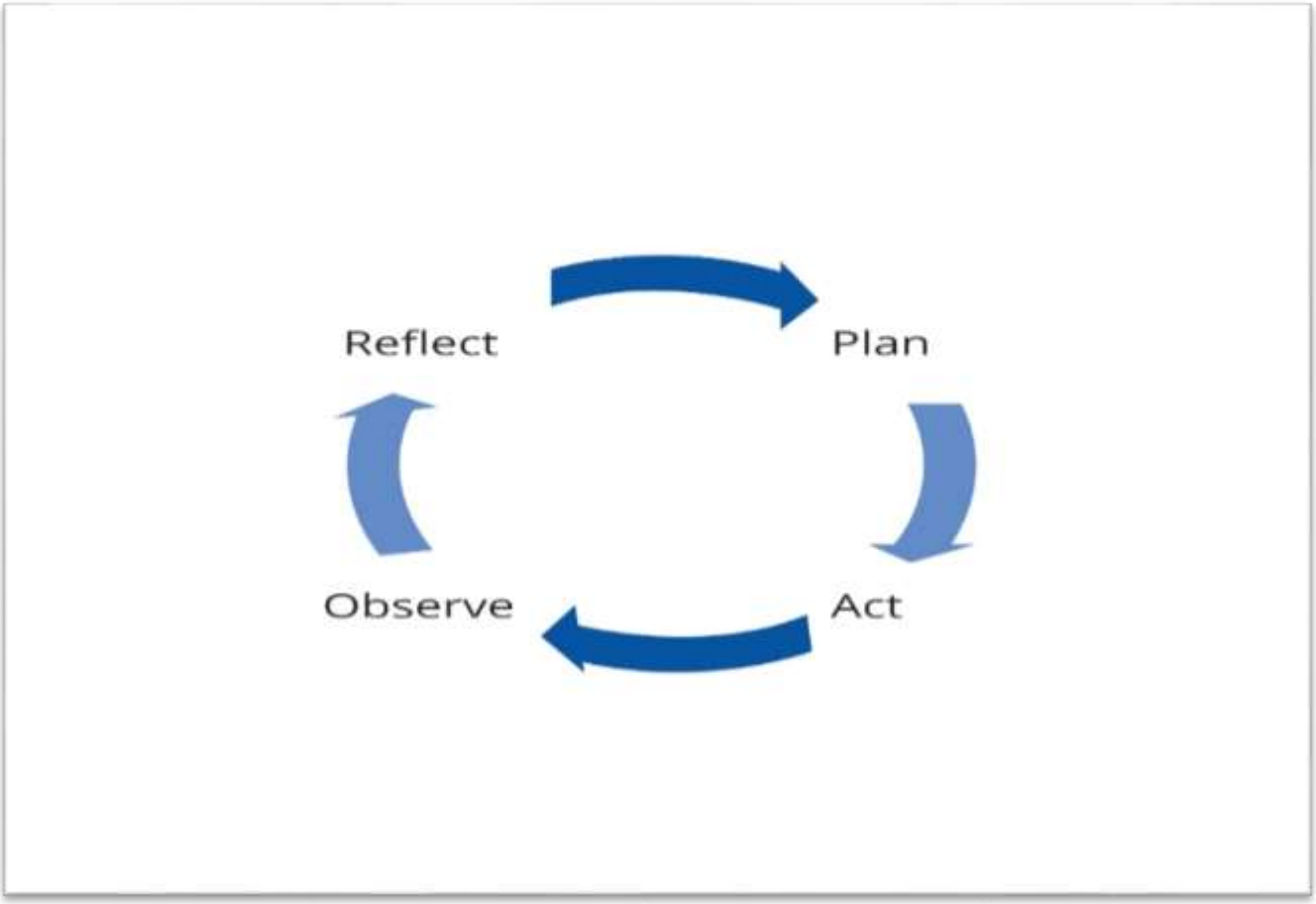


Figure 3.2: Reflects on the process of research comprising of the Reflection, Planning, Action and Observation

3.5 A BRIEF DESCRIPTION OF THE PHASES OF THE COOPERATIVE INQUIRY

The study comprised of four phases namely, the Pre-phase, the Planning, the Action and the Evaluation phases. A brief outline of the phases of a Cooperative Inquiry is given as 3.5.1- 3.5.4.

3.5.1 Reflection phase

The CIG openly reflected on a burning issue that needed their full attention as the people who are directly involved in order to change the situation (Gladkikh, 2015:5). In this study, the CIG found a need to use a Cooperative Inquiry and agreed to address the matter on their own.

3.5.2 Planning phase

According to Mash (2014:3), the CIG and the research organiser come up with plans to institute changes in order to achieve the objectives of the study. The research organiser presented different methods of data collection and the CIG chose a Cooperative Inquiry as the preferred one.

3.5.3 Action phase

The CIG revisited the preliminary questions and objectives of the study and made the necessary modifications for alignment with the circumstances they were faced with. They also decided on the methodology of their choice.

3.5.4 Observation phase

This phase intended to evaluate the success of the whole process. The satisfaction of the CIG with the process followed meant the end of the investigation and they also understood the need for repeating the procedure until the desired outcomes were achieved.

TABLE 3.2: SUMMARY OF THE PHASES OF THE STUDY

PHASE 1: THE INTRODUCTORY PHASE **THE PREPARATORY PHASE: STAGE 1**				
QUESTION 1	**OBJECTIVE 1**	SAMPLE AND SAMPLING METHOD	**METHODS USED**	**OUTCOMES OF THE PHASE**
How can gatekeeping be negotiated in a public hospital following a CIG research approach?	To establish a supportive and trusting relationship in the chosen setting	Leadership and Executive Committee Nursing Management purposive	Group discussion (based on the results of the National Core Standards)	Acknowledgement of challenges regarding the decline in nursing values, ethics and norms Attitudes of midwives were identified

		sampling was used.		Agreement to continue with the study

INCEPTION PHASE **REFLECTION PHASE: STAGE 2**				
QUESTION 2	**OBJECTIVE OF 2**	SAMPLE AND SAMPLING METHOD	**METHOD USED**	**OUTCOMES OF THE PHASE**
How should midwives relate professional value-driven midwifery care in the maternity ward?	To identify the CIG' personal values that contribute to teamwork	Midwives Purposive sampling used	The Hand Diagram Figure exercise to facilitate team building	Collaboration, and teamwork.
Question 2	**Objective of 3**	**Reflection** Sample and sampling method	**Phase: Stage 2** Data collection method **used**	**Outcomes of the phase**
How can midwives prioritise professional value-driven midwifery care following a CI	To explore the midwives' pre-knowledge regarding professional	The midwives Purposive sampling used	Nominal Group Technique to reach consensus on preferred values	Important values were ranked

research approach?	values in midwifery care			Need for upholding the SANC professional values

PHASE 2: CREATION PHASE PLANNING PHASE				
QUESTION 4	OBJECTIVE FOUR	SAMPLE AND SAMPLING METHOD	METHOD USED	OUTCOMES OF THE PHASE
How can midwives promote professional value-driven midwifery care using a Cooperative Inquiry?	To explore and describe the midwives' views regarding professional value-driven midwifery care	The midwives Purposive sampling used	Focus group discussions	Variety of views from the CIG members Collaboration and teamwork

PHASE 4: IMPLEMENTATION PHASE **ACTION PHASE**				
QUESTION	**OBJECTIVE FIVE**	**SAMPLE AND SAMPLING METHOD**	**METHOD USED**	**OUTCOMES OF THE PHASE**
How can Midwives utilise the knowledge of professional value-driven	To develop strategies to empower midwives regarding professional	The midwives Purposive sampling used	Informal interviews	Developed strategies to empower midwives in a maternity ward

midwifery care to develop strategies to empower midwives using a CI research approach?	value-driven midwifery care to improve childbirth			

EVALUATION PHASE PHASE 4: Observation phase				
QUESTION	OBJECTIVE	SAMPLE AND SAMPLING METHOD	METHOD USED	OUTCOMES OF THE PHASE
How can midwives evaluate the attainment of caring and respectful midwifery during childbirth using a CI research approach?	To develop an assessment tool to evaluate the midwives' caring and respectful midwifery care	The midwives Purposive sampling used	Focus group discussions	Developed Assessment tool

Table 3.1 consists of a summary of the methodology followed in this chapter. For details, refer to 3.6 which entails the data collection of the study which is reflected below as follows:

3.6 DATA COLLECTION

Data collection were done in phases. The phases of the study were each discussed in detail according to the sequence reflected in the above table. Below are the discussions, which entailed the practical stages, objectives, the population, specific methodologies followed, and the outcomes of each phase. All the questions followed the interview guide. Refer to annexure E. Data collection started from the Introductory to the Observation phase as 3.6.1-3.6.4.

3.6.1 Phase 1: Introductory phase of the study

The Introductory phase of this CI constitutes the initial phase of the study, which comprises of three stages of reflection namely the Preparatory, Hand Diagram figure exercise and the Nominal group technique. The stages followed each other sequentially. The 1st reflection, the Preparatory phase (stage 1) was conducted with the members of the Executive committee. The two reflection phases that followed were conducted with the CIG and were differentiated as the 2nd Reflection phase, the Hand Diagram figure exercise (stage 2) and the 3rd Reflection, the Nominal Group Technique (stage 3).

3.6.1.1 Phase 1: The Preparatory phase, (stage 1): negotiating entree into the setting

In preparation for the phase, the researcher paid a formal visit to the chosen setting. The population was the leadership comprising of the Executive Committee (Exco) as well as senior midwives. The phase also termed the pre-entry stage of gaining entry to the gatekeepers of the chosen setting. The venue for this meeting was the CEO's office. As the research was conducted in a formal health organisation, a formal entree method was followed. An e-mail with a formal letter on an official letterhead was sent to the CEO requesting permission to conduct the study in the hospital. The CEO and the Exco committee had the responsibility to protect the welfare of the organisation. Understandably, the leadership strongly supported the study and hoped for success. The Nursing-Midwifery management formed part of the meeting as determined by the research theme (Oppong, 2013:206). The leadership, as a collective, possessed special powers to hinder or allow the research (Johl & Renganathan, 2010:42, Mash, 2014:3, Waterman, Tillen, Dickson & de Koning, 2001:45 & Singh & Wasserman (2016.).

3.6.1.1.1 Objective of phase 1, (Stage 1)

The objective of this phase was to establish a supportive and trusting relationship with the leadership of the chosen setting.

3.6.1.1.2 Sample of phase 1, (Stage 1)

Cooperative Inquiry promotes homogeneity among all the CIG of the study. At this stage, homogeneity as an important aspect of a Cooperative Inquiry was not possible until after gatekeeping was completed because the leadership comprised heterogeneous individuals based on elements like gender, positions and areas of speciality who formed a strong leadership in the chosen hospital. The sample in the Preparatory stage (stage 1) also had senior midwives who carried leadership responsibilities in the hospital as well as the researcher whose academic role involves nursing management and leadership. Acknowledging the problems faced by the hospital, in particular, the maternity ward, the CEO invited three executive committee members and thee nursing managers to the meeting. Purposive sampling method was used to recruit only those participant's who were most relevant. According to Grove, Grey and Burns (2015:270), this method refers to judgemental sampling through which the researcher consciously selected certain individuals to include in the study. Due to other commitments, not all the population attended the meeting. However, the partisipants agreed to continue with the meeting since they felt that there was a need and the meeting formed a quorum. The researcher gave the full details of the study. All the 'good to be heard' by the leadership were addressed by the researcher through a power-point presentation. This researcher clarified all areas of concern and questions that the leadership had with regard to the study.

3.6.1.1.3 Data collection method used in phase 1, (Stage 1)

Data collection means gathering of information aimed at addressing the research problem (Polit & Beck, 2017: 725). Data collection methods in this chapter were depended on the suitability and size of the population. The question posed in this phase was phrased as: *"how can gate-keeping be negotiated in a public hospital?"*

Group discussion was used to collect data. Group discussion denoted a forum where people sit together to discuss a common objective of finding a solution to an existing issue (Nagarathinam & Lakshmanan, 2016:169). The benefit of the group discussion was to obtain different views on the chosen topic as the saying goes *two heads are always better than one* (Burke, 2011:87, 88). The

participant's involvement as a group led to improved teamwork and increased collaboration between the leadership and the researcher.

The leadership utilised the hospital records to report on issues of concern, which related to the topic under discussion. The CEO authorised and allowed the usage of the necessary hospital records. Three types of reports namely, the quality assurance officers' reports, the National Core Standards (NCS) accreditations report known as Quality Improvement Plans (QIP) of 2015 (Annexure M) and the Operational Manager's quarterly reports, the Complaint Profile Annexure (O) were provided. The discussion of each of the mentioned reports supported the need for the researcher's type of topic for investigation at the hospital. Iacono, et al. (2009:41) asserted that records are a good source of data in a research study. Relevant and useful data was retrieved from the hospital records, and the information gathered formed the foundation for conducting the inquiry.

3.6.1.1.4 Outcomes of phase 1, (Stage 1)

The leadership thanked the researcher for choosing the institution. As a collective, they agreed that the study was a necessity for the institution and in particular the maternity ward. Therefore, it was agreed that the study should be conducted. The quarterly Quality Improvement plan on the maternity ward and the NCS accreditation reports were jointly discussed as supporting tools to reinforce the existence of an unmet information gap that could turn into litigation for carers.

3.6.1.2 Phase 1: The reflection phase, (stage 2): the Hand Diagram figure exercise

The next step taken by the researcher was to visit the maternity ward in order to build rapport and teamwork with possible the CIG. This phase is also referred to as the inception phase. The objective of the stage was "*to describe the potential CIG values that contribute to teamwork"*. In addition, this phase promoted rapport building and introduced the Cooperative Inquiry research to the CIG. Population involve all the midwives in the chosen district. The term 'sample' refers to the entire set of individuals sharing some common characteristics within a particular geographic area (Polit & Beck, 2017:739).

TABLE 3.3: SUMMARY OF THE REFLECTION PHASE (STAGE 2), THE HAND DIAGRAM FIGURE IMAGE EXERCISE

REFLECTION QUESTION ASKED	STAGE	OBJECTIVE	SAMPLE AND SAMPLING METHOD AND	METHOD USED	OUTCOMES
How should midwives relate personal values that contribute to teamwork in the maternity ward?	Inception	To describe potential the CIG' values that contribute to teamwork.	Midwives Purposive sampling used	Hand Diagram figure exercise	Permission to conduct the study. Gaps identified Attitudes.

3.6.1.2.1 Objective of phase 1, (stage 2)

The objective of the phase was to *describe potential the CIG' values that contribute to teamwork.* In addition, the Hand Diagram figure exercise aimed to build rapport and to introduce the Cooperative Inquiry research to the CIG. The question asked at the beginning of this phases was: "*How should midwives relate personal values which contribute to teamwork in the maternity ward?"*

3.6.1.2.2 Sample of phase 1, (stage 2)

In this study, the sample comprised midwives only. The inclusion criteria was a qualification in Midwifery, third and fourth-year level of training for students. Even though a Cooperative Inquiry is democratic and collaborative in nature, the two enrolled nursing categories could not be involved in this phase because of the intention to maintain the homogeneity aspect of this type of study. The study enhanced the CIG's realisation of the need to create a sense of belonging and/or teamwork.

3.6.1.2.3 Data collection method used in phase 1, (stage 2)

The instructions to complete the Hand Diagram figure exercise were as follows:

The CIG used the Hand Diagram figure exercise with specific reference to different fingers. Instructions included writing about what one could do very well, what the midwife loves more, something the midwife loves but doesn't have, something that the midwife does not like, something the midwife loves but is easily forgotten and something very small that the midwife appreciates. The writings on the cut images of the CIG members' palms constituted the broad topics, which were used as the frame for discussions. The writings on individual fingers were statements supporting the broad topics. For details see chapter 4, image 4.1 on the data collected through the Hand Figure image exercise. The CIG as co-researchers categorised the data from the hand Figure exercise and produced three broad topics, which were classified as professional, social and religious characteristics of individuals within a group.

3.6.1.2.4 The outcomes of phase 1, (Stage 2)

The outcomes of the Hand Diagram figure exercise showed that different personalities exist in any team and the CIG realised the need to tolerate each other, especially when working together. In addition, they realised that collaboration and teamwork might lead to increased co-operation, social and collegial relationships (Vîrgä, CurSeu, Maricutoi, Sava, Macsinga and Magureän, 2015:3) & Smith, (2010:1). Following the exercise, the CIG members appeared encouraged, motivated and ready to participate in this phase of the study.

3.6.1.3 Phase 1: The Reflection phase, (Stage 3): the Nominal Group Technique

The Reflection phase is also referred to as the creation phase of the study. The group agreed to perform a second values clarification exercise, which led to the thought-stimulating discussions between the members of the CIG. The research organiser led the exercise, which involved the use of colourful sticky notes. The intention of the exercise was to confirm CIGs' pre-knowledge of the professional values, which should be uplifted throughout midwifery care. Values Clarification (VC) was used to raise awareness of the nurses' own unique professional values, which are not comparable to those of other professions. Mitchell, Trueman, Gabriel, Fine and Manentsa (2005) wrote that hopingly, these values might uplift midwives professional values so that they become agents of change and prevent routinisation of care.

The Values Clarification exercise was aligned with the 'patterns' strategy which is the second strategy in Uustal (1978). In the study, the VC activity was not intended to introduce professional values to the midwives but to reinforce and test their knowledge since they were not neophyte nursing practitioners. Table 3.4 serves to clarify the activities applied in this phase.

TABLE 3.4: SUMMARY OF THE REFLECTION PHASE, (STAGE 3): THE NOMINAL GROUP TECHNIQUE

QUESTION ASKED	OBJECTIVE THREE	SAMPLE AND SAMPLING METHOD	METHOD USED	OUTCOMES OF THE PHASE
How should midwives prioritise professional value-driven midwifery care?	To explore midwives' pre-knowledge regarding professional values applicable to childbirth.	The midwives Purposive sampling used	Nominal Group Technique to reach consensus on preferred values	Important values were ranked

3.6.1.3.1 Objective of phase 1, (stage 3)

To explore midwives' pre-knowledge regarding professional values in midwifery care applicable to childbirth.

3.6.1.3.2 Sample of phase 1, (stage 3)

The sample for this phase comprised of midwives including third and fourth-year level midwifery students. The sample of this phase comprised of 6 midwives, 4 community service midwives, 2 fourth year students, 1 third-year student. The group engaged in active participation and decision making in order to achieve joint collaboration. The sample size of this phase is supported too by different authors like Vi Hoang (2015:16) and Vander Laenen (2015:3) that a total of thirteen is ideal for a Nominal Group Technique. Thirteen as a group size is manageable and enhance diverse ideas.

The democratic, collegial and active participatory nature of the CI had a positive bearing, and therefore no threats were posed to the CIG.

3.6.1.3.3 Data collection methods used in phase 1, (stage 3)

The nature of a CI is that the research is carried out through co-ordinated activities by a small research group. This unique nature spontaneously matched the Nominal Group Technique (NGT) as a data collection method for this phase. In order to create an understanding of this method, the researcher defined the NGT as a structured group discussion conducted on a small scale with a purpose to reach a general agreement also referred to as consensus. NGT as a consensus building process was used to prioritise data gathered. (Botma, Greeff, Mulaudzi & Wright, 2010:251 and Vi Hoang, 2015:15).

The use of NGT supported the democratic nature of CI research and applied the notion of equal chances for all. NGT prevents dominant the CIG to take control of the group. Additionally, it also prevents the imposition of a research facilitator's own ideas on co-researchers. Lastly, the application of the NGT promotes equal opportunities for the CIG and allows them to freely voice their opinions and talk openly as such group discussions, and interaction are balanced (Vander Laenen, 2015:2). Consequentially, the researcher preferred to use NGT as a method of choice for this phase.

- **The context which led to the utilisation of the NGT in this phase**

In order to proceed with NGT, the researcher provided clarity on the usefulness of the NGT to various research contexts and made mention of the possible positive and/or negative bearing that this can have on this phase of the study (Varga-Atkins, Bunyan, Fewtrell, McIsaac, 2011:1). Details of the context are reflected in the table below.

TABLE 3.5: THE CONTEXT OF THE NGT, (STAGE 3) CIG

CONTEXT	THE USEFULNESS OF NGT
Purpose of the phase	The purpose of the NGT was to explore the CIG' knowledge regarding the values that govern their own practice when rendering a service**.**
Meaning	The importance of an understanding of the purpose of the NGT motivated participating midwives to contribute satisfactorily for their own benefit.
Topic focus	The phase had a single topic. The question was meant to introduce the study fully without ambiguity.
Likelihood of the research questions	The question asked had an aspect of 'how can'. The question allowed midwives to choose values without imposition by anyone. Should the CIG effectively answer the question, it will mean that the methodology might be applicable in other similar situations.
Study focus	The CIG's understanding of the focus led to the realisation that there was a need for the study and therefore interest was shown.
Meaning	The usage of NGT created equal opportunities for every the CIG as such; even the least junior members got a chance to contribute freely. Power related issues did not become a problem.
The CIG	The CIG of the phase comprised of three different categories; advanced midwives, registered midwives, third and fourth-year midwifery students and one tutor. They appreciated the workshop and the methods used and indicated an appreciation of the learning that was gradually taking place.

- **Preparation for conducting a Nominal Group Technique:**

In order to achieve good NGT results, the research organiser made appropriate arrangements for effective NGT participation. The preparation included the venue and specific human and infrastructure as necessary resources towards the achievement of the goals of this study. The venue was addressed and other important topics related to the study were as reflected in table 3.8.

- **The meeting venue**

The venue for the meeting was a room that was adequate. The room was situated in the maternity ward. The researcher could not guarantee the quietness of the area since it was situated inside the ward. The size of the windows were large enough to allow cross ventilation.

- **Opening and welcome**

The research organiser opened the meeting with a prayer and warmly welcomed, thanked the CIG and acknowledged their response to attend the meeting. The purpose of the meeting was introduced. Specific research roles were communicated and assigned to the CIG. The value of each and everyone's contribution was emphasised. In addition, the research organiser used an opening move, which is a statement utilised at the beginning of interaction with the CIG. The type of an opening move used in this study was a written scenario related to the study topic. The scenario contributed to a thought-provoking exercise to improve midwives' clinical insight (Xu, 2016:55). Refer Annexure N for the scenario details.

The scenario encouraged CIG to participate in the actual NGT activity led by the research assistant. The purpose of the session was introduced and, the details of the NGT were presented to the CIG. Then the CIG indicated their readiness to embark on the actual NGT processes. The demographic details of the CIG have been reflected under 3.6.2.2, as table 3.7.

- **Sitting arrangements**

The U-shaped sitting arrangement was maintained. A flip chart was positioned in the middle of the room. This arrangement was used for presentation purposes as well as The CIG s' comfort (Collins, 2004:3, Vi Hoang, 2015:16). The reasons for the u-shaped arrangement was to allow adequate workspace for the CIG. Simmons, Carpenter, Crenshaw and Hinton (2015:56) attest that this type of arrangement increases participation, attentive listening and increased listeners' eye contact. In addition, it allowed the chairperson to have control.

- **Writing material**

Writing material, for example, one flip chart, twelve pens, twelve coloured pencils and paper were supplied (Vi Hoang, 2015:16). In addition, sticky notes were issued to groups; pink and yellow for group one and green and blue for group two.

- **The process of the Nominal Group Technique**

The NGT process might take different forms, that is, it does not strictly follow a specific format at all times. In support of this statement, Vander Laenen (2015:3) referred to the traditional NGT and the modified NGT processes that might be followed during discussions. The NGT process of this study was done in five phases namely presentation of the research question, the silent phase, round-robin phase, the discussion or item clarification and the voting phase (Vi Hoang: 2015:17). The five phases are discussed in depth below.

- **Phase 1: Presentation of the question**

The research organiser read the question aloud for everyone in the group to hear. This was an open-ended and semi-structured type of question, which was phrased as: "*How can midwives prioritise professional value-driven midwifery care in the maternity ward with special reference to SANC (2013)?"*

- **Phase 2: Silent generation**

The CIG were divided into two groups of six members each. The two groups worked separately from each other in silence. An instruction was given for each member to use the given professional values and select and prioritise those that best described them as a unique healthcare practitioner. Each member was issued a single sticky note and a pen to prioritise professional values that guide the practice of midwifery. The responses were consolidated per group.

- **Phase 3: Round Robin phase**

The Round robin phase was achieved through the CIG's collection of ideas within each group. After fifteen minutes, the sticky notes were collected and followed by a discussion of the SANC professional values. The CIG elaborated on what they prioritised on the sticky notes in an interactive manner, for twenty minutes. The groups' responses were stuck to a flip chart without any comments, discussion or rephrasing.

- **Phase 4: Discussions**

The CIGs' ideas were discussed in each group and items were listed on a flipchart. The listed items were edited for clarity and organisation. As co-researchers, the CIG were given an opportunity to

ask for clarity on some of the listed items; clarification was given to the satisfaction of the whole group. Agreements were made in cases of irrelevant and duplication of items.

- **Phase 5: Voting phase**

The two teams met to form one team. The aim of the meeting was to consolidate the group's ideas. Since the ideas of the two groups were worded differently, members jointly collapsed similar ideas, and the wording was simplified (Tuffrey-Wijne, Bernal, Butler, Hollins & Curfs, 2007:83). Thereafter, the two groups developed a value-continuum sheet to be used by individuals to rate the contents of the discussion phase. A Likert scale from 1-5 was filled by each the CIG for two sets of aspects relating to midwives and women. The intention was to establish how each the CIG prioritised values. Every CIG member read aloud what was indicated on the value continuum sheet.

3.6.1.3.4 Outcomes of Phase 1, (Stage 3)

The last phase of the NGT resulted in a Likert scale. The CIG used the scale to rank important SANC professional values according to individual priority**.** The group used prioritisation to consolidate the rankings to develop a value continuum form strategy document according to Uustal (1978:2058). The value continuum strategy comprised of two sets of outcomes classified as individual values inherent in the midwife and values which can instil a sense of respect in an admitted woman. For details and interpretation of the findings of this stage refer to page 93.

- **Benefits of using NGT**

The benefits of NGT in the study was to ensure that the CIG were not dominated by those who possessed power and/or those who were more vocal. In addition, it prevented the CIG's conformity to the pressures of the group. The method was effective and used time sparingly as it was used as a single occasion process. The use of NGT as a data collection method used resources economically because more views were contributed within a very short time span. The CIG acquired information in a very short period of time. Finally, the NGT was economic and easier compared to other methods (Tuffery-Wijne, Wicki, Heslop, McCarron, Todd, Oliver, de Veer, Ahlström, Schäpers, Hynes, O'Farrel, Adler, Riese & Curfs, 2016:4).

3.6.2 Phase 2: The Planning phase

This was the second phase where the actual activities of the study resumed. Reflected below is the sequence of events, which happened in this phase.

TABLE 3.6: SUMMARY OF PHASE 2: PLANNING PHASE

QUESTION ASKED	OBJECTIVE THREE	SAMPLE AND SAMPLING METHOD	METHOD USED	OUTCOMES OF THE PHASE
How can midwives promote professional value-driven midwifery care using a Cooperative Inquiry research approach?	To explore and describe midwives' views regarding professional value-driven midwifery care	Midwives Purposive sampling used	Focus group discussions	Descriptions and Identification of midwives' professional values expected during midwifery care.

3.6.2.1 Objective of phase 2

To explore and describe midwives' views regarding professional value-driven midwifery care.

3.6.2.2 Sample for phase 2, the Planning phase

The end of the NGT determined the actual number of the CIG as other members of the group did not continue their participation. The CI was meant to reflect the democratic characteristics of the involved nurses without discrimination with regards to their professional ranks. Thirteen midwives showed interest to continue with the study and therefore, participated in this phase. The group

comprised of individuals possessing similar characteristics and together had an interest in the study. Based on the idea of one Cooperative Inquiry scholar (Reason, 1999:8) highlighted that the sample size for a CI should at least range between six and twelve, the researcher felt satisfied with the thirteen midwives who willingly volunteered to proceed with the study. Furthermore, the scholar discouraged the use of any sample size below six, as it might be too little to produce diverse opinions while the larger sample above twelve might be too hard to manage. Taking this into consideration the researcher kept the number of the CIG to thirteen to ensure diverse views and easy management of the group. For details of the CIG of the phase refer to table 3.7, which entailed the demographic details of those who took part in this study.

TABLE 3.7: THE DEMOGRAPHIC DETAILS OF THE CIG

DEMOGRAPHIC DATA		
AGE	**NUMBER OF THE CIG**	**PERCENTAGE**
• 30-35 years	5	41.6%
• 36-40 years	2	17%
• 40-45 years	4	25%
• 46 years and more	2	17%
100%		
GENDER	**NUMBER OF THE CIG**	**PERCENTAGE**
• Females	10	92%
• Males	3	8.3%
100%		
YEARS OF EXPERIENCE	**NUMBER OF THE CIG**	**PERCENTAGE**
• 1 year	2	17%
• 2 years	2	17%
• 3 years	3	24,5%
• 4 years	2	17%
• 5 years and more	3	24,5%

100%		
EXPOSURE TO MIDWIFERY	**NUMBER OF THE CIG**	**PERCENTAGE**
• 6 months	1	8.3%
• 7-9 months	0	8.3%
• 10-12 months	1	33.3%
• 2 years • 3 years	4 3	17% 17%
• 4 years	2	17
• 5 years	2	17
100%		

- **Implementation plan and ground rules**

The CIG agreed on ground rules, which were to guide participation throughout. The researcher and the operational manager assisted the CI to develop an implementation plan and the setting of their own ground rules. This was done to follow Melrose's (2001:167) suggestion that experienced researchers should lead the neophytes on plans and way forward as early as the onset of the study. For details of the implementation plan and ground rules set for this study refer to table 3.8.

TABLE 3.8: DETAILS OF THE IMPLEMENTATION PLAN AND GROUND RULES SET BY THE COOPERATIVE INQUIRY GROUP THE CIG

NO	ITEM	DESCRIPTION	REASONS
1.	Meetings and attendance	Meetings to be held for an hour, on Wednesdays from 12:00 to 13:00.	Commitment to the employer and the project.
		Attendance will be determined by the availability of members.	
		The needs of the ward will be first priority.	

2.	Meeting venues	The venue was within the maternity ward.	In order to respect the employer's time. To ensure that the CIG do not incur travelling expenses.
3.	Composition of the research group and roles.	Midwives.	Provision of the actual lived experiences.
		Members voiced increased understanding of the need for assigning specific roles.	To enhance the CIG' skills.
			Effective use of human resources. To give equal and fair chances to all the CIG.
4.	Specific ground-rules schedule	Adherence to the agreed time.	Member Commitment.
		Voluntary active participation.	To enhance collegiality and team spirit.
		Respect and acceptance of one another.	
		Teamwork.	
		Confidentiality should be maintained, pseudo-names would be used.	To maintain the CIG' privacy
			Confidentiality of all data contributed by the CIG.

		Gatekeeping and rapport Data collection Concluding the study	July – December 2015 Jan – July 2016 August 2016 – March 2017

- The benefits of group participation in a Cooperative Inquiry

The research organiser used the initial meeting to communicate GIGs benefits for participating in a Cooperative Inquiry. These benefits differentiate Cooperative Inquiry from the other qualitative researches.

TABLE 3.9: BENEFITS OF PARTICIPATING IN A COOPERATIVE INQUIRY

PERSONAL BENEFITS	SOCIETAL BENEFITS
- Research skills	- United as a community
- Give the CIG a voice	- Social change
- Social support	- Awareness
- Networking	- Creating or improving resources
- Personal empowerment	- Program development

Table 3.9 above reflects the benefits of participating in a Cooperative Inquiry, which were divided into personal and social categories, which mark a change in the knowledge of the members.

- **CIGs' roles**

CI as a PAR requires the description of the specific roles of group members at the inception of the study. Roles were clarified by the group and the CIG agreed to abide by those roles throughout the period of the study. Apparently, the joint role clarification led to a solid research partnership, which was coupled with long-term collaboration. the CIG agreed that the researcher and the research coordinator should facilitate on behalf of the CIG**.** The reasons for this was to improve partnership, disperse power hierarchies, promote accountability and prevent role duplication and confusion (Watters & Comeau, 2010:24).

TABLE 3.10: UNIQUE ROLES OF THE CIG

SPECIFIC ROLES	SPECIFIC TASKS	REQUIRED SKILLS
Principal researcher, organiser and CIG member	Assumes overall responsibility for the research. Facilitation of specific issues relating to the methodology. Decision making. Collection, analysing and transcription of data. Writing-up. Overseeing the day-to-day operations of the project. Ensuring the use of CI specific methods.	Research expertise. Facilitation. Organisational. Supervisory. Interpersonal relations and collaboration.
Research co-ordinator and CIG	Organisation of team meetings. Assist with expertise regarding research methods. Facilitation. Decision making.	Supervisory. Research expertise. Interpersonal relations and collaboration. Delegation. Collect and analyse data. Facilitation.
Research assistant	Technical support. Transcription of data.	Organisational skill ICT knowledge. Interpersonal relations and collaboration.
Research energiser and minor issue distressor & CIG	Energise the CIG Decision making.	Creativity.
Cooperative Inquiry Group		Lived experiences. Collecting data.

		Interpersonal relations and collaboration. Mutual decision making.

- **The Involvement of the Cooperative Inquiry Group in the modification of the research question**

The broad research question for this phase was: *"How can professional value-driven midwifery care be realised in a maternity ward in Mpumalanga?"*

- **The Cooperative Inquiry Group motto and logo**

The CIG agreed on a group motto to remind them of their intentions. Since quality midwifery care is highly ethical, members agreed to align their motto with one of Florence Nightingale's principle of "*do the sick no harm"* as cited in Jansen, Gibson, Bowles and Leach (2013:83). After a short discussion a group motto of "*to promote no harm towards women who are admitted for childbirth"* was adopted. A group logo was designed and kept until the end of the study.

3.6.2.3 Data collection method, techniques and procedures used in phase 2

Data collection method is a way of gathering information with an intention to address the research problem (Polit & Beck, 2017:725). The data collection method for this phase was focus group discussions (FGDs). FGD is a structured discussion used to gather in-depth information from a group of people about a specific topic. Focus group discussion was achieved through the use of midwives as special persons who possessed special knowledge. The diverse categories of midwives were included with intentions to gather a variety of views as guided by Dilshad & Latif (2013:191) and Ryan, Ghandha, Culbertson and Carlson (2014:3). As a result, that led to the effective collection of relevant information and therefore, confirmed the relevance of the methods used (Gerritssen, 2011:4, Dilshad & Latif, 2013:192).

- **Reasons for using focus group discussions**

Masadeh, Al-Ababneh, Al-Sabi and Maaiah (2016: 350) refers to an FGD as a conversation held by a small group of individuals who come together to discuss one topic of interest. The research organiser's choice of the technique is that FDGs comprise of small groups. Therefore, the CIG would easily disclose and discuss issues much more easily and with openness. Jordan, Lyncy, Moutray,

O'Hagan, Orr, Peake and Power (2007:3) mentioned that group participation increase the CIG experience interpersonal dynamics and mutual respect. Davies, Lambert, Turner, Jenkins, Aston and Rolfe (2014:12) agree that FGD's allow sharing of ideas and perceptions, which would not be easily achievable through the use of other data collection techniques like one-one interviews. Additionally, focus group interviews as social forums encouraged talks, which are hard to probe during one-one interviews. FGD's promoted a permissive non-threatening environment and synergy prevailed (Al Ghazali: 2014:7). Ultimately, the method led to valuable and relevant information the researcher did not anticipate (Davies et al., 2014:7, Farnsworth & Boon, 2010: 607).

3.6.2.3.1 The process of conducting focus group discussions

The FGD sessions were scheduled for 12:00 on a two weekly basis. Lengthened focus group discussions of more than 2hrs were avoided to prevent CIG (Nyumba et al., 2018:23). Taking this into consideration, the researcher opted for 60 minutes per session and the CIG felt that was reasonable. Three focus group discussions were held and as a result, comprised the direct consultative process, which was recommended by Waterman et al. (2001). The reason for using focus group discussions was that the technique is the most suitable one for PAR (Waterman et al., 2001:20).

The research organiser formally invited the CIG to attend focus group discussions on pre-arranged dates. The venue for the focus group discussion was an empty space in the maternity ward. The researcher made sure that the area was private and free from distractions in order to promote the CIG concentration. The CIG members sat in a circular manner so as to see each other's faces with an intention to achieve a participatory environment with the improved interaction between the CIG and the researcher (Kinalski, Paula, Padoin, Neves, Kleinubing & Cortes, 2017:425). Nyumba, Wilson, Derrick, and Mukherjee (2018:23) maintain that despite the comfort of the venue, the researcher must take into consideration the duration spent.

Thirteen CIG members attended the first session; the second was attended by 11 while the third was attended by 12. The questions asked were open-ended and allowed group members to answer by expressing themselves openly and fully (Züll, 2016). The advantage of using open-ended questions was that they offered the CIG an opportunity to give out a wide range of answers, which also covered issues which were not raised (Hyman, 2016:3). Transcripts of the exact words from the CIG' words

were kept for example, Annexure H. The total number of FGDs conducted during the study were three. The broad question that directed this chapter was: “How can midwives promote professional value-driven midwifery care using a Cooperative Inquiry research approach?” Each focus group was based on a specific issue raised by the leadership who accepted problems that affected them during the annual accreditation process of the DoH. Each focus group was directed by one or more of the questions below:

FOCUS GROUP DISCUSSION NO.1

Question: “How can professional value-driven midwifery care be uplifted in order to improve the quality of care in the maternity ward?”

FOCUS GROUP DISCUSSION NO. 2

Question: “*How can professional value-driven midwifery care be improved to protect the wellbeing of women who are admitted for childbirth?”*

FOCUS GROUP DISCUSSION NO. 3

Question: *“How can professional value-driven midwifery care be applied in order to improve midwives-women relations?”*

Phase 2 comprised of three sessions and data saturation was reached during the third session, at that point, no new emerging data occurred (Given & Saumure, 2008:195). Despite the adverse conditions of the maternity ward, the CIG remained motivated, attended the focus groups meetings as scheduled and showed commitment.

3.6.2.3.2 Additional data collection techniques used in phase 2

Other data collection techniques applied in this study were the CIG observations and reflective journaling, which are discussed below.

- **The CIG observation**

This is a technique that involves the research organiser's prolonged stay with the group. In this study the CIG observation occurred simultaneously with focus group discussions and continued throughout the research. This allowed the researcher to ask questions and record what was observed in order to keep accurate detailed and valuable information (Polit & Beck, 2012:544, 551).

- **Reflective journaling**

Journaling was used by the group at both personal and group reflective levels. Mash (2014:3) describes personal journaling as a method that involves recording what the CIG midwives think happened in the group, their emotions and thoughts. In this study, every member of the CIG recorded new information and ideas shared. Reflective journals were maintained, and continuous feedback was presented at the beginning and end of each discussion sessions.

3.6.2.4 Outcomes of phase 2

Five main themes and eighteen sub-themes emerged from the data collected from the FGDs. Evidence of the results is available in the form of transcriptions and the findings of the analysed data. See chapter 5, table 5.1 on the summary of findings, major themes and sub-themes.

3.6.3 Phase 3: The action phase

Applicable to this study, the third phase served as an action phase wherein the CIG performed a practical hands-on activity of formulating actual strategies to empower midwives with regards to professional value-driven midwifery care. This was the phase where members reached a consensus to use the "Circle of speakers" (Jacobs 2004:5) as a sitting method while they formulated and developed the intended strategies for the maternity ward. Table 3.11 reflects the summary of the action phase of this study. Details of the phase are presented and interpreted in chapter four, subsection 4.2.5, as the action phase while chapter 7, image 7.1 gave an illustration of the strategies to empower midwives in a maternity ward.

TABLE 3.11: SUMMARY OF PHASE 3: THE ACTION PHASE

QUESTION	OBJECTIVE	THE CIG	METHOD USED	OUTCOMES
How can midwives utilise the knowledge of professional value-driven midwifery care to develop strategies to promote quality care?	To develop strategies to empower midwives regarding professional value-driven midwifery care to improve childbirth.	The midwives. Purposive sampling used	Co-operatitive. Collaborative learning. Focus group discussion	Developed strategies to empower midwives in a maternity ward

3.6.3.1 Objective of phase 3

The objective of the last phase of this study was "*to develop strategies to empower midwives to promote professional value-driven midwifery care to improve childbirth"*. Refer to column 1, in table 3.11 for the research question asked in this phase.

3.6.3.2 Sample of phase 3

The sample of this phase was the midwives. Palinkas, Horwitz, Green, Wisdom, Duan and Hoagwood (2015:2) refer to sampling as the act of identifying the most knowledgeable and readily available CIG members as information-rich cases which form a limited but effective research resource. The CIG trusted that their managers' involvement in the CI would do justice to the evaluation phase due to the mentoring and role modelling qualities inherent in them (Di Cicco & Crabtree 2006:315). The sample size in this phase was seven and comprised of the research organiser, three managers, two registered midwives and one community service midwife.

3.6.3.3 Data collection methods used in phase 3

Data was collected through informal interviews. The specific type followed was a conversational interview, which was based on an unplanned set of questions generated instantaneously at the time of the interview (Jamshed, 2014:87 and Turner, 2010:755). The reason for using unstructured

interviews was that the researcher already developed an understanding of the setting and the CIG also understood the research topic well. The research organiser wished to capture the CIG' actual words so as to establish their preferred intentions to address the topic under discussion in order to sustain the good practices (Cohen & Crabtree, 2008). One open-ended question was asked at the beginning of each FGD session, and that allowed thick descriptions, which come spontaneously from the CIG members.

3.6.3.4 Outcomes of phase 3

The outcome of this phase was the strategies which were developed by the midwives themselves as a group of Cooperative Inquiry Group. The intention of the strategies was to empower midwives in the maternity ward.

3.6.4 Phase 4: The observation phase

During the reflection phase, the CIG revisited the Quality Improvement Plan and thereafter opted to develop an audit tool to address the identified issues, and that led to the emergence of phase 4. The observation phase was the last phase of this study, where an assessment tool was developed. The discussions of this phase also followed the sequence of the objective, population, data collection methods, and outcomes.

3.6.4.1 Objective of phase 4

The objective of the phase was to develop an assessment tool to evaluate the caring and respectful midwifery care.

3.6.4.2. Sample of phase 4

The sample of the observation phase comprised of an operational manager, an advanced midwife and one senior midwife who were chosen by the CIG due to their experience in midwifery. Different opinions were sought from the CIG in order to achieve a collective decision making of the contents of the audit tool.

TABLE 3.12: SUMMARY OF PHASE 4: THE OBSERVATION PHASE

QUESTION	OBJECTIVE	OBSERVATION PHASE SAMPLE AND SAMPLING METHOD	METHOD USED	OUTCOMES OF THE PHASE
How can midwives evaluate the attainment of caring and respectful midwifery care using a CI research approach**?**	To develop an assessment tool to evaluate the caring and respectful midwifery care.	Midwives. Purposive Sampling used	Focus group discussions. Cooperative learning.	Cooperative learning Assessment tool

Table 3.12 represents the summary of the process followed to develop the audit tool. The details of the table are based on the question asked, the objective, the population, methods used.

3.6.4.3 Data collection methods used in phase 4

The data collection method followed was: The CIG maintained the "Circle of speakers" Jacobs (2010) as a suitable position for the development of strategies since they had to work in close proximity to each other. Focus group discussions were used to collect data of this phase.

3.6.4.3.1 The process of audit tool development

The audit tool was developed based on the Australian Government (AG, 2015:3). This includes the three stages of planning, design and development, as such quality checks were applied as follows:

Step 1: Planning

The scope of the assessment covered the midwives and two categories of auxiliary nursing services in the maternity ward rendered by enrolled nurses and the enrolled nursing auxiliaries. The cooperative agreed that the tool should be applied on a quarterly basis and form part of the individual annual staff performance review.

TABLE 3.13: THE METHOD OF ASSESSMENT TO BE USED WHILE USING THE TOOL

METHOD	DESCRIPTION
Observation	Assessed during real on-the-job situations
Questioning and recordkeeping (continuous) Questioning and recordkeeping (situational)	By the operational manager By external assessors

Table 3.13 displayed the assessment method to be followed during the assessment of staff in the maternity ward.

Step 2: Designing and developing the audit tool

In order to promote the quality of the designed tool, the following aspects were addressed as context and the conditions of implementation. The tool also reflected five broad items, which formed the requirements (AG, 2015:6) from the staff members in the maternity ward.

Step 3: Promoting the quality of the audit tool

The CIG agreed that clear signatures of the attending staff member and the admitted woman should be reflected on every tool. Again, since the issue of caring and respectful midwifery care is the core of midwifery, the CIG agreed on the immediate usage of the tool in order to test its effectiveness. The CIG indicated that their understanding that the tool may warrant urgent modification even before the researcher's post-doctoral study. For details of the developed tool refer to chapter 4, as .4.2.7, the Observation phase; phase 4.

3.7 DATA ANALYSIS

Only the data of the planning phase was analysed following a formalised data analysis process. The two data analysis methods applied were the Cooperative Inquiry and the thematic data analysis methods, which are qualitative in nature. These methods are briefly discussed hereunder:

3.7.1 Cooperative inquiry data analysis

The Cooperative inquiry data analysis method is specific to Cooperative Inquiry research (Mash, 2014). The analysis involved a practical act of looking back at the proceedings of the activities of the study whether formal or informal. THE CIG raised their satisfaction with the learning acquired through workshops and research processes. They openly alluded to the fact that the exercises were really energising and eye-opening. They did not raise any concerns or contradictions during their participation (Mash, 2014:4).

3.7.2 Thematic data analysis

Thematic analysis (TA) is defined as the method used to identify, analyse and report patterns and/or themes. Themes capture something important within the collected data in relation to the research question. In addition, themes stand for a patterned response within a specific set of data. Researchers are made aware that themes should not be determined by the frequency or repetition of ideas but should rely on the suitability to the topic and study questions (Clarke & Braun, 2013:120)

3.7.2.1 The application of the thematic data analysis

Various TA data analysis methods were employed in a different phase. Clarke and Braun (2013:121) mention six steps also referred to as phases to follow during the analysis of qualitative research data. These phases depict the process of data analysis as applied in this study, which followed the sequence of familiarisation with data, coding, searching, reviewing, defining and naming themes and writing-up. The phases were described according to Braun and Clarke (2006:16), Braun and Clarke (2012) and Clarke and Braun (2013:4). Refer to the descriptions hereunder.

- **Phase 1: Familiarisation with data**

The phase involved the actual immersion of the CIG with the transcribed data. This immersion involved the analytical and critical reading of the written data. The research organiser and the CIG'

representatives repeatedly read the data until they felt they were fully conversant. They reinforced what they read through listening to the recorded material. Finally, they wrote themselves little notes, which served as memory aids and triggers for coding (Clarke & Braun, 2013:121).

- **Phase 2: Coding**

Coding involved the segmentation of data to code either in large or small chunks. The CIG were involved in another intense reading of every item in order to code it in its entirety before moving to the next code. They started with open coding which involved manual coding and then to the computerised coding, which involved marking and highlighting of keywords and phrases in all the transcripts. This was followed by the axial coding where codes were rearranged to define them according to their commonality (Clarke & Braun, 2013:121) finally; the CIG compared their coding with that of an external co-coder and revealed areas of commonality in both.

- **Phase 3: Searching for themes**

The search for themes allowed the CIG to construct themes and collate all the relevant data. The CIG were actively involved in searching and discovery of themes (Clarke & Braun, 2013:121).

- **Phase 4: Reviewing the themes**

The act of reviewing themes involved the CIG reflecting on their workability in relation to the coded extracts and chosen data sets. The group revisited the themes to check on their relevance and quality. As a result, they checked their adequacy and boundaries of their inclusion and/or exclusion. The scope of the themes was finally checked for coherence (Clarke & Braun, 2013:121).

- **Phase 5: Defining and naming themes**

Defining and naming involved the selection of extracts to present, analyse and bring about a specific story with regards to each extract. The selection of extracts was supported by an interesting and compelling narrative from the data. The CIG representatives reported on the narratives of the CIG. The reporting comprised of the interpretations and organisation of the narratives, which fitted into an overarching umbrella, which constituted a conceptual framework with regards to the topic discussed (Clarke & Braun, 2013:121).

- **Phase 6: Writing up**

Writing up comprised of the provision of convincing and clear writing depicting a scholarly context. This phase involved the weaving together of the analytic narratives and data extracts into a coherent and persuasive narrative. The research organiser carried the responsibility to write-up and therefore started practising the skill of writing with the hope to improve gradually as the study progresses (Clarke & Braun, 2013:121).

3.8 MAINTAINING TRIANGULATION OF THE COOPERATIVE INQUIRY

3.8.1 Methods triangulation

The CIG collaborated to establish various data collection methods for specific issues and situations addressed in this study. As a result, triangulation was achieved through the application of one or more data collection methods, collection techniques, analysis methods, data sources and theories (Carter, Bryant-Lukosius, DiCenso, Blythe & Neville, 2014:545). The importance of triangulation of methods was to triangulate data generation, problem-solving and to overcome the biasness which usually result from single-method (MacDonald, 2012:14, Yeasmin & Rahman, 2013:154).

3.8.2 Theoretical triangulation

Specific to this study, triangulation did not only serve as a lens to reflect the trustworthiness of the proceedings. It also reinforced the research support that became evident within the academic-clinical partnership that was built between the researcher and the CIG (Yeasmin & Rahman, 2012:154). Therefore, it may serve as a bonus towards the empowerment of the CIG. Each phase was presented differently. Therefore different theories were applied and still produced the related type of data. The triangulation of data in this study might render the study as an academic tool.

3. 9 PROMOTING RIGOR OF THE STUDY

- **Orientated to action**

CI continuously reflects on issues and then takes action (Dick, 1999:5). The aforementioned statement fulfilled the study's orientation action because after every action taken the CIG reflected back. In case of satisfaction, the CIG moved to the next cycle, but where they hesitated they were excepted to repeat or augment the action. In this study, the fourth phase was done after the reflection of phase three. The CIG realised that the completion of the third phase did not bring the solution to the problem at hand. The CIG reached a mutual decision to develop on their own an inward-policy to improve the care. See attached Hospital policy, Annexure I.

- **Increased accountability**

The CIG promoted joint accountability. CI ensure the CIG' full understanding of the discussed matters by explaining disagreements until everyone feels satisfied and a consensus is reached (Dick, 1999:6). This confirms that CI is not a 'one-man-thing' as it is the case with the other types of research.

- **Cooperative Inquiry as ethical research**

During one reflection stage, the CIG revealed their realisation of the importance of ethical consideration towards the women they care for and that bind them too throughout this study. According to Springette, Atkey, Kongats, Zulla and Wilkins (2016:10), the CIG usually welcome the title of "the CIG-researchers" they assume as compared to the one of being mere subjects of research who serve to give information that benefits the researcher alone. The latter statement might be applicable to the CIG of the study.

- **Active involvement**

The CIG were actively involved in different cycles of the CI. Despite the fact that the involvement in this CI might have been their first research exposure, the repeated discussions led to more contribution of research information. In support of the latter statement, Dick (1999:8) points out that CI as a PAR leads to increased data. CI allowed the CIG to put to the test new plans and that was evident when the group ensured that the suggested plans were immediately implemented. The aspect of rigour was promoted when the CIG decided on plans never applied before with success, i.e. the development of a unit operational policy.

- **Rigorousness**

Members of the CIG engaged in different cyclic stages of the study on their own and that added to their pride and also strengthened the rigour of the study. The CIG looked at the problem from different angles. Melrose (2001:166) asserts that repletion provides information from differing points of view and therefore improves participation and knowledge. Members managed to stay in the group from the beginning to the end, and that is referred to as consistency of the CIG and the willingness to support the study. CI involves a series of phases as reflection, planning, action and observation to complete a full cycle hence the activity is referred to as cycling the phases of reflection and action (Heron, 2006:3). Mash (2014:4) maintains that participation adds to new knowledge gained by the

CIG. Participation instilled feelings of hard work and ownership of the study. Mash (2014:4) adds that a sense of ownership by members portrays pride in involvement and that is an important element that determines the quality of the study.

- **Power shifting**

The researcher and the OPM were selected by the CIG to become research facilitators of the study due to their research expertise and as such power sharing took place. One shift leader took the initiative to present topics about mother-friendly care, and during that presentation, power shifting occurred. The whole CIG engaged in cycles of action and reflection and as such became co-creators of the study (Springette, Atkey, Kongats, Zulla & Wilkins 2016:12). Power shifting relates to fair sharing within a Cooperative Inquiry, and in this study, this was achieved through the tasks through which the CIG jointly took efforts to assign responsibilities to members (Watters & Comeau, 2010:20) and considered member's strengths when assigning roles (Melrose, 2001: 167). Refer to table 3.10 for unique roles assigned.

- **The credibility in the research Cooperative Inquiry Group**

The researcher cherished the relationship with the CIG due to the understanding that the study was dependent on them for its success. Therefore, their knowledge and experience rendered the whole study credible. Credibility among group members may be strengthened by the individual's commitment.

- **Transferability**

The researcher hoped that the activities of the study were clear to guide the reader to find the emergent nature of the study. In addition, aspects like the context of this study were sufficiently and satisfactorily elaborated upon so as to provide the reader with details about this study. Mash (2014:4) supports that detailed context is necessary for a Cooperative Inquiry since it may allow the readers who experience similar work-related issues to extract and appropriate aspects of importance from this study to improve their own contexts.

- **Member checking**

After the analysis, the researcher paid a special visit to the CIG for feeding back the data they actually originated. The CIG were given a chance to add and/or subtract from the given themes and subthemes. As a result, the CIG verified the accuracy of the analysed data, and that increased the rigour of the collected data.

3.10 SPECIFIC ETHICAL CONSIDERATIONS RELEVANT TO A COOPERATIVE INQUIRY RESEARCH

Nolen and Vander Putten (2007:402) highlight that action researchers meet increased ethical issues as compared to traditional researches. Armstrong and Banks (2011: 25) assert that CI is associated with unique ethical challenges and dilemmas, which should be tactfully addressed, as such, the researcher should promote strict adherence to a specific three-tier level that contrasts CI to other qualitative researches. The special ethical considerations include aspects related to the research project itself, which do not exist in traditional researches as stated in Waterman, Tillen, Dickson & de Koning (2001:44) which will be a yardstick for the group to assess the adequacy of this project as reflected in annexure G.

3.11 CONCLUSION

The CIG as a collective in decision making in a collegial and collective manner, they worked together in order to cover the activities, which led to the achievement of the goals of the chapter. The next chapter will be on the findings of the study and the discussions thereof.

CHAPTER 4
THE PRESENTATION AND INTERPRETATION OF FINDINGS OF PHASE ONE, THE INTRODUCTORY PHASE OF THE STUDY

4.1 INTRODUCTION

This chapter comprises of the presentation and interpretations of the findings of the introductory phase of the study. Reason and Bradbury (2002:169) suggest that it is the stage where researchers interpret stories. The chapter address only the findings of the first phase of the study, which comprises of three stages namely the preparatory (pre-entry), and the two reflection phases. The three phases were consolidated into one and the CIG referred to these stages as the Introductory phase. Reason and Bradbury (2002:169) state that a CI should give details on how the inquiry evolved and researchers' descriptions should not only concentrate on the theory but utilise the methodology in a manner that suits their plan. For the sake of the emergent nature of this CI, the two values clarification exercises were paired to form the reflection phase. The reason for this combination was that the three stages were used to gradually introduce the study to the leadership and the CIG before the actual data collection. A summary of the phases and the stages of this chapter are reflected in chapter 4, Table 4.1.

As a Cooperative Inquirer, the researcher co-operated with the CIG so as to gain their trust, support and co-operation. The researcher communicated the intentions of the study in a respectful and supportive manner. Supportive statements were used to make it clear that the intentions of the study were not to cast blame but assist in addressing an existing problem. The above statement is supported by Greenwood and Kelly (2017:3) as they wrote that CI compels the researcher to work with the CIG to allow their voices to be heard and to channel them to make sense of their own world. This researcher supported the above statement and believed that CI would help the CIG to look at the matter with a different eye and apply different ways to solve the existing problem.

An obvious characteristic of this CI project was the embracement of the spirit of togetherness, which is commonly known as 'Ubuntu' in South Africa. Specific to this study the researcher allowed increased democratic, collaborative, interactive and participation with the intention to promote

Ubuntu and co-operation. The notion of togetherness referred to in this study meant that there existed the CIG relationship of interdependency. Specific to this study, the notion of interdependency was important, and the researcher maintained a research organiser and CIG member's position so as to win the support and commitment of the group. The researcher intentionally wished to do away with old ways of doing research as advocated for by Mulaudzi and Peu (2014). The researcher implemented a CI approach as a research strategy, which took the affected individuals into consideration and uplifted them to the CIG-researcher status. This CI was meant to benefit both the setting and the CIG directly. According to Mulaudzi, Libster and Phiri (2008:47), the interdependency nature of the research organiser and the CIG partnership contributed to increased cohesion, collaboration, collectivism and solidarity among members.

TABLE 4.1 SUMMARY OF THE THREE STAGES OF THE INTRODUCTORY PHASE OF THE STUDY

PHASE 1: THE INTRODUCTORY PHASE **THE PREPARATORY PHASE: (STAGE 1)**				
QUESTION 1	**OBJECTIVE OF THE PHASE**	**SAMPLE AND SAMPLING METHOD**	**METHODS USED**	**OUTCOMES OF THE PHASE**
How should gatekeeping be negotiated in a public hospital?	To establish a supportive and trusting relationship in the chosen setting	Leadership and Executive Committee Nursing Management Purposive sampling was used.	Group discussion based on the results of the NCS	Acknowledgement of challenges regarding the decline in nursing values, ethics and norms Attitudes of midwives were identified Agreement to continue with the study

INCEPTION PHASE 1ST REFLECTION PHASE: (STAGE 2)				
QUESTION 2	**OBJECTIVE TWO**	**SAMPLE AND SAMPLING METHOD**	**METHOD USED**	**OUTCOMES OF THE PHASE**
How should the midwives prioritise professional value-driven midwifery care?	To describe the potential the CIG' values that contribute to teamwork in the maternity ward.	Midwives Purposive sampling was used	The Hand Diagram Figure exercise to facilitate teambuilding	• Need for collaboration • Need for upholding the SANC professional values
2ND REFLECTION PHASE: (STAGE 2)				
QUESTION 3	**OBJECTIVE THREE**	**POPULATION**	**METHOD USED**	**OUTCOMES OF THE PHASE**
How should the midwives prioritise professional value-driven midwifery care?	To explore and describe the midwives' pre-knowledge regarding professional values in midwifery care.	The midwives Purposive sampling was used	Nominal Group Technique to reach consensus on preferred values	Important values ranked

Table 4.1 reflects the three stages that formed the Introductory phase which were labelled the pre-entry, reflection and planning of the study. The stages, objectives, population, methods and outcomes were fully discussed in chapter three.

4.2 THE INTRODUCTORY PHASES OF THE STUDY

The CIG referred to the three first phases as the Introductory stage of this study because each of them played an important role in the introduction of the study to different stakeholders in the chosen setting. The three phases are outlined in a logical manner from 4.2.1 to 4.2.3.

4.2.1 The preparatory phase, (Stage 1)

The preparatory phase formed the pre-entry stage of the study. The phase involved collaboration with key leaders of the chosen setting. For details of the phase refer chapter 3, subsection 3.6.1.1.3 and parts of the QIP, which were appropriated to the themes of the study. Refer to table 4.2.

TABLE 4.2: PARTS OF THE QIP WITH LOW SCORES AND THE CLASSIFICATION IN RELATION TO THE THEMES OF THE STUDY

RATINGS OF THE QIP	RELATED THEMES
Inaccurate recordkeeping Lack of adherence to appropriate values and attitudes Failure to promote reporting of adverse events	Theme 1: Providing quality midwifery care to women during childbirth
Unmet needs for special high-risk patients Uncaring and disrespectful care	Theme 4: Maintaining ethical midwifery care throughout childbirth

4.2.2 The Reflection phase (Stage 2), the hand diagram Figure exercise

The reflection phase is the Inception phase of this study, according to (Vaughan & Burnaford, 2015:287) and it is a base for Cooperative Inquiry research, which depicts the quality of the study. The inception stage marked the initial meeting with potential CIG from the maternity ward. The sample comprised of the midwifery category only. It was during this phase that the CIG formulated a cohesive Cooperative Inquiry Group in order to address the goal of the study. Another intention of the phase was to create rapport and to maintain a trusting relationship with potential GIG of the study. Ospina, El Hadidy and Hofmann-Pinilla (2008:131) maintain that rapport should be the first step before the actual initiation of the Cooperative Inquiry Group (CIG) is taken.

4.2.2.1 The use of the hand diagram exercise: Values clarification exercise no.1

The research organiser and the research coordinates used the Hand Diagram Figure exercise to collect data and therefore introduced the method to the CIG. The reason for choosing the hand diagram was to raise awareness regarding the CIG' uniqueness and individualism while working within a team in the maternity ward. It was a good exercise to promote unity, support and develop a sense of belonging to the group despite member differences. In addition, it was aimed at establishing an enabling environment for the CIG to thrive and portray good interpersonal relations towards each other. Tee, Lathleen, Herbert, Goldham, East and Johnson (2007:138) also maintain that the

importance of the first meeting is to introduce a trust-exercise, which would promote the shared aspirations by the CIG within a group.

4.2.2.2 Clarification of the metaphor applied in the reflection phase

The CIG agreed to use a metaphor in order to introduce a Hand Diagram Figure exercise during reflections. The metaphor was used to compare two dissimilar circumstances, which are judged on a similar scale (Fadaee, 2011:21). It represents a figurative expression by which a phrase is altered from its usual meaning. The author adds that it is an analogy of shifting meaning to something else. In addition, a metaphor means an act of assigning the qualities of a person to something that is not human. For this study, the palm of the hand represented 'the maternity ward as a family unit' with the fingers representing 'midwives as family members'. The size, shape and the position of each finger represented several unique characteristics like age, gender, years of experience and more, as reflected in chapter two. Despite the uniqueness in the fingers midwives are expected to remain attached to the palm and work together despite their differences and mishaps that may occur.

4.2.2.3 The application of the Hand Diagram Figure exercise

In order to identify the individual values of each CIG the Hand Diagram Figure exercise was used. The hand diagram exercise was aligned to group functioning. The alignment rendered the instructions different from those in Smith (2010) which were aligned to individual functioning. No specific research questions were asked during this phase. The CIG were instructed to address the six instructions of the hand diagram exercise. Six instructions were given according to each part of the hand. They used the palm of the hand to write a broad topic that might enhance teamwork. They further identified what they valued which might contribute to the effectiveness of one's functioning which might contribute towards coherence and improved relations within a team.

The Hand Diagram Figure exercise reflected in the table below with names of the five fingers of a human being matched with specific instructions, which each the CIG answered to reflect own personal values that depict unique traits they possess.

TABLE 4.3: INSTRUCTIONS FOR THE HAND DIAGRAM FIGURE EXERCISE

PART OF HAND	INSTRUCTIONS
Palm	Write down something you can do well within a group
Thumb	Write down something that you love
Pointer	Write down something that you want but don't have
Middle	Write down something that you do not like
Ring finger	Write down something that you easily forget about from a group
Pinkie	Write down something small that you appreciate from group members

Smith, J. (2010)

The above table comprised of instructions of the Hand Diagram Figure exercise, which the CIG engaged in. No formal research questions were asked during the hand diagram exercise. The instructions of the hand diagram substituted the questions. The CIG were required to attach different responses to the relevant finger. The researcher could not predict the classification of responses before the actual responses were consolidated. Details of the relationship between the part of the hand and the CIG' responses are reflected in table 4.4.

4.2.2.4 The process of conducting the Reflection phase (Stage 2), Hand Diagram Figure exercise

All the day duty midwives in the maternity ward took part in the exercise. Due to the democratic stance of this study, the researcher introduced the research by giving the necessary information to all the midwives considering their democratic right to knowledge and information. In support of the aforementioned statement, Mash (2014:6) confirms that the research organiser should make a presentation before inviting the potential the CIG into a study. As such, the researcher could not decide who should form part of the exercise.

This phase involved values clarification and therefore, the plan to effect a value preference method to elicit members priority personal values which should be accommodated while working in a team. All the interested CIG used the value-ranking forms to record their individual preferences. After the exercise, the manager announced that all those who partparticipated in the study should hand in their Hand Diagram Figure exercise forms. Thirteen the CIG inclusive of the manager and the

researcher handed in their forms. The manager could not instruct other members to hand in their individual forms since that is not supported by a Cooperative Inquiry and could have indicated coercion to participate. In addition, in order to be as democratic as possible, an announcement about the inclusion of the OPM's completed form was made even though she formed part of the response consolidators.

The completed CIG members' forms were all assigned pseudo-names in the form of alphabets, and the individual responses were assigned numbers from 1- 6 as follows:

Key: Alphabet A – L = pseudo names assigned to the CIG.

Numbers from 1 – 6 = parts of the Hand Diagram Figure exercise.

A single Hand Diagram Figure exercise was conducted. The findings of the exercise were equal to the number of the CIG and were numbered A – L. See Figure 4.1 on the data collected through the Hand Diagram Figure exercise.

FIGURE 4.1: THE DATA COLLECTED THROUGH THE HAND DIAGRAM FIGURE EXERCISE

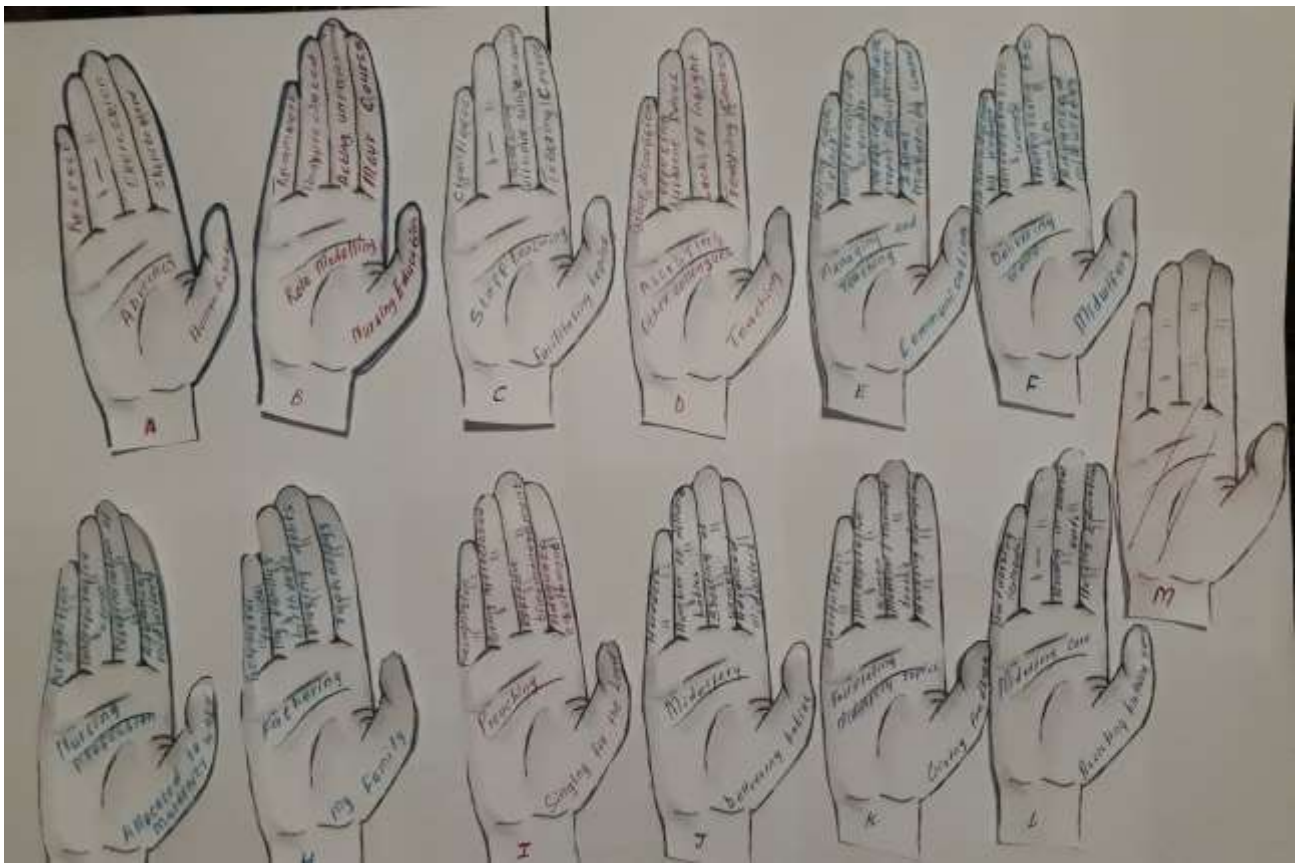


Figure 4.1 on the Hand Diagram Figure exercise reflect the CIG' responses to the values clarification exercise 1. Each Figure represented an individual members' responses regarding personal values portrayed by individuals within a team. The individual responses of the Hand Diagram Figure exercise were consolidated and classified into broad categories of social relations and professional responsibilities of midwives as members of a health professional group. See table 4.4, on the findings of the Hand Diagram Figure exercise, values clarification exercise 1; no.1.

TABLE 4.4 DATA COLLECTED THROUGH THE HAND DIAGRAM FIGURE EXERCISE, VALUES CLARIFICATION EXERCISE 1. (See Table 4.4)

Table 4.4 reflects the findings of the Hand Diagram Figure exercise achieved through a consensus for using a Cooperative inquiry data analysis by the group according to meaning and categories as headings to group the gathered information. Items belonging together were classified together and highlighted through colour codes.

Key: Alphabet A – L = Alphabet assigned to participant name.
Numbers from 1-6 = part of the hand diagram

	1 Palm	2 Thumb	3 Pointing	4 Middle	5 Ring	6 Pinkie
A	Advocacy for patient & staff	Human rights Midwives/ women	shop steward Midwives/ women	oppression by senior	----	Respect Midwives/ women
B	Role modelling	Nursing Education	M Cur course	Acting unprofessionally	Being unappreciated	Team work
C	Staff Teaching	Facilitating topics	Tutoring course	working without insight	----	Cleanliness Midwives/ women
D	Assisting other colleagues	Teaching	Teaching course	Lack of insight	Opposing dif-ferent ideas	Group discussions
E	Managing and teaching the midwives	Communication	Ideal Maternity ward	working without proper equipment	Unappreciative women and families	Helping each other
F	Delivering women	Midwifery	Advanced midwifery	Harassment	uncooperative women	Being acknowledged by the women
G	Nursing profession	Delegation to the maternity ward	Advanced midwifery	Discrimination	Uncooperative women	Recognition
H	Fathering	My family	Technology	Payday debts	My family's birthdays	Respect by the families
I	Preaching	Singing for the Lord	adequate equipment	Ineffective use of time	Being unappreciated	Recognition
J	Midwifery	Delivering babies	Advanced midwifery	Lack of respect	Number of babies I delivered	Hard work
K	facilitation of midwifery topics	Giving feedback	Nursing management	maternal/ neonatal deaths	Uncooperative women	Recognition Midwives/ women
L	Midwifery care	Assisting women to give birth	Nursing education	Working in the general wards		Hardworking colleagues

The results of the above table were consolidated in the bottom table.

PARTICIPANTS' DIFFERING RELATIONS	COLOUR CODING	FREQUENCY
Social relations		7
Staff relations		12
Nursing profession		12
Patient care		13
Human rights		6
Individual interests		7

4.2.2.5 Description of the responses of the Hand Diagram Figure exercise

Since the Hand Diagram Figure exercise was done at the onset of the study prior to the focus group discussions, its findings were not derived from the actual themes of the study. The CIG reached a consensus to classify the findings into groups to highlight teamwork and acceptance of their differing beliefs and values within a single team. The CIG further classified the responses of the Hand Diagram exercise into six. The first classification of the CIG' differing relations within a group comprised of staff relations, social humanistic relations and individual interests. This category reflected differing forms of relations that complement each other and should be cherished by members of the group. The second category of the nursing profession and patient care stemmed from the CIG's belief that the category shows the love and passion they have for the profession despite the challenges. The last classification of human rights was acknowledged as a requirement for securing the dignity of the women and midwives which when applied cautiously should lead to a respectful partnership.

4.2.3 The Reflection phase (Stage 3), the nominal group technique (NGT)

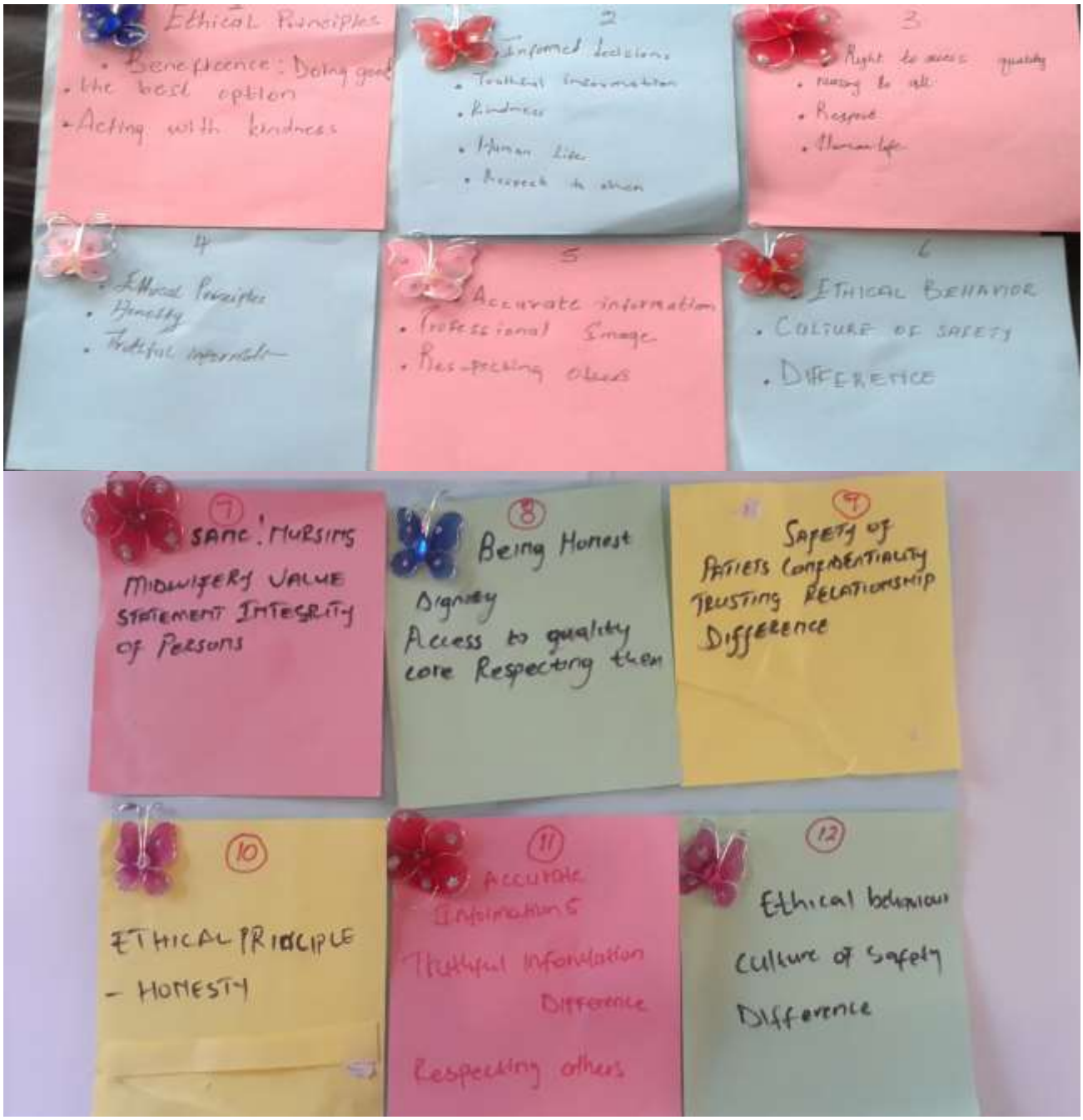
The researcher suggested using the reflection phase, NGT stage 3 to test the CIG' pre-knowledge of the professional value-driven midwifery care. The test was intended to confirm the Exco report regarding the effectiveness of the success of the hospital in-service program to remediate nurses continuously on the SANC value-statement in order to ensure that the clients were treated accordingly. A nominal group technique (NGT) was used to collect the data of this phase.

4.2.3.1 Values clarification exercise 2: Nominal Group Technique

The CIG used a NGT as the second values clarification exercise. The reason for this was the realisation of the relationship caused by values clarification strategies. The Silent and Round Robin phases of NGT were done at the same time with the Strategy of Patterns of Values Clarifications (VC). The research question for the planning phase was *'How should the midwives prioritise professional value-driven midwifery care in the maternity ward with special reference to SANC?'*

An instruction was given to the CIG to silently prioritise the professional values that best suited them which were applicable to nursing and midwifery practice according to SANC. The Round Robin was covered through attachment of sticky notes to a flip chart. The VC strategy 2 was used to list and prioritise the SANC values. The individual values are reflected in Figure 4.2 as follows:

FIGURE 4.2: THE SILENT PHASE OF THE NOMINAL GROUP TECHNIQUE



The Figure reflected in 4.2 served as a tool for the collection of data from the NGT which was obtained through the application of the VC strategy of Patterns according to Uustal (1978:2058). The findings of the NGT were shared, and at the end, the CIG realised that individuals within a group are unique and value different things. The individual rankings contained professional values, value statements as well as ethical principles. The CIG finally accepted the aspect of individualism and highlighted their understanding that the women who are admitted to the maternity ward are unique individuals just as midwives are.

4.2.3.2 Likert scale

Each CIG members used a Likert scale to independently rate midwifery values and aspects which may increase feelings of being respected in any admitted woman on a scale of 1-5. Finally, using Likert scales, the CIG were requested to attach a numerical value of 1-5 to reflect the order of importance of each value to the individual the CIG as reflected in table 4.5. The activity motivated and boosted their sense of worth and self-confidence to attach their diverse ratings on the Likert scales without fear of judgement by other members of the group. See table 4.5 for the findings of the Likert scale as rated collectively by the CIG.

TABLE 4.5: A COPY OF A COMPLETED LIKERT SCALE

CATEGORY A: VALUES INHERENT IN MIDWIFERY	INDIVIDUAL RANKING FROM 1-5 ACCORDING TO NUMBER OF THE CIG
Kindness to others	5
Uniqueness of individual healthcare users	4
Accurate and truthful information	4
Image of my profession	5
Health and wellbeing of healthcare user	3
CATEGORY B: VALUES WHICH CAN INSTIL A SENSE OF RESPECT IN AN ADMITTED WOMAN	**RANKING FROM 1-5 ACCORDING TO NUMBER OF THE CIG**
Safe and ethically friendly environment	5
Right to access quality healthcare services	4
Integrity of persons in my care	4
Confidentiality and privacy	3
Respect and dignity	5

Table 4.5 represented a Likert scale which was filled which by a single CIG comprised of thirteen members. Each numeric number on the Likert scale was rated according to an order of importance from 1-5. The added responses from all members gave rise to a value-continuum form.

4.2.3.3 Value ranking, a value-continuum form

As a team, the CIG revised and developed a value-continuum form as highlighted by (Uustal, 1978:2059). The form contained two classifications of values derived from the individual value-statements. These classifications covered values inherent in midwifery and those, which can instil a sense of respect in an admitted woman. The instruction was that each CIG member should attach a numeric value to each aspect listed on the sticky notes to prioritise individual values of own choice. Individual ratings were counted and the number of the CIG who were in favour of the rated values were reflected on the value continuum form based on their value preferences.

For details of the contents of the value-continuum form, refer to table 4.6 below.

TABLE 4.6: A COPY OF A COMPLETED VALUE-CONTINUUM FORM USED TO CONSOLIDATE THE CHOICES MADE BY INDIVIDUAL THE CIG

Name of the CIG: B, C, D, E, F, G, H, I, J, K, L & M

CATEGORY A: VALUES INHERENT IN THE MIDWIFERY	INDIVIDUAL RANKING FROM 1-5 ACCORDING TO NUMBER OF THE CIG
Kindness to others	13
Uniqueness of individual healthcare users	13
Accurate and truthful information	12
Figure of my profession	10
Health and wellbeing of healthcare user	10
CATEGORY B: VALUES WHICH CAN INSTIL A SENSE OF RESPECT IN AN ADMITTED WOMAN	**RANKING FROM 1-5 ACCORDING TO NUMBER OF THE CIG**
Safe and ethically friendly environment	13
Right to access quality healthcare services	10
Integrity of persons in my care	10
Confidentiality and privacy	10
Respect and dignity	7

TABLE 4.6 Represent a value continuum form which reflected responses according to SANC (2013) as agreed upon by the CIG.

4.2.4 The Planning phase: Phase 2

The presentation and the interpretations of the findings of the Planning phase were separated from chapter four. The themes and subthemes of the planning phase led to a variety of participants' views; opinions and collaborative efforts that depleted professional value-driven midwifery care in the maternity ward.

4.2.5 Action phase: Phase 3

The presentation and interpretations of the findings of the action phase led to the development of strategies to empower midwives regarding professional value-driven midwifery care in the maternity ward. The findings used were presented in chapter 5, table 5.1 as a summary of the findings, major themes and sub-themes

4.2.6 The Observation phase: Phase 4

The Observation was the last phase of this study and took place after the last reflection of the study. The phase was addressed after the Action phase due to the wish to contain the sequential flow of the phases only. The outcome of the phase was an audit tool development. Details of the process of audit tool development commenced from Chapter 3, as 3.6.4. The process of the development of the audit tool took place in 3.6.4.3.1. For details of the presentation and interpretations of the actual audit tool development see chapter 4, as 4.2.6, followed by 4.3, as the final reflection phase of the study which gave rise to the actual audit tool which is shown in chapter 4, table 4.7.

4.3 THE FINAL REFLECTION PHASE OF THE STUDY

This was the final reflection of the study which took place before the Observation phase which formed the fourth phase of the study. The phase came into being after the last reflection of the whole research. This was a positive reflection in which the CIG felt that all the phases evolved according to the arranged plan and therefore, a need to repeat any phase was not found and that meant that a full cycle was successfully completed. The reflection led to CIGs' realisation of a need to address the aspect on caring and respectful midwifery care which had been a problem during the NCS so as to improve professional value-driven midwifery. The CIG's participation in the study intended to

improve the quality and respectful care during childbirth. Literature review led to the CIG's realisation of women's experiences as revealed by Oosthuizen, Bergh, Pattinson & Grimbeek (2017:6, 7) and developed interest in them. Additionally, the CIG also found the domains of respectful maternity care which were derived from a qualitative study by Shakibazadeh, Namadian, Bohren, Vogel, rashidian, Noqueira Pileggi, Madeira, Leathersic, Tuncalp, Oladapo, Souza & Gülmezoglu (2017:935) worthwhile for usage in their study for the benefit of the women they care for in their own ward. Ultimately, the CIG adapted Oosthuizen et al. (2017) & Shakibazadeh et al. (2017) to develop an in-ward audit form to promote caring and respectful care in the maternity ward. For details of the audit tool refer to table 4.7.

TABLE 4.7: THE PRESENTATION OF THE OBSERVATION PHASE OF THE STUDY XXX HOSPITAL, MATERNITY WARD TYPE OF RECORD: AUDIT TOOL

PURPOSE: ASSESSING MIDWIVES/THE AUXILLIARY CATEGORIES' CARING AND RESPECTFUL TREATMENT TOWARDS THE WOMEN ADMITTED FOR CHILDBIRTH

TARGET: Midwives, enrolled nurses and enrolled nursing auxiliaries

1.	PROMOTING COURTESY AND RESPECT OF THE ADMITTED WOMAN THROUGHOUT CHILDBIRTH	YES	NO	ELABORATE ON ANY POINT RESPONDED TO WITH "YES"
	Did the midwife greet you?			
	Did the midwife ask you your name and how you prefer to be called? (name/ title?)			
	Did the midwife call you according to the preferred name/title throughout your hospital stay?			
	Did the midwife ask your language preference?			
	Did the midwife use of the language you understood throughout the admission period?			
	Did the midwife offer you a bed to rest in?			
	Did the midwife come to listen to you when you wished so?			
	Did the midwife offer to assist you when you wished so?			
	Did the midwife ask you about your personal values you wished to practise during your admission?			

2.	**SPECIFIC EFFORTS TO INVOLVE WOMEN IN THEIR ISSUES DURING CHILDBIRTH**			
2.1	**ENHANCING THE WOMAN'S DECISION MAKING DURING CHILDBIRTH**	**YES**	**NO**	**ELABORATE TO ANY POINT RESPONDED TO WITH A "YES"**
	Did the midwife involve you in your own treatment and care?			
	Did the midwife tell you about her wish to involve you in the planning of your own care plan when you arrived?			
	Did the midwife ask you of your personal care preferences?			
	Did the midwife give you information about the procedures, which were done, on you?			
	Did the midwife listen to your personal opinions?			
2.2	**PROVIDING THE WOMAN WITH THE NECESSARY INFORMATION THROUGHOUT CHILDBIRTH.**	**YES**	**NO**	**ELABORATE TO ANY POINT RESPONDED TO WITH A "YES"**
	Did the midwife introduce herself when you first met?			
	Did the midwife give reasons for the meeting/presence?			
	Did the midwife ask permission to perform any procedure on you?			
	Did the midwife give you permission to ask questions where you feel a need?			
3.	**SPECIFIC EFFORT TO ENHANCE SAFETY AND COMFORT OF LABOUR AND ITS PROGRESS**			
3.1	**ABDOMINAL PALPATION**	**YES**	**NO**	**ELABORATE BRIEFLY TO ANY POINT RESPONDED TO WITH A "YES"**
	Did the midwife consider the temperature of her hands before touching?			
	Were the reasons for the palpation given?			
	Was the palpation gentle?			
	Did the midwife tell you the findings in simpler terms?			
	Were you thanked for allowing the procedure to be done?			

	Did the midwife allow you to ask any questions at the end of the procedure?			
3.2	**VAGINAL EXAMINATION**	**YES**	**NO**	**ELABORATE BRIEFLY TO ANY POINT RESPONDED TO WITH A "YES"**
	Did the midwife fully explain what cervical dilatation is?			
	Did the midwife give you information in simpler terms about how far your cervical dilatation was after every vaginal examination?			
	Did the midwife tell you of the presence of and type of complications (if any)?			
	Was the procedure gentle and not painful?			
	Was the examination full of discomfort and pain?			
	Did the midwife allow you to ask any questions at the end of the procedure?			
4.	**ENHANCEMENT OF A CARING ATTITUDE: CHILDBIRTH/BETTER BIRTH INITIATIVES**	**YES**	**NO**	**ELABORATE BRIEFLY TO ANY POINT RESPONDED TO WITH A "YES"**
	Did the midwife provide you with pain medication when such need was identified?			
	Did the midwife allow you to maintain the birth position of your choice under supervision?			
	Did the midwife give you a chance to deliver naturally at first without a cut on the bottom part of your body?			
	Do you think the midwife used the cut on your bottom as a last resort and gave you reasons thereof?			
	Did the midwife educate you about the care of the cut laceration after the delivery?			
	Did the midwife give you solutions to clean the cut laceration on the bottom part of your body?			
	Did the midwife administer an anal solution to purge your stomach without your permission?			
5.	**RECOGNITION OF THE WOMEN'S RIGHTS**	**YES**	**NO**	
	Did the midwife admit you to a clean area?			
	Do you think you were somehow ignored during the course of childbirth?			

	Do you think the intentional pain was somehow inflicted upon you during your stay?			**ELABORATE BRIEFLY TO ANY POINT RESPONDED TO WITH A "YES"**
	Do you think you were somehow made to feel disrespected and belittled?			
	Do you feel you needed emotional reassurance throughout your admission?			
	Do you feel you were emotionally reassured during the admission?			
	Do you think you were discriminated upon and somehow treated differently from others? on issues like your skin colour, age, number of children you have, where you come from, educational status, etc.?			
	Do you think your personal information was treated with confidentiality?			
	Do you think your privacy and confidentiality was maintained throughout?			
	Do you think you were physically abused through acts like being pinched, clapped, rough handling, etc?			
	Do you think you were mentally abused through acts like being neglected, ignored, shouted at, mocked, insulted, threatened, etc?			
	Did the midwife orientate you on the ward surrounding on your arrival?			
	Did the midwife demonstrate increased privacy throughout your hospital stay?			

Oosthuizen et al. 2017 and Shakibazdeh et al. 2017

Compiled by: Cooperative Inquiry Group members: A, B, C, E, F, J, K, L, M.

Date: 24/10/2016

Table 4.7: The presented table will contribute to the quarterly performance review of each staff member in the maternity ward.

4.4 CONCLUSION

Chapter 4 served as the presentation and the interpretation of the findings of the introductory chapter, which comprised of the pre-planning, the 1st and the 2nd Reflection phases of the study. The following chapter will address the presentations and the interpretations of the findings of phase 2, namely, the planning phase of this study.

CHAPTER 5
THE PRESENTATION AND INTERPRETATIONS OF THE FINDINGS OF PHASE TWO, THE PLANNING PHASE

5.1 INTRODUCTION

Chapter five addresses the presentations and the interpretations of the findings of phase two. The aim of the study was to facilitate professional value-driven midwifery care using a CI research approach in the chosen maternity ward. The CI approach followed in this study allowed the CIG to cooperate, willingly collaborate, actively engage and freely verbalise their intentions to improve the delivery of service in the maternity ward.

5.2 OPERATIONALISATION OF CHAPTER FIVE OF THIS STUDY

The data used in this phase was gathered through the use of three focus group discussions and two informal group discussions. The findings, which will be presented and interpreted, comprised of thick descriptions of what midwives perceived as professional value-driven midwifery care. This phase comprised the real 'spade-work' of this study. It was through this phase that the actual views of the group regarding professional value-driven midwifery care were brought to the fore. During this phase, the CIG got a chance to play their specific agreed upon roles in fulfilling the CIG-co-researcher status as reflected in chapter three, table 3.10. The findings were presented; interpreted and were backed by excerpts from the CIG (exact verbatim). The presentations and interpretations are reflected through normal font; italics were used to differentiate the verbatim from the researcher's presentation and interpretations.

5.3 THE FINDINGS OF PHASE TWO

The research question asked was: *How should professional value-driven midwifery care be realised in the maternity ward?* The findings were derived from three questions, which were preferred by the CIG, which formed the base for phase two of the study. The three questions were related to quality midwifery care, mother-friendly care and customer-related care. Probes were used to get clarity of the CIG meaning and intentions.

The nature of the questions asked in this CI allowed the CIG' to give thick descriptions of the professional value-driven midwifery care. The text analysed resulted in massive data. The findings were categorised into five main themes and eighteen subthemes. The themes and subthemes are reflected as a summary in table 5.1.

5.4 THE PRESENTATION AND THE INTERPRETATION OF THE FINDINGS OF THE SECOND PHASE OF THE STUDY

The presentation and the interpretations of the findings of this phase were done as reflected in table 5.1.

TABLE 5.1: SUMMARY OF THE FINDINGS, MAJOR THEMES AND SUB-THEMES

THEMES	SUB-THEMES
Theme 1: Providing quality midwifery care to women during childbirth	*1.* Understanding the concept of 'quality' midwifery care *2.* Creating a risk and harm-free midwifery environment
Theme 2: Preserving the holistic well-being of women during midwifery care	*1.* Addressing the women's physical safe midwifery care • Enhancing the environmental hygiene of the admitting environment • Applying a 'therapeutic touch' to soothe women's bodies • Provision of health education to women during pregnancy, labour and delivery 2. Addressing the psychological aspect of care during midwifery *3.* Treating every woman as a social being in need of support

Theme 3: Upholding professional practice to improve midwifery care	1. Recruitment of skilled and knowledgeable midwives 2. Conducting in-service training 3. Applying compassionate and committed care 4. Portraying acts worthy of professional image
Theme 4: Maintaining ethical Midwifery care throughout childbirth	1. Promoting beneficence during childbirth • Enhancement of safer childbirth initiatives • Avoiding acts of harm and abusive midwifery care 2. Showing respectful midwifery care towards women admitted for childbirth 3. Promoting acts of justice towards women during childbirth towards women who give birth 4. Encouraging women's rights during birthing 5. Portraying commitment towards women who undergo childbirth
Theme 5: Outlining barriers towards professional value-driven midwifery	1. Lack of resources • Inadequate medical resources • Lack of human resources 2. Barriers towards the right to companionship initiative 3. The role of culture during childbirth • Providing culturally sensitive care towards women who are admitted for childbirth

	• Culture-related barriers preventing professional value-driven midwifery care

The above table reflected the findings of phase two, which comprised of five main themes and eighteen subthemes substituted the broad views of the CIG regarding professional value-driven midwifery care. Each finding was reflected as a table with a summary of themes and subthemes, which formed a base for the presentations and the interpretations of the study, which were reflected in this chapter from 5.4.1 to 5.4.5.

5.4.1 THEME 1: PROVIDING QUALITY MIDWIFERY CARE TO THE WOMEN DURING CHILDBIRTH

The CIG' short descriptions of the term 'quality' led to the view about quality midwifery care. The views led to the emergence of three sub-themes of quality care are addressed hereunder.

TABLE 5.2: SUMMARY OF THEME 1: PROVIDING QUALITY MIDWIFERY CARE TO THE WOMEN DURING CHILDBIRTH AND SUB-THEMES

THEME 1	SUB-THEMES
Providing quality midwifery care to the women during childbirth	*1.* The understanding of the concept of 'quality' midwifery care. *2.* Creating a risk and harm-free midwifery environment.

5.4.1.1 Sub-Theme 1: The understanding of the concept of 'quality' midwifery care

The mentioned subtheme intended to give descriptions of the concept 'quality' which according to the CIG may promote professional value-driven midwifery care. The CIG understood quality as the ultimate goal further realised the interrelationship between professional value-driven midwifery care and quality care. The following descriptions of the concept 'quality' emerged:

> "*I will check the patient, and I will report at the same time if there are abnormalities so that she's transferred, to save her and her baby*".

The CIG felt that it was important to ensure that women are continuously monitored since failure to do so may be perceived as poor quality midwifery care.

The CIG also voiced a wish to consider the safety of the women by not exposing them to any forms of dangers, which can harm them while rendering care. The suggestion to protect the women from harm were reflected in the following quotes:

> *"to give effective care by being careful to prevent dangers, by preventing harming the patient in any way like the issue of vaginal examination at times… its done in a painful manner. I have seen it several times".*

> "*By physical harm, we talk of a midwife refusing to remove a swollen intravenous infusion because the patient is complaining a lot. I want to teach her a lesson. I want her to feel pain. At the end, the patient's limb swells until dressings are prescribed. By the way, she came with a maternity problem, but now she becomes a surgical patient, do you see we invite unnecessary litigations? We are not supposed to neh. We should avoid such things at all costs".*

The CIG highlighted an understanding and the importance of not postponing care which should be given since that may lead to complications, which may be hard to manage and may result in unnecessarily costly interventions with unnecessary litigations.

5.4.1.2 Sub-Theme 2: Creating a risk and harm-free midwifery environment

The CIG agreed that the safety of women admitted for childbirth was a priority, and as such made a binding statement to protect women from the risks associated with childbirth. The quotes below are their exact words:

> *"I will monitor the woman's health and well-being on a continuous basis".*

> *"I will tell the woman that since you are here, whenever you need me just know that I am available. Do not postpone. Attend to the woman immediately and update her of what is happening."*

The CIG highlighted that in order to produce quality care midwives should update themselves with the childbirth status of each woman under their care. They agreed that women should be assessed on a continuous basis. They also reiterated that their actual physical presence is important throughout since that plays a major role of reassurance for women who are admitted for confinement. Consequently, they noted that negative and or unintended consequences might occur when they ignore women under their care. They further noted the need to protect themselves through accurate recordkeeping and agreed that this would promote professional value-driven midwifery care. This is supported by the following quotes:

> *"Do not wait… do it before it is too late. My role is to assess on my own, and I keep accurate records, which should give clear information about the woman's progress. I will follow the SOAP method to come to the management of the problem. If I fail to do the right things, example… the next time I go there, I may find that the foetal heart is lost and not there anymore. Should I have acted earlier maybe I could have been able to save the baby and contribute to the woman's joy"?*

Additionally, The CIG indicated that transparency should prevail as a good step towards assuring professional value-driven midwifery care. The findings were expressed as follows:

> *"Keep on informing the patient on what you are doing, for example, the patient who is giving birth should be told what to or not to do in order to save lives".*

> *"and don't slap a woman whenever she is not doing what you are telling her to or whatever you don't like what she is doing. Ask her politely, tell her that 'what you are doing is wrong and for that, you are going to put the baby's life in danger so let us do this",*

5.4.2 Theme 2: Preserving the holistic well-being of women who undergo childbirth

The CIG mentioned that they value the notion of caring for women as "whole beings". The wholeness of the women denotes the completeness of their bodies as a unit with dependent systems. The CIG referred to the holistic well-being as the midwives' ability to address the total needs of women who visit the setting for childbirth. By bringing forward, the holistic aspect of care implied that the CIG understood the interrelationships of the systems functioning of a human body. Therefore, the CIG revelation of the interconnectedness of the women's body systems meant that the physiologic-psycho-socio-spiritual care of women should be attended to.

Failure to attend to these needs might expose a woman to poor quality midwifery care. Notably, the CIG acknowledged the need to promote the socio-cultural aspect of care. The quotes below supported the notion of holistic well-being:

> "*OK…I say we should always be there for patients. It means we should attend to patients' needs in totality. We should not concentrate on the physical problems only. The psychological, the socio-spiritual aspects of care should also be looked at. We should do it in totality, at that time".*

> *"The woman's physical, social, spiritual and mental care should be taken care of at the same time. Failure to do so will lead to more problems. I believe the woman's body is one and no one part can be separated from the other. The environment should promote healing as much as possible. The physically healing environment involves the therapeutic touch which as a weapon to soothe the woman's body during childbirth."*

The quotes above showed that the CIG were aware of the care requirements; to provide the four-fold aspects of care in order to ensure women are holistically cared for. Due to CIGs' increased understanding of the anatomical functioning of the human body, it seemed the issue of the interrelatedness of care will not be a problem.

Three subthemes emerged from the theme of preserving the holistic wellbeing of women during midwifery care. The details of the sub-themes are tabulated and reflected below in table 5.3.

TABLE 5.3: SUMMARY OF THEME 2: PRESERVING THE HOLISTIC WELL-BEING OF WOMEN DURING MIDWIFERY CARE AND SUB-THEMES

THEME 2	SUB-THEMES
Preserving the holistic well-being of women during midwifery care	*1.* Addressing the women's physically safe midwifery care • Enhancing the environmental hygiene of the admitting environment • Applying a 'therapeutic touch' to soothe the women's bodies • Provisioning of health education to the women during pregnancy, labour and delivery 2. Addressing the psychological aspect of care during midwifery 3. Treating women as a social beings in need of support 4. Applying compassionate and committed care

Table 5.2 depicted the major theme of promoting holistic well-being, which gave rise to three sub-themes namely, addressing the women's physical safe midwifery care, addressing the psychological aspect of care and treating every woman as social being in need of support of significant others and these were presented and interpreted as follows:

5.4.2.1 Sub-Theme 1: Addressing women's physically safe midwifery care

The CIG provided detailed description and understanding of the safe, and effective maternity care as a need for the attainment of professional value-driven midwifery care. In addition, the CIG valued safe and effective care for women in the maternity ward as the cornerstone of midwifery care. The following excerpts, which concentrated on the physical safety and the comfort of women, were raised by two CIG the CIG:

> *"A safe area is that in which we maximise the safety and comfort in the maternity ward, for example, disposing of our sharps in a correct manner to prevent potential physical injuries."*

> *"We continuously care for our patients in a clean and highly hygienic environment. The safety of our clients is very important for us in the ward. Usually, our major problem is waste disposal*

since we run short of the necessary facilities far before the new financial year. We run a risk of needle prick injuries which may expose us to litigations."

From the above statements, it became clear that midwives valued the physical safety of the women admitted in the maternity ward. Two components of safe and effective maternity care emerged.

- **Enhancing the environmental hygiene of the admitting environment**

The CIG realised that in order to render safe and effective midwifery care the physical safety of admitted women is of great importance. Their emphasis was on the comfort of the environment that women were admitted to. They further highlighted that they value caring for their patients in a clean area as that contributes to a healthy environment in which infection, prevention and control (IPC) practices were adhered to. Quotes, which supported the above statements, were communicated as follows:

"To ensure that we nurse all our patients in a safe area. By making sure that our unit is clean and then we care for our patients in a clean and safe environment, which promotes enhanced infection control. They are human beings, being here does not change their status."

"*A safe area is that one in which we maximise the safety and comfort of the maternity ward, for example, disposing of our sharps in a correct manner to prevent potential physical injuries. We also make sure that the environment is free from bad smells". A clean and safe environment promotes enhanced infection control in the maternity ward."*

The above statements indicated The CIG s' understanding that cleanliness and safety are inseparable. The quote further indicated their realisation of the need for a healthy and comfortable environment. The humanness of the admitted women was pointed out. As such, the realisation that these women deserve to be treated with respect and humanness was stressed.

- **Applying a therapeutic touch as a healing mechanism to the women's bodies**

The CIG acknowledged that professional value-driven midwifery care may be promoted through the application of therapeutic touch to women who are in labour. They also added that usually, good

results are produced through the application of the therapeutic touch to women who are in labour. This subtheme was supported through the following quotes:

> *"The environment should promote healing as much as it is possible. The physically healing environment involves the therapeutic touch which serves as an instrument to soothe the woman's body during childbirth."*

> *"Isn't that when we use our hands mostly as natural tools to care for the women during childbirth? We assess them for measuring the length of their pregnancy which is the gestational age using our hands. We feel the strength of their contractions using our hands, and we use our fingers for checking their cervical dilation and the presenting part. We also provide circular movements to soothe the woman's abdomen and back during childbirth."*

The above comments reflected that the CIG understood that women admitted for childbirth were supposed to be treated with tender care in order to automatically heal some of their physical ailments.

- **Provision of health education to women during pregnancy, labour and delivery**

The CIG could not underestimate the power of health education on the women they care for in the maternity ward. Two openly proclaimed that safe and effective maternity care will be enhanced through the provision of health education. The quotes below emphasised the value of giving health education to women during childbirth:

> *"There should be information-giving, in the form of pamphlets, health education for those who can read and for those who cannot read verbal health education information should be given."*

> *"Information posters for those who can read on their own. Information giving may prevent patients from harm and suffering which might result in adverse events and errors."*

The reflected quotes revealed that written and verbal information was necessary to communicate directly or indirectly to women under the care. It became clear that due to time constrain The CIG preferred to issue pamphlets to literate women so that they could read on their own and use the little time they have to inform those who are not literate verbally. They argued that information would

increase knowledge and understanding of admitted women. Notably, increased knowledge may contribute to change in behaviour patterns in women admitted in the maternity ward.

Three other CIG members mentioned the significance of imparting sufficient and relevant knowledge to women especially with regard to the do's and don'ts of childbirth. This was how the finding was expressed:

> "*Women giving birth should be advised as to what to do and point out clearly what they should avoid to prevent misunderstandings".*

> *"Yes, maybe if the patient closes their thighs when the baby is born, the baby may suffocate, and they should all know that. I should also advise them not to do that since that might bring serious risks to the baby.*"

> *"…and will further teach them about the dangers that may arise which may*
>
> *affect them and the babies. By doing that I may save lives."*

The above quotes indicate that the CIG realised their responsibilities and admitted that it is their duty to ensure that admitted women are well equipped with the understanding and knowledge.

5.4.2.2 Sub-Theme 2: Addressing the psychological aspect of care during midwifery care

The findings also added the need to address the psychological wellbeing of admitted

women. The findings revealed the acts, which can easily affect the psychological aspect of women during childbirth as follows:

> "*Like you are a nuisance, you want special attention", this and that to patient neh, yah … at the end of the day, if something negative happens to that patient, we will be accountable".*

> "*Like being told you have been here last year, you were here last year delivering a child, and now you are here again, ah… ah… Is it you …again?*

The aforementioned comments showed that the CIG realised a need to mind their words when caring for women since failure to do so might offend the cared women and that might affect them psychologically.

5.4.2.3 Sub-Theme 3: Treating every woman as social being in need of support

The findings revealed a need for the woman's support by family members and/or significant others since everyone comes from a specific family. The need for accommodating family members and or significant others was shown in the following quotations**:**

> "*Okay err… on the issue of the space, if this gentleman… yes I understand you (meaning the woman's fiancé/husband) says I would like to be there, to be a companion to my… whoever, what do you do?"*

> *"We have to adhere to this initiative. The husband, a friend of the pregnant woman, can be a doula, the siblings of that woman can be doulas, anyone including the mother and a professional nurse can be doulas, depending on the wish of this woman. The woman… the pregnant woman must trust that person".*

The findings revealed the CIGs' increased understanding that admitted women do not live in isolation. Their comments revealed the importance of accepting each admitted woman as a member of a family and/or community. The findings further revealed the importance of accepting the admitted women as social beings whose views are important.

5.4.3 Theme 3: Upholding professional practice to improve midwifery care

The findings mentioned that in order to promote value-driven midwifery care midwives should adhere to professionalism. Professionalism in midwifery is portrayed through special skills, knowledge and behaviour, which are unique and different from other professions. The CIG identified special skills and knowledge needed in order to perform their duties, refer to table 5.4.

TABLE 5.4: SUMMARY OF MAJOR THEMES AND SUB-THEMES: UPHOLDING PROFESSIONAL PRACTICE TO IMPROVE MIDWIFERY CARE

THEME 3	SUB-THEMES
Upholding professional practice to improve midwifery care	1. Recruitment of skilled and knowledgeable midwives 2. Conducting in-service training • continuous professional development 3. Applying compassionate and committed care 4. Portraying acts worthy of the professional image

The table above reflects a summary of the theme of upholding professional practice to improve midwifery care, which shows the understanding that in order to provide quality midwifery care midwives have to be professional. The four sub-themes namely recruitment of skilled and knowledgeable midwives, conducting in-service training, applying compassionate and committed care and portraying acts worthy of professional image emerged.

5.4.3.1 Sub-Theme 1: Recruitment of skilled and knowledgeable midwives

The comments showed that even though midwives are highly skilled, they somehow still meet challenges due to staff shortages. They indicated that it is imperative that more skilled midwives are recruited to help ease the pressure. They further suggested that an alternative might be to reinforce their skills so as to increase their expertise in the field of Midwifery. Quotations below revealed the exact words said by these CIG:

> *"Our actions should be supported by relevant and updated professional guidelines, standards and protocols".*

> *"In order to be skilful enough, we should be continuously be empowered as that may motivate us to work harder. As midwives, we will be empowered, while in the workplace we will gain experience in maternity matters".*

"Training is very important. It should be offered by knowledgeable midwives. Knowledge will help us to improve quality care in the maternity ward".

The CIG suggested that continuous development might be a solution to improve their skills. They agreed that employee development might uplift the professional value-driven midwifery care. In addition, a need for conducting research in order to enhance their knowledge and keep abreast with the latest developments in midwifery was reflected in quotes like:

"*I think we can also conduct research. Using published materials, which are written about topics or problems, we have, then we read as to how other people have dealt with the same problem somewhere else. We, as midwives in the maternity ward …we…yes have experience now".*

*"We live in a continuously changing nursing environment. The care we give has totally changed. This means that in order to enhance professional value-driven midwifery practice, we, as midwives in the maternity ward should empower ourselves through research so as to be able to investigate the care rendered in maternity, and compare with that of others**."***

From the quotes above it is clear that the CIG realised the value of doing research at their level in order to improve clinical care in the maternity ward. Seemingly, their involvement in this study increased their confidence.

5.4.3.2 Sub-Theme 2: Conducting in-service training

A need for in-service training was identified from the findings. The CIG also suggested several ways to address their empowerment needs. They uttered the following:

"Oh…I think by training us through workshops and attending conferences will keep us abreast with the developments in midwifery and will help us to be skilful professionals who render safe care to our patients."

The above comments supported the need for training and development of midwives in order to reinforce their skill and update their knowledge. The CIG also suggested opportunities for in-service

training. Although they acknowledge attending some workshops, the general feeling was that opportunities for training were not sufficient.

The findings revealed the unit manager's effort to fulfil the teaching role in order to keep them up to date. The CIG acknowledged the efforts of the Operational Manager who facilitated the research process on their behalf. The quote below comprised the actual spoken words by one The CIG member:

> *"We appreciate the efforts of our manager who draw a teaching program to include important aspects of this research. She keeps on updating us on this research and even promised to send some of us to relevant workshops".*

The CIG acknowledged the topics presented by the manager with regard to the maternity ward during this study. They revealed that they wished to be involved in more research studies in the future. The manager's contribution in this regard contributed to the implementation of the universal Sustainable Development Goal (SDG) number 4 to develop staff (in this case midwives) at the local level. The consequence of the manager's actions to teach staff implied their readiness to embrace change.

5.4.3.3 Sub-Theme 3: Applying compassionate and committed care

The findings exposed that the CIG accept and acknowledge that their relations with the communities they serve is volatile and as a result, two CIG members verbalised their realisation for the need for increased compassion and committed care. The CIG's exact words were:

> "*That is why we remain with the woman 24/7, no any other healthcare provider do that more than we do. We are the only ones who specialise in bringing new life to earth and do our duties with passion and love that no other nurses do. That on its own really counts and may also send a sense of love and passion to the woman whom we care for. Who else does?*"

The above testimony reinforces the passion and love that midwives have for their work. The statement reveals the midwives' continued interest to care for women throughout childbirth despite the challenges. In addition, the group proudly bragged about their unique circumstance speciality of bringing new lives to earth, which other nurses could not do. The comment on its own indicated their

commitment to midwifery care. As this was said another CIG member's face glowed and she smiled, that on its own confirmed the truth said in those words.

Another CIG member alluded to the fact that compassionate care is necessary especially when caring for the women who are admitted for childbirth. The quote that supported the finding read as:

> *"For instance, a patient comes here knowing that she is carrying an alive baby and upon delivery, you realise that there is no foetal heartbeat, you must show sympathy and not act like it does not affect you or it is normal. You must show that you feel for her, for what she is going through."*

The above quote shows that midwives are also human beings who have feelings and should show compassion for the women they care for. The fact that the midwife's appealed to colleagues to empathise with women every time a childbirth mishap occurs signified a change in their approach. In turn, the empathetic relationship will eventually lead to the notion of "being with the woman" which is a cornerstone for midwifery care.

> "*I do not spare her for the others. Immediately the woman calls "sister!" and you realise that this woman is ready to push then you need not say you know what, lie on your side the next staff will come and attend to you because we don't know what could happen between the period when I left her, and the other midwife comes to attend to her. Anything can go wrong, and we are being blamed because we would have ignored this patient. I will also blame myself for that …for life".*

The aforementioned comments motivated the CIG to refrain from tendencies such as playing delay tactics and postponing care, which might result in decreased professional value-driven midwifery care. The CIGs' words housed warning and caution to midwives to work cautiously in order to cover themselves so as not to face negative or unintended consequences.

5.4.3.4 Sub-Theme 4: Portraying acts worthy of professional image

A finding of unappreciative patients who are painting a negative image of the maternity ward emerged. The comments on this subtheme revealed a frustrated and demotivated midwifery team. Immediately the discussions around this theme started, some the CIG' faces changed. Some

appeared bored, reluctant while others opted to keep quiet. Only one The CIG commented. In an angry tone, the CIG strongly voiced the so-called acts of 'unfairness and injustice' towards the midwives.

> "*The communities usually spread false news quick. Seemingly, the local radio gets excited by reports about the hospital and concentrate more on negative than positive reporting. The newspaper (concealed newspaper name reporters) will be all over the place just because it's "us". Where is our reputation? Gone. Gone. Gone … eish! What will the Council say about us*?"

The same speaker continued as follows:

> *"Other families go straight to the media". Is this not unfair? Where is justice here?"*

The quotes above indicate the CIG members' worry about the negative media comments on the hospital and midwives in particular. These comments have a bearing on the relationship between the hospital and the communities. As a result, the midwives interpreted this as intentional reporting of negative and bad stories. In addition, The CIG members were left with feelings of despondency since they felt that this might ruin their professional reputation.

The previous statement was supported by another from the same the CIG, still in a strong and angry voice.

> "*Other patients come with an attitude and they grab everything that you say, even though maybe you are not wrong, they report you and/or take steps against you."*

This clearly indicates the unpleasant relationships between admitted women and midwives. The unacceptable behaviour by admitted women might be due to the rumours going around in the media and community about the standard of care rendered. Consequentially, women come prepared in order to fight the system and/or as a way of survival.

5.4.4 Theme 4: Maintaining ethical midwifery care throughout childbirth

The findings revealed the knowledge and understanding of ethically safe practices that form the basis for midwifery care. The CIG indicated an increased understanding of the need for professional value-driven midwifery care in order to promote quality care. The theme of ethical midwifery care gave rise to five subthemes. Refer to the brief summary, which is reflected as table 5.5.

TABLE 5.5: SUMMARY OF MAJOR THEMES AND SUB-THEMES: MAINTAINING ETHICAL MIDWIFERY CARE

THEME 4	SUB-THEMES
Maintaining ethical midwifery care throughout childbirth	1. Promoting beneficence during midwifery care. • Enhancement of safer childbirth initiatives. • Avoiding acts of harm and abusive midwifery care. 2. Showing respectful midwifery care towards the admitted women 3. Promoting acts of justice towards women during childbirth. • Prevent acts of discrimination. • Promoting equity among admitted women. 4. Encouraging women's rights during childbirth 5. Commitment towards women who undergo childbirth.

Table 5.5 above shows the major theme of ethical midwifery care and its five subthemes of acts of promoting beneficence during midwifery care, portraying respectful midwifery care throughout childbirth and promoting acts of justice towards women during childbirth, encouraging women's rights during birthing and commitment towards the women during childbirth. The presentation and the interpretations of the findings of this theme are presented in 5.4.4.1-5.4.4.5.

5.4.4.1 Sub-Theme 1: Promoting beneficence during midwifery care

The findings pointed out the need for ethical practice through which midwives are expected to make a judgement regarding what is regarded as good or wrong while caring for women. The findings revealed the need for consideration of the risk-benefit ratio of the women who give birth, which was to be achieved through the enhancement of safer childbirth initiatives, which are elaborated hereunder:

- **Enhancement of safer childbirth initiatives**

The CIG indicated that safer methods should be employed when executing their duties. They highlighted the importance of promoting safer childbirth/better birth initiatives. As a result, they indicated that practices like cutting the perineum is wrong and should be stopped. Direct quotations, which support the enhancement of safer childbirth initiatives, were as follows:

> *"Yes we do allow them to deliver without it and the women are happier when their perineum are not* cut."

The CIG were proud of changing and or doing away with some disrespectful midwifery practices and procedures while advocating for more humane methods that constitute better birth initiatives.

Hereunder are the excerpts that reflect the exact opinions of group members:

"*At first women were just cut without their permission. We do not do it anymore unless somehow it is requested … and we are proud. Dr Bell said cutting a woman is only giving more pains after delivery because women have to nurse the uterus, which is still in pain. The vagina can stretch by itself until where it can accommodate the baby's head. We do not allow unnecessary cutting in here…"*

Disrespectful practices referred to are midwifery care procedures, which are done routinely without consent from women. Seemingly, women had no choice this eventually led to degrading treatment of the women receiving midwifery care.

The CIG s' comments indicated their understanding that cutting of episiotomies does not always indicate agreed upon decision with women undergoing childbirth. Therefore, its performance may violate the requirements of professional-value-driven midwifery care. The following arguments were put forward:

> *"I was taught that delivery is a natural process so if things happen naturally, healing will be faster than if you alter it. It is more painful to woman than…, unlike when she pushed by herself because the head will just tear the perineum according to its size [referring to the size of the baby's head]*.

I teach every midwife who is allocated here to respect this initiative. We do not compromise. Surely, we really do good in this aspect. We do not consider it routine".

- **Avoiding acts of harm and abusive midwifery care**

The findings revealed the need to avoid any forms of harm and abusive midwifery care. The CIG highlighted what was referred to as acts of harm and abusive midwifery care as shown in the following spoken words:

By physical harm, we talk of a midwife refusing to remove a swollen intravenous infusion because the patient is complaining a lot. I want to teach her a lesson. I want her to feel pain. We are not supposed to. We should avoid such things at all costs.

The voice in the aforementioned quote unhesitantly showed that at times intentional harm is inflicted to "fix the women" for the acts perceived as wrongful by the attending midwife, a warning to refrain from such acts was communicated by one member of the group.

*"For example midwife slaps a delivering woman… (*the CIG imitated the midwife*) …open these thighs of yours, then slap*" (a CIG used both hands to imitate the actual slapping).

"*No patient should be slapped; no patient is going to be pinched neh…*"

The comment indicated how midwives could be involved in acts of intentional harm. At the same time, the quote reflects an appeal to discontinue such practices which may harm the women' physical wellbeing. In addition, quotes highlighted the need for consideration of the women's involvement in any procedure performed on them.

The aforementioned comment indicated the CIGs' understanding to work cautiously and do good while rendering midwifery care in order to detect issues, which may expose them to unnecessary litigations. In addition, the findings revealed disrespectful acts that reduce the dignity of the women who are admitted for childbirth should be avoided.

5.4.4.2 Sub-Theme 2: Showing respectful midwifery care towards women admitted for childbirth

The CIG accepted that at times they portray a lack of respect in their interaction with admitted women. They further alluded that lack of respect usually affects the midwife-woman relationships. Their exact words were:

> *"Just imagine if it was you who needed the service at a specific point and then the staff is there but is just passing with no one is asking you if you have ever been helped they are just talking among themselves ignoring you. Put yourself in her boots, and then you will understand what is it that she will be feeling".*

One CIG member who was a final midwifery student highlighted pain of ignoring the women who are in need of maternity services even in times of manageable workload. An appeal was made to the CIG to put themselves in the boots of the women. The student also indicated the importance of respecting and taking into consideration admitted women's feeling.

> "*Let me say there are students and you cannot just call them and say come and see the delivery and everybody is standing around the patient's bed. It is embarrassing … let there be a few people attending to the delivery, not everybody like: go in and feel the cervix is here…, and next…!"*

> *"For example, we cannot let the patient, like err… when we are busy delivering, or a patient is undressed somewhere, we cannot just leave the door open so that anyone passing can see a naked patient. That is why we must maintain privacy because it boosts the woman's dignity and self-esteem*".

One CIG member showed an increased understanding of the need to respect for women's privacy as a priority and further highlighted the lack of this aspect as a violation of women's right which should not be condoned.

The findings also demonstrated the midwives' self-introspection when it comes to disrespectful practices. The quotes contained messages, which serve as reminders, warning, and raised

awareness to refrain from hurtful comments, which may prevent the women from revisiting the maternity ward:

> "*Maybe the patient is para… gravida…oh…let's say the patient is crying and the sister (meaning midwife) asks "why are you are crying? You have so many children, but you are crying as if you don't know the pain. The patient doesn't like that. They may hate to be here again."*

5.4.4.3 Sub-Theme 3: Promoting acts of justice towards women who undergo childbirth

The CIG became vocal about the prevention of unjust acts towards the women during childbirth. They acknowledged the need for respecting every woman admitted into the maternity ward. The findings revealed the CIG' acknowledgement that a professional value-driven midwifery environment may be achieved through humane and respectful treatment for women. This realisation was communicated through excerpts like:

> "*You need to respect her private space because the way we address them and our attitude towards them can affect them…like a woman who just arrives to be told that that 'hey, you have many children'. Let us say you are admitting a patient and you find that a patient is 43 years old. It is not right to say 'hey, you are too old'. Why did you just decided to have a baby at this age, things like that.*"

> "*Another thing is the way we address our patients like she is the one with warts. And we call them names, she is that one with TB or, did you give TB her treatment that side? We must really change. We must address them with their correct names and titles."*

> "*What do you want here?". Heey… you left your hospital there at XXX place and then came here*".

The aforementioned quotes show that at times women are discriminated upon based on attributes like age, diagnosis, demography and more. The CIG confirmed an understanding that attributes like age, and others may trigger feelings of being disrespected. The group warned that usually, the aforementioned comments create negative feelings and might cause lifelong memories, which may damage the self-esteem of admitted women.

Additionally, the issue of treating the admitted women differently depending on their professional and societal standing was raised. It was agreed that women should be treated equally and without prejudice. See comment below:

> *"We should treat all of them equally because we have professionals who are coming to visit us at hospitals who are treated on the merit of their personal status or professional status and that is not fair. Let us be careful."*

The CIG highlighted that attributes that may easily trigger sensitivity should not be used as a yardstick to prioritise care of the women who are admitted in the maternity ward. In addition, the quotes showed that even though the aforementioned treatment was revealed, an appeal for behaviour change was captured from the CIG members.

5.4.4.4 Sub-Theme 4: Encouraging women's rights during childbirth

One CIG member became too vocal when addressing this particular subtheme. They clarified the power of the women's rights in matters pertaining to their health needs as follows:

> *"Women have rights … like taking blood specimen… explain the reason why blood must be taken, and it is going to be painful of course it is but if you explain that we going to draw blood, and it is doctor's orders as you are going to theatre. We need your consent so that should it happen that you bleed too much then you are transfused. In that way, we treat her fairly. We must not just do it".*

The above quotes were advice shared; it was agreed that they have to continuously consider the values of the women they care for first. In addition, midwives were warned not to sideline the women on issues involving them.

5.4.4.5 Sub-Theme 5: Commitment towards women during childbirth

The CIG planned to reinforce the responsibility of maintaining ethical midwifery care. They vowed to follow the White Ribbon Alliance, Tamara (2013) as a guide for their commitment. In this way, they portrayed their intended positive working relations, and respectful and dignified midwifery care to all the women admitted to the maternity ward.

The phrases used in the role-play were as follows:

"No one can physically abuse me."

> "*No patient is going to be slapped; no patient is going to be pinched. For me, no procedure is going to be done without permission and or communication. No urinary catheter is going to be inserted without an indication".*

These quotations reflected the CIG' intentions to prevent any form of abuse and/or harm inflicted to admitted women. It is also shown that they are advocating for their clients by an undertaking to prevent forms of physical abuse and disrespect. The next undertaking show the CIG were taking a firm stance to promote the admitted women's right to information and taking an informed decision.

"No one can force me or do things to me without my knowledge and consent."

> *"Like err… if we perform any surgical procedure to a patient, you have to explain first and obtain her consent. No matter you need to give treatment you explain this is treatment is for you and so on".*

The above-mentioned shows the CIG's understanding and knowledge that procedures should not be imposed on women as that may signify a violation of their right to decision making.

"No one should discriminate against me in any way."

> *"Like ah… ah… ah… how old are you? Just 22 years? No, No, No! The midwife calling others come …come and see. She is only 22 years but has come to deliver her third child today. Yo yo yooo!"*

The above quote reflects a form of discrimination against an admitted woman. It further showed members' awareness and commitment to non-discriminatory midwifery care.

5.4.5 Outlining barriers towards professional value-driven midwifery care

The CIG members mentioned three themes barriers towards professional value-driven midwifery care, barriers towards the right to doula support initiative and the role of culture during childbirth, which prevent them from providing professionally value-driven midwifery care. They classified these themes as barriers towards professional value-driven midwifery care. The midwives openly declared their frustration since the viewed the barriers as contributors to poor quality care.

Three subthemes emerged from the theme barriers towards professional value-driven midwifery care. The subthemes comprised of lack of resources and its two related compone**n**ts - inadequate medical resources and inadequate human resources. The second subtheme is barriers towards the right to doula support initiative followed by the role of cultural beliefs and practises. Refer to table 5.6 for a summary of the theme also reflecting the subthemes.

TABLE 5.6: SUMMARY OF THEME AND SUBTHEMES OF THE PRACTICES THAT PREVENT THE ATTAINMENT OF PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE

THEME	SUB-THEMES
Theme: 1: Outlining barriers towards professional value-driven midwifery care	**1.** Lack of resources • Inadequate medical resources • Inadequate human resource ***2.*** Barriers towards the right to doula support initiative. ***3.*** The role of culture during childbirth • Providing culturally sensitive care towards women who are admitted for childbirth • Culture-related barriers towards professional value-driven midwifery care.

5.4.5.1 Sub-Theme 1: Lack of resources

The findings revealed that there was a severe shortage of resources that were aligned with their failure to meet the standards expected of them in order to achieve professional value-driven midwifery care. Generally, the CIG attributed the inability to attain the prescribed level of the care in the maternity ward to lack of resources.

- Inadequate medical resources

The CIG attested the lack of medical resources as a challenge that prevents them from providing services accordingly. This finding was expressed as follows:

> "*Systems challenges can channel us to show unexpected behaviour, for example, lack of medication as a resource for midwifery care… in an instance where an episiotomy is cut what do I do when a local anaesthetic injection is not available in the pharmacy? I will feel forced to suture the poor woman without localising her perineum since I cannot just leave her like that but..."*

> *"Can one imagine the pain? I will not be doing it according to my wish… It's just that I would not leave her un-sutured in the meantime. This is a system's failure. Who sutures the woman, myself or the pharmacist? I always apply the law that says I should explain every procedure to my patient and what do I say in this case?"*

The above quotes echoed the serious dilemmas, which leave midwives helpless and unable to take charge of situations they are faced with. They also indicated that at times the challenge of lack of resources push them to the extremes and they end up compromising the safety of both women and their own. They ashamedly mentioned acts of extreme unethical violations, which they unintentionally engage in because of these shortages.

Another CIG member whose voice was full of anger and pain had a concern about the negative image that is portrayed on them due to systems issues and failures. The CIG member's feelings were evident in the following quotation:

> "*But even though I may try to explain to the woman I still have to suture the cut, can you imagine who will I be negatively judged in the eyes of that woman? That might be labelled anyhow like attitudinal, devilish, harsh and monstrous and the worst".*

This extract highlighted the type of sensitivities, which may eventually lead to the negative labelling of midwives. These judgements revealed negative labelling which are usually done by admitted women and/or their families. One CIG member talked without hesitation and looked straight into the researcher organiser's eyes while pointing out the effects of a lack of resources and their contribution

to the human rights violation. The below-mentioned extract contained the exact words uttered by the CIG member:

> "*Exposing woman to a situation of lack of resources may also be a form of disrespect for our [the midwives'] own values and those of women themselves or what sister [with reference to the researcher]? It also puts the lives of the women in danger since their needs are not fully catered for. Our reputation is also tarnished".*
>
> *We are the only ones who are exposed to them [women] for longer periods. That is why they continuously blame us more than the other healthcare professionals."*

During the above presentation, the CIG invited the researcher's support in what they viewed as wrong practices. However, the researcher maintained the neutral researcher-stance regarding the matter. At a certain point, the comment appeared to seek to report the nursing management team. Finally, the statement may be indicative that midwives are faced with a detrimental situation, which might negatively affect quality-driven midwifery care.

- Inadequate human resources

The CIG also mentioned the shortage of midwives as a serious constraint, which prevents them from the attainment of professional value quality-driven midwifery care. The following are the actual words of midwives who participated in the study:

> *"It is usually hectic, nurses are resigning. That is where you turn to prioritising the care. We cannot perform all the required activities under severe shortage of staff and increased number of patients who give birth right through. You end up doing all the work that should be done by others including the non-nursing duties. The situation in here is pathetic!"*

The CIG alluded to the fact that in the midst of that dilemma there was a problem of the performance of the non-nursing staff, they accepted that in order to achieve professional value-driven midwifery care these duties are a necessity. Therefore, resort to performing some of these duties. Midwives end up taking several tasks simultaneously with the notion of "first things first". The prioritisation of care has a disadvantage of leaving out other important nursing care activities.

The following words echoed the above realisation:

> *"We are compelled to perform the non-nursing duties at times. They are important for our survival as midwives, for the women's sake. They are here to stay".*

> *"You know what? During the severe shortage when the ward is over-populated, you automatically become "Jack of all trades and do all sorts of activities of the maternity ward alone."*

The findings revealed that the CIG' have accepted and continue performing the non-nursing duties as that is acting in the interest of the admitted women. Moreover, the CIG indicated that they were exposed to a very strenuous work environment that is hard to manage due to severe staff shortage with increased workloads.

5.4.5.2 Sub-Theme 2: Outlining barriers towards the right to doula support initiative

The findings revealed obstacles that prevent them from achieving professional value-driven midwifery care. Therefore, quality midwifery care is negatively affected. The CIG further indicated that even though they fully support the doula support initiative, they still could not apply it fully due to reasons, which are beyond their control. The exact the CIG' members' words are:

> *"It's just that in our maternity, the setup is not practical."*

> *"Since we have a sideward we can utilise it because not all women are being active at the same time."*

Irrespective of the importance of the doula support initiative, the quotes above revealed a situational problem that forced the midwives not to apply the initiative fully.

5.4.5.3 The role of culture during childbirth

The CIG stressed their understanding of culturally sensitive care was a necessity in order to provide professional value-driven midwifery care. They alluded to the fact that the outcomes of embracing

culturally sensitive care may lead to increased knowledge, understanding and skills which will improve midwives' interaction with women during childbirth. The following comments supported the subtheme:

> "*I mean culture counts a lot. Culture makes the women to act and think in a certain manner. It points out the difference in people, and that also happen to women admitted for birth".*

> *"Yes, I realised that people are not the same. They are different in many ways. For example, we do not see value in the same things, women are brought up differently, and they belong to different cultures.*"

The above quotations reflect the CIG acknowledgement that the admitted women are unique beings raised in different families and or societies. Therefore, the unique traits of the admitted women should not be used to judge them but should be acknowledged and taken into consideration.

- Providing culturally sensitive care towards women who are admitted for childbirth

The CIG realised that due to the deep-rooted and lifelong nurture of culture, the women's behaviour will not be changed overnight and should be tolerated. The quotations below are supportive of embracing different cultures:

> "*If I understand Sister G well, she indicates that when dealing with women in the wards we should accept them as they are. We must understand that changing a person is not easy. What each woman was taught in her family cannot be changed easily. Like in our African culture, some come with ropes on their waists, and so they'll tell you, sister, you'll have to wait until the last minute of delivery then you can cut it."*

> *"We should discuss issues of individuality and bring up uniqueness of these individuals. Unique cases should be discussed during ward meetings so that the staff may gain knowledge thereof so as not to offend them and possibly affect them negatively."*

Through the above comments, it was clear that the CIG did not blame the women for their cultural practices, but they were ready to learn, share the knowledge of different cultures and promote cultural awareness.

- Culture-related barriers towards professional value driven midwifery care

The quotes from the CIG maintained that cultural beliefs and practices formed barriers towards professional value-driven midwifery care in the maternity ward. The CIG members' comments showed their interest in acquiring knowledge of different cultures in order to benefit the midwife-woman-partnership. The exact words that support this were:

> *"In the ward, we come across women who just keep quiet and push on their own. Some of them eventually get third-degree tears despite the advice given. They believe that if you 'scream' of pain when delivering your firstborn child, you will do the same with all future deliveries. If you scream, they say you are like a goat and not a sheep.*"

The quote above shares light on reasons and the results of solitary, lonely, unsociable delivery, which takes place due to cultural beliefs. Under this practice, women pretend that nothing serious is taking place, they are supposed to be brave and not become an embarrassment. The CIG added that according to their realisation, this practice stands a risk of last-minute complications that are hard to manage with disastrous end results for which they [midwives] are usually blamed.

The comments below further explain of unusual practices, which midwives are not familiar with and can result in complicating conditions for women who undergo birthing:

> *"Some women believe in the 'things' they wear on their bodies during childbirth."*

> *"They say … some women drink a mixture of crushed ostrich eggshell for birth-related purposes."*

> *"There was a patient here who said that she drank 'something' at home, and when she arrived here the pain was so severe and intolerable. Immediately they sent her to theatre, and they found that she had uterine rupture… something like that. …at the end she blamed the hospital for the complication."*

"The problem with the stuff they take is that it causes increased severe painful contractions. The contractions become too strong but the cervix doesn't dilate faster, and most of them end up going for an operation."

The above statements show cultural beliefs and customs, which somehow affect the provision of professional value-driven midwifery care.

Other cultural practices, which involve the socio-cultural restrictions, emerged and these included cultural taboos. Certain cultural beliefs, practices and customs place restrictions on particular actions and some women practise and respect these practices. A direct quote from one CIG male member was reflected below as:

"Other females reveal their natural hatred to us [males]. She meets me for the first time and blatantly refuses to be helped by me under the pretence of culture."

"I understand you, Mr X. Those are females whose cultures do not allow them to be touched by any male people. I think is best for you to say 'do you allow me to work next to you? Do you feel free to be assisted by me?"

The CIG indicated that they are worried about some of these beliefs and attitudes, which form cultural myths and stereotypes which are practised by some women admitted for childbirth. They felt that other cultural beliefs are risky and not beneficial to women and their unborn babies and should not be ignored. Since people have different beliefs, the CIG agreed that midwives should get women's opinion before exposing them to midwifery care by male staff members.

5.5. CONCLUSION

Chapter five comprised presentations, interpretations and implications of the findings of phase three to quality midwifery care in the maternity ward. The emerged themes supported the need for professional value-driven midwifery care. Additionally, barriers towards the application of professional value-driven midwifery also emerged and were presented, interpreted and supported through verbatim. This chapter will be followed by chapter six, which entails the discussions and the literature control of phase two.

CHAPTER 6
DISCUSSION OF FINDINGS AND LITERATURE CONTROL

6.1 INTRODUCTION

Chapter five dealt with the presentations and the interpretations of the findings of phase two of the study. Different themes, as well as the subthemes, were presented and interpreted. The findings were described in chronological order as shown in Table 5.1. Chapter six will address the discussions of the findings and the literature control of phase two specifically. The discussions and the literature control will follow the same format used in chapter five.

6.2 THE UNIQUE NATURE OF THE FINDINGS OF THIS COOPERATIVE INQUIRY

The findings point out the unique nature of this study. Several studies were conducted in South Africa in order to explore the obscured nature of quality midwifery care in the country. The studies concentrated on healthcare quality with special attention to the midwife-woman partnerships. Some of the studies explored the experiences of midwives and admitted women in order to establish factors that led to the declined care in selected maternity settings in South Africa.

A list of studies arranged according to publication dates is outlined in this chapter. A few examples of these studies are used to confirm difficulties experienced by women admitted for midwifery care in some state-owned maternity wards. The authors of these studies include, Jewkes, Abrahams & Mvo (1998), Tlebere, Jackson, Loveday, Matizirofa, Mbombo, Doherty, Wigton, Treger and Chopra (2007), Honikman, Fawcus & Meintjies, 2015), Human Rights Watch, (2011), Lumadi and Buch, (2011), Chadwick, Cooper and Harries (2014). The consolidated findings of these studies include among others, poor working conditions, social sanctioning, abuse of the admitted women, ideologies of the inferiority of the admitted women and forceful ambulation of women prior to birth. More findings like the introduction of clear sounds and bells to alert midwives about the women's readiness to deliver were also reported. In addition, feelings of being neglected, neglect, lack of pain management, provision of inadequate information, failure to embrace doula support are disclosed. Lastly, bad interpersonal relationships, the attitude of caregivers and acts of discrimination were

found. Notably, the above-mentioned authors do not provide solutions to the challenges of midwifery care in the country.

This CI has intentions to assist midwives to correct and improve the level of care in a maternity setting in Mpumalanga. Different stakeholders' co-operated and also showed willingness to participate. The CIG revealed their wish to form part of the study and also voiced their wish to address issues that prevent them from attaining professional value-driven midwifery care. They suggested that since the CI approach does not point a finger of blame at them, they will not use personal pronoun 'I' but agreed to use 'you' as they felt that might be indicative of advice to each other.

6.2.1 The operationalisation of the chapter and literature control

Quality healthcare is not static hence different definitions of the term were sought from different authors. Applied to midwifery care quality may be defined as the product which is of 'value', 'excellence', 'product fitness for utilisation' and 'conform to specifications and requirements' of the midwifery care (Mosadeghrad, 2014:78). Quality in midwifery care should include the ability of care rendered to meet and or exceed the customers' expectations. Consequentially, quality midwifery care should produce services that fall within the functionality of the latest specifications for care. The results of quality midwifery care should satisfy the woman and the midwife (Mosadeghrad, 2014:78). Therefore, quality midwifery care should also contribute to an increased sense of wellbeing of those who are involved. This part of the study intends to provide the reader with adequate arguments regarding the findings.

6.3 DISCUSSION OF FINDINGS AND LITERATURE CONTROL OF PHASE TWO

The researcher outlined the discussion of the findings in order to reflect specific details of what the study accomplished. In addition, Drotar (2009:341) maintains that the chapter on the discussion of findings is the most challenging piece of a research project and should be sufficiently addressed to provide the relevant 'take-home-message'. The aim of this study was to facilitate professional value-driven midwifery care using a Cooperative inquiry research approach.

The discussion and literature control of this chapter addresses the five main classifications, which came up strongly from the analysed data, which formed the major themes of phase two. The subthemes, which emerged from the main themes, are eighteen**.** The main idea of chapter six was

to discuss each theme, subthemes followed by the literature control. Each discussion was wrapped up through an implication of the discussed items in relation to midwifery care. The discussions and the literature control of the study are presented in sequential order from 6.3.1 to 6.3.5.

TABLE 6.1: SUMMARY OF THE FINDINGS, MAJOR THEMES AND SUB-THEMES

THEMES	SUB-THEMES
Theme 1: Providing quality midwifery care to women during childbirth.	*1.* Understanding the concept of 'quality'.midwifery care*.* *2.* Creating a risk and harm-free midwifery environment.
Theme 2: Preserving the holistic well-being of the women who undergo childbirth.	*1.* Addressing the women's physical safe midwifery care. • Enhancing the environmental hygiene of the admitting environment. • Applying a 'therapeutic touch' to soothe the women's bodies. • Provisioning of health education to the women during pregnancy, labour and delivery. 2. Addressing the psychological aspect of care during midwifery. 3. Treating every woman as a social being in need of support. 4. Avoiding acts of harm and abusive midwifery care.
Theme 3: Upholding professional practice to improve midwifery care.	*1.* Recruitment of skilled and knowledgeable midwives. 2. Conducting in-service training. 3. Applying compassionate and committed care. *4.* Portraying acts worthy of professional image.

MAIN THEMES	SUB-THEMES
Theme 4: Maintaining ethical Midwifery care throughout childbirth	1. Promoting beneficence during childbirth: • Enhancement of safer childbirth initiatives • Preventing acts of harm and abusive midwifery care 2. Portraying respect towards the women who give birth. *3.* Promoting acts of justice towards women during childbirth. 4. Encouraging women's rights during childbirth. *5.* Portraying commitment towards ethical midwifery care.
Theme 5: Outlining barriers towards professional value-driven midwifery	*1.* Lack of resources: • Inadequate medical resources • Lack of human resources. *2.* Barriers towards the right to companionship initiative. *3.* The role of culture during childbirth: • Providing of culturally sensitive care towards women • Culture-related barriers preventing professional value-driven midwifery care.

6.3.1 THEME 1: PROVIDING QUALITY MIDWIFERY CARE TO THE WOMEN DURING CHILDBIRTH

Whittaker, Shaw, Spieker and Linegar, (2011: 60) refer to quality care as an extent to which an organisation meets the expectations and needs of those who are cared for. Mosadeghrad (2014:78) refers to quality healthcare as the ability of the healthcare facility to produce the care that exceeds the clients' expectations. Therefore, a health facility aims to attain positive clinical outcomes from the available resources to the satisfaction of those who are cared for.

In support of the major theme, two subthemes emerged namely, the understanding of the concept 'quality' midwifery care and creating a risk and harm-free midwifery environment, which are discussed sequentially in 6.3.1.1 to 6.3.1.2.

6.3.1.1 Sub-Theme 1: Understanding of the concept "quality" midwifery care

WHO (2016:12) maintains that for quality care to be rendered, midwives should possess the ability to timely diagnose and implement appropriate measures to prevent complications on both the mother and the baby. According to Machel (2017:14), Every Woman, Every Child Global Strategy for Women, Children and Adolescents' health initiative, regular assessment is necessary so as to promote quality care and save lives.

The findings also showed confirmation that at times pain is inflicted through harsh vaginal examinations, which cause women unnecessary pains. According to the Royal College of Midwives (2012:2), vaginal examination is a routine invasive method of measuring the progress of labour, which is performed when the attending midwife justified the finding as an addition of important information that is necessary during childbirth. On the contrary, Abed El-Moniem and Mohamady (2016:1) vaginal examination can cause disruption of the woman's natural body functioning with resultant pains. Additionally, Bohren, Vogel, Hunter, Lutsiv, Mak, Souza, Agular, Saraiva, Coneglian, Luíz, Diniz, Tuncalp, Javadi, Oladapo, Khosla, Hindin and Gülmezoglu (2015:11) concur that painful vaginal examinations are performed on women within frequent interval without their consent. The Royal College of Midwives (2012:4) concurs that at times vaginal examination cause pains and therefore stresses and embarrass women who are exposed to the procedure. In addition, this invasive procedure leaves women with feelings of powerlessness and embarrassment and therefore should be used carefully.

The findings also uncovered acts of refusal to care by midwives. Khosla, Zampas, Vogel, Bohren, Roseman and Erdman (2016:135) refer to the acts of refusal to care as failure to meet the expected standard of care by midwives. Bohren et al. (2015:11) associated acts of refusal to assist with acts of neglect and abandonment, which should be avoided as they might invite litigations. Dunn, Lesyna and Zaret (2017:72) concur that lawyers are ready to provide communities with information that highlight women on issues that devalue their self-esteem for which they [women] could take legal action.

6.3.1.2 Sub-Theme 2: Creating a risk and harm-free midwifery environment

The findings showed the CIG s' increased understanding of the need to prioritise a less risky and harm-free midwifery environment in order to promote professional value-driven midwifery care.

The CIG also stressed the importance of continuous monitoring while caring for women in labour. This type of care is referred to as routine monitoring by the DoH (2015) who highlights that it should commence from the latent to the end of the active phase. The routine monitoring is achieved through regular vaginal examination. The vaginal examination involves the midwives' use of two fingers to feel the cervical dilatations of the cervical opening and the application, and thinning process of the cervix in order to establish the labour progress (Downe, Gyte, Dahlen & Singata, 2013:1). The reason for the examination is to save the woman and the unborn baby from possible risks (Lloyd & de Witt, 2013).

Without hesitation, the CIG proclaimed their awareness that accurate recordkeeping plays a dual life-saver role for them and the women who receive midwifery care. The Nursing and Midwifery Council (NMC) (2015) concurs that midwives who wish to gain the status of 'effective practitioner' should maintain clear, adequate and accurate records. One of the CIG members maintained that in order to maintain the risk and harm-free midwifery care environment they should habitually apply the Subjective, Objective, Assessment and Planning (SOAP) method throughout. Blair and Smith (2012:162) recommends SOAP as a preferred method for nursing records and that reinforced the CIG's opinion. The aforementioned authors added that the method play a dual role of easily guiding the writing and providing the reader with a holistic picture and that may suit the records of women during childbirth. Consequently, the availability of accurate and sufficient patient information will speed-up further decisions and promote speedy recovery of the women. Porter, Perry, Stockert and Hall (2013:354) added that the SOAP method through which the midwife-woman contribution is sought to the satisfaction of the users.

Midwives are advised that useful and accurate records should be kept and should be free from any falsifications. The records should be clearly written, dated, timed and free from jargon (New Zealand Nurses Organization, 2017:4). The CIG believed that the plan on its own will send a wake-up call and motivates midwives to promptly response to women's problems and so as to prevent serious adverse events (SAE) from taking place. Adverse events (AE) or serious adverse events (SAE) according to the Medicine Control Council (2014:1) refers to any unfavourable and unintended sign, symptom or disease temporarily associated with the use of a medicinal product. As an example specific to the maternity ward, one the CIG highlighted the midwives' failure to keep track of the foetal heart until its disappearance. The Royal College of Obstetricians and Gynaecologists (2009:5) concurs that in midwifery, SAE occurs as a result of midwives' failure to act efficiently.

6.3.2 Theme 2: Preserving the holistic wellbeing of the women who undergo childbirth

The findings showed that the holistic wellbeing of women was a priority, which should lead to the achievement of professional value-driven midwifery care. The CIG strongly felt that the maintenance of holistic care is crucial for childbirth. Sengane (2013) mentions that holistic care refers to the generalised well-being of the women, which is determined by holistic being, or the care of the 'whole being'. This type of care concentrates on the physical, mental, social and cultural state of care of the individual. According to Zamandeh, Jasemi, Vaizadeh, Keog and Taleghani (2015), the holistic care is a nursing philosophy, which points out the 'completeness' or the 'wholeness' of the care given. Zamandeh et al. (2015) meant that caring for a woman during midwifery care should address her as a complete being. Specific to this study this philosophy means that the care given to each woman during childbirth should be approached as a system composed of 'units', which when put together comprise the 'holism' of care. The nursing notion of 'holism' involves the acknowledgement that the normal functioning of an individual depends on the inter-relatedness of different systems existent within the body.

The CIG agreed that they would apply the nursing model of holistic care in order to promote professional value-driven midwifery care in the maternity ward. According to Gagnon (2013:362) the CIG indirectly meant that midwifery care should be different from the medical model of care. In support for the need for the holistic model, Gagnon (2013:362) refers to the medical model of care as a scientific, time-conscious and a highly technocratic type of care through which pregnancy and birth are seen as pathologies of a female body. Gagnon (2013) elaborates that usually, the only way to correct a pathology following a medical model is through the use of the woman's body as an object for experimentation. The medical model-believes that the body and mind are separable. The social, the spiritual and the mental aspects of care are not a consideration for care in the medical model as it is a case with the holistic type model. The CIG realised that the application of a medical model in the maternity ward was disadvantageous and therefore might impede them from rendering professional value-driven midwifery care. As a result, the CIG opted for the application of a woman-centred model, which views woman as a unique being whose physical, psychological, social, spiritual wellbeing is addressed jointly to form a unified, healthy whole.

To fulfil the theme of preserving the holistic wellbeing of the women who undergo childbirth, the following subthemes of addressing the women's physically safe midwifery care, addressing the women's psychological aspect of care during midwifery care and viewing the woman as part of the family are discussed hereunder in 6.3.2.1 – 6.3.2.3.

6.3.2.1 Sub-Theme 1: Addressing the women's physically safe midwifery care

The findings discovered that in order to attain professional value-driven midwifery care the CIG should aim to achieve safe midwifery environment. The CIG highlighted the need to promote increased safety and comfort of women who are admitted for childbirth. Safety in midwifery care denotes the delivery of services that contribute to the physical and the mental well-being of women and their new-born babies (The Royal College of Midwives, 2014:6). Carter, Corry, Delbanco, Clark-Samazan, Foster, Friedland, Gabel, Gibson, Jolivet, Main, Sakala, Simkin, and Simpson, (2010:9) add that safe care is rendered in a co-ordinated environment which portrays the culture of safety. Three components of safe and effective midwifery care namely the environmental hygiene, therapeutic touch, provisioning of health education were discussed.

The findings pointed out that the CIG understood the importance of admitting women to a scrupulously clean and comfortable area with no bad smells. Even though the CIG did not have a problem with the cleanliness and hygienic standards of the ward at the time of the study the point was raised to highlight their understanding that a clean area is a necessity when rendering quality midwifery care. Balde, Diallo, Bangoura, Sall, Soumah, Vogel and Bohren (2017:8) pointed out a maternity ward, which was characterised by unacceptable conditions like poor hygiene, insufficient resources like water supply, delivery beds and more. The CIG concentrated on the improper waste disposal with specific reference to the management of needle sharps. The CIG were worried about the lack of adequate sharp disposal facilities and agreed that this was unacceptable and contribute to unsafe practice and has to be addressed as soon as possible. The DoH (2011) introduced the National Core Standards in order to uplift the health conditions in healthcare facilities in the country. The National Core Standards reflect the need for good hygienic conditions, which is a health right for everyone. Abkar, Wahdan, Sherif and Raha'a (2014) confirmed that unsafeness in most healthcare facilities occurs as a result of preventable unsafe injection practices, which pose serious health hazards to those who are cared for. The CIG raised awareness regarding the responsibility they carry to save the women they care from harm like nosocomial infections as highlighted in the rules and regulation number 387 as tabled in SANC (1990). They further indicated their understanding that needle-prick injuries might result in nosocomial infections, which may negatively influence the average length of stay (ALOS) for women.

Midwives should ensure good hygienic conditions they admit women to. They should always keep in mind that every woman admitted has rights as enshrined in the Constitution of the country (1996). Therefore, they should realise the unwritten contract they automatically enter into immediately a

woman is admitted for childbirth. The woman has a right to be admitted to an environment that is safe and not harmful to their health. As a result, it becomes the responsibility of the admitting ward to ensure that all the precautionary measures are taken to protect a woman from both internal and external environment.

The findings highlighted the importance of considering the therapeutic use during the care of women who are admitted for childbirth. The CIG had a positive impression regarding the application of the therapeutic touch (TT) as a non-drug natural remedy towards the women who are admitted. Tabatabaee, Tafreshi, Rassoali, Aledavood, Alavi-Majd and Farahmand (2016:145) mention that TT aims to restore harmony, balance and to improve the well-being of admitted women. Therefore, TT may achieve positive outcomes to cure general bodily ailments irrespective of health classification. As a result, TT helps in decreasing anxiety and improves the woman's mood and is considered a compassionate healing touch for uterine contractions (Spencer, 2004). Sengane (2013) confirms that uterine contractions are regular and rhythmic relaxations and retractions of the uterine muscles that result in slow opening and thinning of the cervical opening in preparation for the birthing process. As a result, TT lessens labour and back pains and may ultimately decrease the women's chances of complications (Spencer, 2004). One woman in a study conducted by Sengane (2013) suggested that in order to rate a midwife as a first-class midwifery care specialist she should possess the art to apply a therapeutic touch. This opinion was also supported by the CIG of this study.

Even though the findings supported the idea around TT, mixed feelings erupted among the CIG. Other CIG members attributed midwives' failure to apply TT to lack of interest to work in the maternity ward, allocation of unskilled midwives and a shortage of staff. Finally, it was agreed that midwives should consider TT as a remedy suitable for women despite the challenges experienced in the maternity ward.

The discussions went on to imply that midwives might be perceived as better carers should they institute TT as a natural tool to soothe women admitted for childbirth. Literature has proven that the application of this resourceful remedy might promote positive experiences of care for admitted women. TT might result in women's satisfaction regarding the care rendered. The ability of midwives to apply TT might obviously lead to the achievement of the desired professional value/quality-driven midwifery care.

The findings proved the importance of health education to women who are admitted. The CIG indicated their realisation that health education might improve the women's understanding of childbirth issues and the risks inherent therein. Health education according to WHO (2012:15) refers to the learning opportunities which are constructed consciously. These learning opportunities involve communication, which is designed to promote the health literacy, to provide a conducive environment for individual learning. Usually, this type of education contributes to increased knowledge and improved life skills. In general, health education includes the communication of the information that covers the social, environmental and economic factors that influence women's health. WHO (2012:17) maintains that access to health education promotes health literacy.

The CIG agreed to provide literate women with written reading materials due to the staff shortages. In addition, the CIG mentioned that they realised that knowledgeable women usually understand the labour processes well and portray increased co-operation with resultant excellent childbirth outcomes. Van Kelst, Spitz, Sermeus and Thomson (2013:e6) assert that information giving is a necessity. They further highlight that knowledge of what to expect may allay fear of the unknown.

The findings showed that the CIG understood that childbirth education is related to increased informed decision making by admitted women. Lothian (2009:50) states that midwives should provide women with the specifics of childbirth as knowledge thereof may lessen unnecessary complaints whereby a finger of blame is pointed at individual midwives and/or organisations. In particular, health education should comprise real facts, which might be not easily told by any other health provider.

Consequentially, the CIG agreed that they should resort to the specifics of health education in order to live by the notion of *better safe than sorry*. The findings highlighted their intentions to use evidence-based information to improve health education and/or literacy. The information will include the dos and don'ts as well as the risks and dangers associated with childbirth. Giving of sufficient and specific information might reverse the belief that women lack the relevant and specific information regarding childbirth matters (Maputle, 2010:9). The health education provided should avoid generalisations but should be specialised and contain specific, relevant individualised care information. Pregnancy may be a very stressful period for women and in most cases tend to worry about themselves and their babies. Iranzad, Bani, Hasanpour, Mohammadalizadeh and Mirghafourvand (2014) asserts that pregnancy is associated with maternal stressors that present as depressive symptoms, stressful

family events and pregnancy-childbirth related complications and more. Therefore, the provision of childbirth education is necessary since it may result in increased woman's knowledge, co-operation and increased satisfaction in the midwife-woman partnership.

6.3.2.2 Sub-theme 2: Addressing the women's psychological aspect of care during midwifery

The findings revealed that in order to promote professional value-driven midwifery care midwives should address the psychological aspect of the care given to women who are admitted for birthing.

The CIG raised a concern to prevent psychological harm towards women during childbirth, which can be triggered by harsh and hurtful, humiliating and disrespectful talks and remarks, which might affect the women's emotions negatively. The type of comments revealed forms of offensive language, mockery, belittlement and judgements, which may decrease the women's self-confidence. Bohren et al. (2015:33) concur that harsh and hurtful as well as judgemental and accusatory remarks voiced by midwives may be a trigger to the women's psychological well-being and as such should be discouraged.

6.3.2.3 Subtheme 3: Treating every woman as a social being in need of support

The findings showed that in order to promote holistic wellbeing during midwifery care women should be seen as part of a society, which somehow influences their lives. The CIG openly acknowledged women as social beings who do not live in isolation and should be viewed as a social being in need of support. Sarker, Rahman, Rahman, Hossein, Reichenbach and Mitra (2016:13) maintains that families are important decision-makers in issues of childbirth. The CIG stressed that they will always keep the notion that women belong to the families and societies. Abdollahpour and Keramat (2016:1) assert that social support is voluntary assistance from other sources like family, friends and community members. The WHO (2016) maintains that during childbirth women prefer the accompaniment by a spouse or partner, family member or any other self-chosen person and that cause them to feel supported and cared for. Abdollahpour and Keramat (2016:748) concur that spousal support increases the woman's commitment and as such lead to outstanding childbirth results. In addition, the women's mothers and mothers in law are excellent support.

The findings showed that in order to address the holistic wellbeing of the admitted women, midwives should show an ability to listen to women they care for. Lothian (2014) refers to listening to women as a way to 'Listen Up'. "Listening Up" is an initiative appealing to midwives to listen to women's views. In most instances, admitted women listen attentively to midwives who give them instructions,

which are carried out as they are. The CIG agreed that they would allow an active and conscious process in which midwives also listen to women (Tyagi, 2013:4). Listening to women may relief the CIG from the chains of the medical man since their views may be used to democratise the delivery of service. Hopefully, the understanding of the imparted message might lead to appropriate actions being taken with resultant satisfaction to both parties.

Maputle (2010:6) concurs that usually, midwives impose their policies, standard operating procedures, guidelines and standing orders. As a rule, women are in most cases never included in the formulation of these prescripts. Ebert, Bellchambers, Ferguson and Browne (2014:135) concurs that women always conform to the instructions of the midwives. Notably, the CIG communicated their intentions to include women in some decision making. The findings showed that in order to achieve professional value-driven midwifery care there is a need for engagement and consideration of the women's inputs.

6.3.3 Theme 3: Upholding professional practice to improve midwifery care

Professional practice in midwifery according to Poitras, Chouinard, Foitin and Gallagher (2016:1) refer to a combination of practice standards, nursing skills and the expected professional performance. The theme of upholding professional practice to improve midwifery care came up strongly from the findings as a way to promote professional value-driven midwifery. The CIG maintained that continuous development is necessary for them to stay attuned to current developments. Kennedy, Hardiker and Staniland (2014: 488) argue that employee empowerment is a management responsibility. Therefore, it should aim to uplift and motivate employees.

The CIG indicated that they are capable of providing the necessary midwifery care and as such represent the good image of the midwifery profession, however, they will appreciate opportunities for further learning so as to keep abreast with developments in their field of work. Eo, Kim and Lee (2014:42) concur that learning empowers prominent nurses to excel. The subthemes that emerged from the above theme were the recruitment of skilled, knowledgeable midwives, conducting in-service training, applying compassionate and committed care and portraying acts worthy of a professional image. These subthemes are addressed in a logical manner from 6.3.3.1-6.3.3.4.

6.3.3.1 Sub-Theme 1: Recruitment of skilled, knowledgeable midwives

The finding highlighted the worth of midwives as skilled healthcare providers who represent the heart of maternal care services in the country and worldwide. This is confirmed by the Royal College of Midwives (2014:5) which noted that midwives are skilled professionals who render midwifery care in a responsible and accountable manner.

The CIG further highlighted that the availability of relevant prescripts should be used to empower them and provide quality midwifery care. These prescripts are made available by the DoH and SANC. These prescripts are presented in the form of guidelines for maternity care in South Africa, DoH (2015), and the Nursing Act of 2005. On the contrary, in the Birth-rights (2013:19) it is documented that guidelines and protocols may influence midwives to act with inconsideration towards women they care for. The author adds that strict reliance on these prescripts may influence midwives to be rigid and limit their flexibility and creativity where the care environment require such. Therefore, midwives should not solely rely on available guidelines as that might turn them into stereotypical individuals who ignore the democratic co-operation and collaboration.

In addition, the study revealed a need to conduct clinical research in the maternity ward. The CIG felt confident that they might resort to conducting their own research to investigate the existing clinical problems that hamper quality care in their ward. They, therefore, highlighted a need for further research for their organisation as indicated in Jiyane, Phiri and Peu (2012:127). The current findings revealed a need for midwives to familiarise themselves with published studies and they agreed that by adopting a habit of reading and perusing published materials might equip and update them on how similar clinical problems are addressed.

6.3.3.2 Sub-Theme 2: Conducting in-service training

The CIG posited that their skilfulness as midwifery professionals should be enhanced through opportunities for empowerment, which should occur through on the job training. The Royal College of Midwives (2014:5) asserts that the provision of skilled midwifery care is enhanced through intense in-service training. Specific to South Africa, the South African Nursing Council (SANC) (2012:38) highlighted that midwifery departments experience decreased numbers of advanced midwifery care specialists. Therefore, an improvement in the field was suggested since midwifery care was identified as declining. The CIG showed their understanding that in-service training may empower them to gain experience with resultant work satisfaction. They further alluded to the fact that workshops and

conferences can be tools, which add to the professional value-driven midwifery care. Letlape, Koen and Coetzee (2014) concur that in-service training update midwives with new information. Letlape et al. (2014) add that in-service training uplift midwives' motivation, increases their possibility to gain respect from others and increases their potential to function independently.

6.3.3.3: Sub-Theme 3: Applying compassionate and committed care

The CIG maintained that compassionate care is a remedy to heal women involved in childbirth mishaps. Therefore, it requires midwives to act with empathy, respect and dignity. Sinclair, Beamer, Hack, McClement, Bouchal, Chochinov and Hagen (2017:439) refer to compassion as a method used to develop human kindness and show support to others. It increases the carer's courage and actions which reinforces the well-being of individuals. Applicable to midwifery care, compassion is portrayed through the ability of midwives to pick up signs of pain. It includes the ability of a midwife to take appropriate actions to handle the admitted women with sensitivity and commitment (Fotaki, 2015:199). In support, Larson (2014:3) argues that compassion to care is the essence of healthcare, most importantly, midwifery care.

Therefore, it is essential for the well-being of all women who are admitted for childbirth. Details of the findings are elaborated upon as follows:

The findings highlighted the need to treat the women with kindness, just as anyone might wish for especially during the needy moments of childbirth. In support of the above statement, Sinclair, Norris, McConnell, Chochinov, Hagen, Hack, McClement and Boucal (2016:1) describe compassionate care as a caring act characterised by acts of humanity towards those who are cared for. Acts of humanity relate to the prevention of harm while acts of harm include violence, torture, hate, demeaning actions and rudeness (Khosla, Zampas, Vogel, Bohren, Roseman & Erdman 2016). Rad, Mirhaghi and Shomoosi (2016:1) argue that nursing has changed to an uncaring practice characterised by decreased love and inhumane relationships with the clients. However, Rad et al. (2016:1) caution that failure to provide humane midwifery care might cloud the unique characteristics, which distinguish midwives from other members of the multi-disciplinary team. Therefore, compassionate care should form the cornerstone for quality care.

The CIG revealed the importance of portraying commitment and caring towards the women who are admitted to the maternity ward. They mentioned that their compassion is portrayed through staying

longer hours with women who are admitted for childbirth. Therefore, they are not comparable to any other healthcare practitioners. They also maintained that caring during midwifery care takes passion and is innate in midwives. Dennett (2015) concurs that actually, midwives kindness, helpfulness, their unique and humane character makes them unique care providers. Rad, Mirhaghi and Shomoossi (2016:1) add that love is a natural humanitarian concept and it is characterised by respect for human dignity and co-operation with women who are cared for. The author adds that respect for women's values and commitment to care promotes lasting relations between midwives and the women they care for.

The findings reflected midwives' empathetic stance in times of need. The CIG indicated that in order to promote professional value-driven midwifery care they should show empathy to women and treat them with dignity. The CIG declared their intentions to put themselves in the shoes of the women by imagining the treatment they wish to receive. That is, by imagining one's self in a real mishap might help midwives to understand the women's situation (The American College of Obstetricians and Gynaecologists, 2011:2). Jamil Piro (2016:164) concurs that women's right to sympathetic care is not a favour and that should be applied unquestionably. A sympathetic treatment may instil humanistic value and self-worth in the admitted woman (Jamil Piro, 2016:165). In an Australian study investigating the women's experiences of maternity care by Lewis, Hauk, Ronchi, Crichton and Waller (2016:4) a CIG member felt delighted by the mere sight of a known midwife and openly declared that meeting that midwife provided her with feelings relief and security. Lewis et al. (2016:5) concluded that a midwife-woman relationship, which is dominated by harmony and respect, should render the maternity ward as a decent place every woman wish to be admitted to.

The findings maintain that midwives should refrain from acts of postponing midwifery care. The CIG should keep a watchful eye on women and do a proper handover throughout midwifery shifts. The Royal College of Obstetricians and Gynaecologists (2009:5) add that the notion of 'being with woman' which is referred to as midwives' continuous presence should be the core of midwifery care. The midwives' effort to work in close proximity to women might provide them with a chance to pick up problems and to intervene promptly before complications occur. As a result, Hodnett, Gates, Hofmeyr and Sakala (2014:12) refer to the period of 'being with woman' as a chance to always 'be there'. Hodnett et al. (2014:12) add that as a result, the women will be reassured and will eventually feel supported and not abandoned.

On the contrary, other authors like Ball, Murrells, Rafferty, Morrow and Griffiths, 2013:4) and Hessels, Flynn, Cimiotti, Cadmus and Gershon (2015: 60) maintain that the physical presence might be misleading since that does not always depict the truth. As midwives might be physically available, however, that does not guarantee that midwifery tasks are adequately performed.

6.3.3.4 Sub-Theme 4: Portraying acts worthy of professional image

The findings also revealed a problem of poor relationships between the hospital and communities. The CIG' indicated their disappointment at the plan to ruin midwives professional image by communities around the hospital. They argued that this is sometimes done through negative media reports about the hospital and in their case the maternity ward in particular. Oosthuizen (2012:51) and van Bekkum and Hilton (2013:1) refer to media as any form communication that is used to disperse information on a massive scale. This includes magazines, films, television, print media, radio, internet, social media and more. Specific to this study midwives reported their dissatisfaction with the local community radio station. Oosthuizen (2012:53) adds that media reporting might be two-fold, it might be positive or negative, but in most instances, media ignores the good to 'blow a whistle' on negative issues which in most cases are blown out of proportion.

The CIG maintained that media reporting concentrates more on the negative than the positive and do not consider the emotions and reputations of those who are reported on. The South African Federation of Mental Health (SAFMH) (2016:3) concurs that negative reporting is a standing rule for media providers and invites both national and international public discourse on the topic. As a result, SAFMH (2016:3) asserts that since the media forms a cornerstone for public information and education, it has a responsibility to report fairly and accurately. Failure to fair and accurate reporting might impact negativity on those who are being reported on and in this case midwives. Finally, even though the CIG complained; negative attitudes portrayed by women are never reported and/or made public in the media, literature that supports the claim is limited.

6.3.4 Theme 4: Maintaining ethical midwifery care

Theme four revealed midwives' belief regarding the contribution of ethics to midwifery with resultant quality midwifery care. The CIG showed increased understanding of the value for ethical midwifery care. The Health Professions Council of South Africa (2008:2) mentions that ethical midwifery practice is a core determinant of professionalism in midwifery care. The findings formed a broad umbrella that constitutes safe, respectful, dignified and humane midwifery care. The above-

mentioned theme was backed up by four subthemes namely promoting beneficence during midwifery care, portraying respect towards the birthing women, promoting acts of justice towards admitted women, women' rights during birthing, and commitment towards admitted women. These themes were discussed individually as 6.3.4.1- 6.3.5. 4.

6.3.4.1 Sub-Theme 1: Promoting beneficence during childbirth

The findings highlighted the midwives' understanding of rendering ethically sound midwifery care as a necessity for quality care. The CIG showed an understanding that good practices must be upheld at all times. The CIG also identified acts that depict harm and abusive midwifery care which, might affect women either physically and/or psychologically**.** Acts of harm and abusive midwifery care may result in infringement of women's rights (WHO, 2014) and Bohren et al. (2015:7). Details of the findings of this theme were addressed as hereunder.

The findings identified acts of intentional and indirect punishment endured by women during childbirth. The CIG communicated their experience of intentional neglect to women in need of care. Applicable to Midwifery neglect means failure to fulfil the basic needs of admitted women (Reader & Gillespie, 2013). Reader and Gillespie (2013:7) go further to say that the term neglect concentrates on passive omissions, which occur due to attitude or laziness. Khosla et al. (2016:137) assert that at times care is withheld intentionally to frustrate and demonstrate power. In addition, neglect is portrayed through a lack of compassion, intentional ignorance and avoidance of women in need of assistance. Bohren, Vogel, Hunter, Lutsiv, Makh, Souza, Aguiar, Coneglian, Luíz, Diniz, Tuncalp, Javadi, Oladapo, Khosla, Hindin and Gulmezoglu (2015:7) classify neglect as a sign of inefficiency.

Notably, the CIG added that wrongful acts like slapping should not be used on women who are admitted for childbirth. A different view was brought up by the participants in a study by Balde, Bangoura, Diallo, Sall, Balde, Niakate, Vogel and Bohren et al. (2017:5) who openly formalised the women's punishment under specific conditions for example dealing with difficult patients whose behaviour might harm their babies, for example acts like running, standing and hopping, screaming, impoliteness towards others and more (Balde et al., 2017:7).

The findings further revealed the importance of adhering to the principle of beneficence throughout midwifery care by refraining from performance of unlawful, insignificant and unconsented procedures

that may expose women to unnecessary pain and suffering. The CIG gave examples to maintain the respect of women by adhering to the better/safer birth initiatives, which maximise respectful care. Bohren et al. (2015:33) asserts that practical non-consented care does exist in midwifery and these include non-consented examinations, procedures like episiotomy and more.

The findings highlighted the importance of the CIG's vigilance at all times since they work under unpredictable conditions. The CIG pinpointed the need to use own discretion to separate urgent situation from the normal situations. They agreed that failure to interpret the woman's voice-call might fail to pick up the urgency of a care situation, which might be indicative of ignoring women. Bohren et al. (2015:11) concur that ignoring women during childbirth might be or interpreted as neglect and abandonment.

6.3.4.2 Sub-Theme 2: Portraying respect towards the women who give birth

The findings displayed an awareness of lack of respect towards admitted women. The CIG openly admitted to disrespectful behaviours directed towards admitted women. Shimoda, Horiuchi, Leshabari and Shimpuku (2018) confirmed evidence of lack of respectful midwifery care in one hospital in Tanzania and this finding showed that disrespectful care exists in other countries just as it is in South Africa.

The findings further revealed a need for respecting the rights of admitted women as follows:

Timeous assistance to admitted women was also highlighted. The findings revealed that in order to promote respect; midwives should take the initiative to offer themselves to assist women who seem frustrated and/or confused. Shakibazadeh, Namadian, Bohren, Vogel, Rashidian, Nogueira Pileggi, Madeira, Leathersich, Tuncalp, Oladapo Souza and Gülmezoglu (2017) appeal to midwives as the carers to promote a positive atmosphere which should send a sense of welcome to women.

The findings portrayed the women's exposure to forms of vulnerability as they do not have a say. The CIG highlighted a need for increased consideration of the admitted woman. The CIG realised that sometimes their actions lead to rights violations of admitted women. Shakibazadeh et al. (2018: 936) revealed that during childbirth women may feel inclined to just obey discussions by others.

These violations may occur especially in situations where women become exposed to a large group of spectators as a specimen as is reported in Pickles (2015).

6.3.4.3 Sub-Theme 3: Promoting acts of justice towards women during childbirth

The findings disclosed the principle of justice as a necessity towards the attainment of professional value-driven midwifery care. The CIG proclaimed that treating women on the merit of age, parity, type of diagnosis, personal attributes and more, contribute to acts of injustice. An appeal was made that midwives should refrain from these practices. Watson and Downe (2017) denote acts of unfairness and injustice, which are portrayed as discrimination against others, who in this study are the women admitted for childbirth. Furthermore, Watson and Downe (2017:1) refer to discrimination as an act of mistreatment based on an individual's economic stance, ethnicity, spoken language, demography and more.

The findings also revealed that practising equity may assist midwives to attain professional value-driven midwifery care. Miltenburg, Lambermon, Hamelink and Meguid (2016:3) refer to equity, which is an endeavour to strive for a state of fair treatment to all the women who are admitted.

6.3.4.4 Sub-Theme 4: Encouraging women' rights during birthing

In addition, the findings disclosed the midwives' infringement of the women's rights during confinement. The CIG highlighted the need to promote the right of admitted women's privacy. They continued that maternity wards should acknowledge women as individuals whose rights should not be infringed upon in any way. According to Tamara (2013:2) of the White Ribbon Alliance, Burrows, Holcombe, Jara, Carter & Smith (2017:3), caregivers should refrain from all forms of undignified care in order to uplift the corresponding right to dignity and respect. Disrespectful and abusive acts during childbirth might form serious human rights violations, which might invite scrutiny and unnecessary litigations (Kruk, Kujawski, Mbaruku, Ramsey, Moyo & Freedman, 2014:4). The CIG understood that women have a right to make inputs. They further reiterated that such an involvement signify decision making and giving consent as part of their human rights.

The findings further revealed a confirmation of negative labelling of women by midwives based on physical features. The CIG realised that negative labelling is not acceptable and warned that the act contributes to discrimination towards the admitted woman. The finding revealed that midwives were aware of the requirements of the Convention on the Elimination of All Forms of Discrimination against

Women (CEDAW) (1979). According to Watson and Downe (2017:2), the discrimination regarding one's personal characteristic is classified under the prohibited ground of discrimination, which individuals should guard against. The implication is that no healthcare provider is entitled to abuse the women under their care. Women who are admitted to the maternity wards deserve to be respected as human beings with rights and midwives need to treat them with respect.

6.3.4.5 Sub-Theme 5: Portraying commitment towards ethical midwifery care

The findings revealed midwives' readiness to work towards an improved professional value-driven midwifery care. The CIG took an undertaking to improve the delivery of service through a dignified respectful and committed midwifery care. They came up with an undertaking to improve relations with their clients. Refer to table 5.5; subtheme 5.4.4.5.

A brief discussion of the CIG commitments towards the women was classified into three as reflected hereunder:

- Commitment to prevent abusive, discriminatory and disrespectful and humiliating midwifery care
  The presence of abuse and discrimination in midwifery are undeniable. Different forms of abuse were confirmed, for example, physical abuse through pinching, slapping and verbal abuse. Evidence of abuse through harsh, rude threats and judgemental comments and discrimination are confirmed in Bohren et al. (2015:7, 10) Khosla, Zampas, Vogel, Bohren, Roseman and Erdman (2016:133). Miller and Lalonde (2015) highlight that abuse and disrespect are not localised but are a global epidemic, which should be addressed.
- Commitment to eliminate women's decreased informed decision making
  Khosla et al. (2016:134) assert that the decrease and/or lack of admitted women's consultation and decision making impinges on their rights to a dignified and autonomous service.
- Commitment to no woman detention in hospital.
  Devakumar and Yates (2016:277) highlight the detention of women who recently underwent childbirth as a common concern. This problem was reflected as instances where women are detained in maternity wards for failure to settle their bills (Cowgill & Ntambue, 2017:4); which is an act that should not be condoned.

6.3.5 Theme 5: Outlining barriers towards professional value-driven midwifery care

The findings disclosed the presence of barriers that inhibit the attainment of professional value-driven midwifery care. According to Eygelaar and Stellenberg (2012), a barrier refers to anything that forms a hindrance to the progress of service delivery. Specific to this study, the CIG reported systems related hindrances, which impacted negatively on the delivery of quality midwifery care. In this study, the barriers were systematic and emanated from the organisation and not the service provider who in this case are midwives (Scheppers, van Dongen, Dekker, Geertzen & Dekker (2006:326). Three subthemes of barriers identified in this study were related to lack of resources, barriers regarding the right to companionship initiative and the role of culture during childbirth.

6.3.5.1 Sub-Theme 1: Lack of resources

The CIG understood that resources are a key to satisfactory and quality midwifery care. They confidently went public to reveal how lack of resources prevent them from achieving intended outcomes. The truth of the claim mentioned regarding the shortage of adequate resources was confirmed through a study conducted in Gauteng where the participants also proclaimed resource challenges, which affect service delivery negatively (Magobe, Beukes & Müller, 2010). Additionally, lack of resources that is, both material and human was asserted by DENOSA (2012:1) which referred to shortages as the 'dwindling numbers' of resources in healthcare facilities in the country. In support of the inadequacy of resources, Chadwick, Cooper and Harries (2014:862) add that the resource decline in midwifery care environments exposes midwives and women to risks.

From the category of barriers towards professional value-driven midwifery care, three subcategories emerged and are discussed as follows:

- Inadequate medical resources

The CIG highlighted organisational-related issues, which gave rise to inadequate medical resources that affected service delivery in midwifery care. They emphasised that the system error emanates as a lack of essential supplies such as medication, equipment and stock, which contribute to poor quality patient care in the maternity ward. Chimwaza, Chipeta, Ngwira, Kamwedo, Taulo, Bradley and McAuliffe (2014:5) indicate that midwives become powerless over these system errors and as a result, they resort to facing the situation as is. The CIG further stated that the lack of medical resources might create a negative impression on women. Therefore the professional value-driven midwifery goals might also be threatened. Karkee, Lee and Pokharel (2014:4) concurred that lack of essential material resources might affect professional value-driven midwifery.

The findings discovered that the scarcity of medical resources might compromise the safety of women who are admitted for childbirth and as a result, the women's right to receive quality care may be infringed upon. The CIG gave an example of failure to acquire the necessary medication for women's post-delivery needs, i.e. lack of suturing materials. They also felt that women in those cases will experience unfulfilled needs which might signify a denied right to receive quality midwifery care. Freedman, Ramsey, Abuya, Bellows, Ndwiga, Warren, Kujawsky, Moyo, Kruk and Mbaruku (2014:915) refer to the lack to acquire the necessary resources as an organisational barrier that constitutes a systemic deficiency. Freedman et al. (2014) add that deficiency eventually expose women to disrespectful and abusive midwifery care environments. Karkee et al. (2014:4) highlight that the availability of sufficient and relevant material resources have inherent benefits for midwives. The findings portrayed the CIG's feeling that systemic deficiency might have a negative connotation on their image as care providers. The CIG verbalised their fear of negative labelling and/or reporting. Mannava, Durrant, Fisher, Chersich and Luchters (2015) mention that in extreme cases midwives are labelled as uncaring, neglectful, abandoning and abusive. As a consequence, the CIG was concerned that a lack of resources might be interpreted as a violation of patients' right. The CIG also indicated their displeasure for the ever apologising tendency for activities they could not fulfil due to lack of resources.

- **Inadequate human resources**

The findings emphasised inadequate staffing that threatens the attainment of professional value-driven midwifery care. Chimwaza, Chipeta, Nqwira, Kamwendo, Taulo, Bradley and McAuliffe (2014:5) argue that shortage of midwives really exists and is aggravated by increased workloads in midwifery care environments. Some CIG members indicated that it is sometimes difficult to care for all women to their satisfaction due to overpopulation in the maternity ward. Paudel, Mehata, Paudel, Dariana, Aryal, Paudel, King and Barnett (2015) assert that usually, the overcrowding of maternity wards results in decreased time to care for admitted women. Paudel et al. (2015) add that overcrowding of the maternity wards prevents midwives from sufficiently addressing care related priorities and needs. In general, the situation in the maternity ward does not promote healthy employment. Aslan, Karaaslan, Yildiz, Doğan and Evirgen, (2016:596) view a healthy environment as the one which exposes midwives to continuous availability of an adequate number of staff with diverse skills and knowledge. On the contrary, the failure to cover the necessary care needs of admitted women might be regarded as a human right violation (Mosadeghrad 2014:80).

One CIG member in this study alluded to the fact that at times, midwives find themselves in a predicament of being thrown into the deep end. They are left on their own and are expected to

manage enormous workloads, and therefore, they have to prioritise care activities creatively. Prioritisation is referred to as an ability to organise activities based on the merit of urgency (Mamabolo, Jali, Mothiba, Kgole & Lekhuleni (2014:463). Applicable to midwifery, Kieft, Brouwer, Francke, and Delnoij (2014:5) attest that prioritisation of activities refers to an effective reorganisation of care based on the type of patients, the urgency of the condition and the importance thereof as decided upon by an experienced individual midwife. On the contrary, the findings showed the CIG concern that the reorganisation of care through prioritisation may also have a negative impact on the attainment of value-driven midwifery care. The CIG maintained that even though care modality may be trusted as a relief measure during hectic workloads, it also has its own disadvantages. They pointed out that prioritisation of activities usually result in compromised care. Wells and Pierce-Anaya (2015:19) refer to missed care as 'rationing of nursing care', 'unfinished care', 'task incompletion' and 'care or nursing care left undone'. The findings showed that among others, recordkeeping was left undone. This finding correlated with the contents of the hospital National accreditation report (DoH, 2015:95), standard 6.7.1, with a measure to be taken: 6.7.1.1.1. The unit manager's Quality Improvement plan for March 2016 also supported the inaccuracy of records as a problem in the said maternity ward**.** Inaccurate records in the maternity ward create a room for doubts with regards to the quality of care rendered. Stevens and Pickering (2011:1) asserted that poor recordkeeping signified the declined of quality midwifery care. The causes of 'task incompletion' are always attributed to a shortage of staff and or time. On the contrary, Kalisch (2006) argues that the lack of staff is not the sole cause of task incompletion but another cause could be 'it's not my job syndrome'. Negativism becomes a drawback towards the achievement of professional value-driven midwifery care.

In addition, the findings also reflected that midwives switch to multi-tasking in order to curtail the shortage of staff. One CIG member revealed that in that case of dire need, she does all the activities alone for the patient's sake. This act is referred to as multi-tasking according to Douglas, Raban, Walter and Westbrook (2016). Multi-tasking involves the ability to shift one's attention to different tasks simultaneously. According to Yen, Kelly, Lopegui, Rosado, Migliore, Chipps and Buck (2016:1264), multitasking refers to a fundamental function that promotes the ability to allocate resources to several tasks. The multi-tasking approach applied in this study is referred to as the interleaved multitasking or task switching. Ultimately, the CIG highlighted that multi-tasking leads to the performance of non-nursing duties during hectic periods and this caused uneasiness in them. According to John, Mgbekem, Nsemo, and Maxwell (2017:3), non-nursing duties lead to missed care and diminish the nurses' time for actual patient care.

Mixed feelings were realised from the CIG's narratives on the topic regarding the non-nursing duties. Their opinions differed on this issue; some revealed that they have actually accepted the performance of the non-nursing duties since they felt that failure to do so might affect the rendering of quality service. Others, for example, one senior midwife pointed out the potential risks of multi-tasking and performing non-nursing duties. She indicated that these practices might put their profession at risk. As a result, the CIG agreed to disagree and reminded each other of their professional responsibility.

Alternatively, the findings portrayed that not all the midwives respond to excessive workloads by prioritising care. Other midwives refer to excessive workloads as 'unhealthy'. This is a situation that is characterised by disparities between the numbers of midwives who render care and the workloads in the maternity ward (Aslan, Karaaslan, Yildiz, Doğan & Evirgen, 2016). The CIG further revealed that some of their colleagues react to the perceived risky situation by opting out or quitting their positions and this creates a greater shortage. In principle, midwives who resort to exchanging their positions for better conditions of service do so with the hope for better 'healthy employment' conditions. A healthy employment environment refers to the ability of the workplace to retain knowledgeable and skilled midwives based on appropriate skill mix and relevant staffing norms (Aslan et al., 2016:596).

The findings also revealed a need for midwives to take into cognisance their own professional safety. One the CIG member strongly cautioned the group to respect their profession by taking into cognisance the operational risks for which drastic steps might be taken against them. Nacioglu (2016:2) concurs that midwives should guard against unsafe acts since that might expose them to operational risks. Nacioglu (2016) cautions that operational risks might constitute deliberate deviations from operational standards and might viewed as serious misconduct punishable by law. Therefore, as independent practitioners, midwives are advised to practice their leadership attributes like courage, bravery, autonomy and accountability to enhance their ability to 'speak-up' against system failures that affect them (Nacioglu (2016:19). In this study, speaking-up refers to an ability of individuals to raise concerns and become aware of deficits, which hamper patient safety (Okuyama, Wagner & Bijnen, 2014:1). Therefore, speaking up creates a good platform for the prevention of unnecessary adverse events and unnecessary litigations.

6.3.5.2 Sub-Theme 2: Barriers towards the right to doula support initiative

The CIG asserted that doula support is important, but they have space constraints at their ward. The maternity ward comprised of eight rooms, made of cubicles and single bedded rooms. The cubicles were demarcated into four parts namely the Caesarean, the Ante-Natal and two Post Natal sections that accommodated 6 beds each. In addition, two other cubicles comprised of 1 Labour room with 2 delivery beds and a Nursery ward with 6 incubators. The ward had a four one bedded extensions used as admission room, sideward, kitchen and storeroom. In addition, 3 toilets with a hand-basin each were also added as part of the ward. As a result, the infrastructure of the maternity ward could not offer adequate space to cater for women's privacy. The CIG indicated that they might utilise any available space however that was not always possible since nearly all the rooms were always fully utilised on a continuous basis. As a result, episodes of lack of space were experienced, and therefore, midwives usually found themselves in a dilemma of no space to cater for the doula support initiative. Manyisa and Van Aswegen (2017:35) attest that poor infrastructure has a negative bearing on the performance of the midwives. The author adds that lack of space infringes on the women's rights to privacy. Therefore, women might experience deprivation of the need for this initiative as long as infrastructural challenges are ignored. The lack of space formed a barrier for the implementation of this initiative in most maternity wards, and that was confirmed as a general problem by the WHO (2016:3).

6.3.5.3 Sub-Theme 3: The role of culture during childbirth

The study revealed that some women from surrounding communities still held cultural beliefs, which are ancient, and these are brought into the maternity ward. The CIG mentioned that they come across the women who are accordingly informed by their cultural beliefs and practices. Norton and Marks-Maran (2014:40) refer to culture as a system of shared rules, ideas and meanings that guides individuals' actions and behaviour. It is important to note that culture forms a lens to view life by a particular society. A study conducted in one province in South Africa highlighted that automatically, cultural beliefs become traits which are past from a generation to the other and as such societies become entrenched in them for life (Mogawane, Mothiba & Malema, 2015:4). Coast, Jones, Portella and Lattof (2014:2) assert that childbirth and delivery are social moments which are associated with the women's unique social norms. Unfortunately, at times, healthcare institutions may impose the dominant culture on women through standards, regulations; policies and guidelines.

The findings strongly emphasised the value of culture on individuals. The CIG openly declared that culture is an important determinant of an individual's way of life and as such, affects the behaviour of women admitted for childbirth. The above statement is supported by Norton and Max-Maran (2014:40) as they wrote that culture is a system of shared ideas, rules and meanings that guide the

individual actions and behaviour and is passed on from one generation to the other. Norton and Max-Maran (2014) commented that culture guides the individual actions and therefore directs human behaviour. Coast, Jones, Portella and Lattof (2014:1) refers to culture as cultural prominences regarding shared beliefs and individual expectations which include spoken language as well as behavioural customs.

The findings further highlighted that cultural differences that exist between admitted women and as such, they should not be compared as no one woman is the same as the other and should be treated as unique individuals. The CIG's understanding of the uniqueness of the individual woman showed their readiness to embrace the cultural differences that admitted women practiced (de Beer & Chipps, 2014). The discussion about the role of culture further revealed topics on cultural sensitivity and barriers towards professional value-driven midwifery care which are addressed below.

- **Culturally sensitive care**

The CIG added that childbirth is influenced by social dimensions, which channel women to act in a certain way and sometimes different from the expectations of the current modernised care (Behruzi, Hatem, Goulet, Fraser & Misago, 2014:1). Koneshe (2016) maintains that multi-culturalism is an obvious characteristic of the South African society. Therefore, values and beliefs can be totally dissimilar especially between healthcare providers and women admitted for childbirth. Larson (2014:3) concurs that maternity wards admit women of different cultures and beliefs and as such co-operation and understanding are encouraged.

In this study, the role played by culture, and its impact on midwifery care was brought to the fore. The CIG felt that cultural differences are important and should not be ignored. In support, Nyabwari (2016:17) mentioned that healthcare facilities should refrain from their old ways of doing things and embrace cultural sensitivity towards those who are being cared for. Midwives should accept, be aware and utilise knowledge about different cultures to provide better service for the admitted women. The maternity wards should refrain to operate on the notion of 'same care suits all' (Nyabwari, 2016:17). Same care for all is not suitable to the ever-changing midwifery care environment (Nyabwari, 2016:17).

- **Culture-related barriers towards professional value-driven midwifery care as experienced in the maternity ward**

The findings revealed several potential culturally-related hindrances towards the attainment of professional value-driven midwifery care. These hindrances include the potential bravery of the birthing women, un-researched acts influencing childbirth, ingestion of foreign and unreliable substances and gender-based discrimination on accoucheurs by some women.

Normally, the thought of labour has a significant impact on the women who is waiting in anticipation for the unknown. Aziato, Acheampong and Umoar (2017:1) assert that the thought of labour sends a cold shiver through the spines of pregnant women. In return, some women respond through worries, scares and sleeplessness as well as intense panic attacks. Noticeably, the CIG realised that women are socialised differently with regard to labour pains. Labour pains are intense abdominal, pelvic and back pains that are extremely unbearable.

The CIG revealed that on the contrary, some societies have a different view about labour pains. These societies believe and encourage the notion of 'bravery of womanhood'. As a rule, women who are socialised in this practice believe in pain endurance as a sign of bravery and increased strength to undergo childbirth. The women who are socialised in this manner do not cry from labour pains since crying might be perceived as a weakness and/or cowardice (Caulfield, Onyo, Byrne, Nduba, Nyagero, Morgan and Kermode (2016:1). As a result, these women usually deliver silently on their own. Caulfield, et al. (2016:1) argue that women who deliver on their own are the brave ones and do not accommodate any assistance. The author adds that these women prefer to keep quiet so as not to make anyone aware of the proceedings of birth. Notably, these women uplift the cultural belief that unassisted birth signifies 'real womanhood'. Ntozi and Katusiime-Kabazeyo (2016:2869) added that the act of bravery during childbirth provide women with some sense of self-fulfilment as the 'courageous ones' who can deliver alone without any help and make the in-laws proud. The CIG highlighted that the so-called "the courageous women" usually end up with complications like severe haemorrhages and perinneal tears. As a result, these women have to receive extra care and add to the average length of stay (ALOS) in the maternity ward. Consequently, the quality of midwifery care becomes compromised.

Secondly, findings also revealed unfamiliar acts that influence childbirth. These practices, which are not documented and/or reported anywhere take place to serious dilemma to midwives. The CIG

reported that they noted that some women wear unusual ornaments like a 'holly' bracelet or a rope, a small stone wrapped in a scarf and more. They added that the ornaments are believed to expedite labour and delivery and might have special protection from bad occurrences that can turn birthing into a danger and bad-luck. Therefore, the women prefer the ornaments to remain on their bodies until the end of childbirth. Aziato, Odai and Omenyo (2016:3) refer to the ornaments as artefacts, which form the religious anointment of women to prevent evil spirits from taking over the birthing process. M'soka (2015) concurs that cultural practices and beliefs might fasten labour and/or assist difficult labour. Mixed feelings came upon the matter.

Additionally, an act of ingestion of foreign and unreliable substances by some women was identified. The CIG reported a practice through which some women ingested different concoctions immediately they start experiencing labour pains. The CIG revealed that at times the derivation of these mixtures are inedible particles that are not meant to be taken orally like crushed ostrich eggshells and more. There is not enough literature on traditional uses of ostrich eggshells in assisting childbirth. However, one research was conducted on the use of ostrich products like eggs, meat feathers and other body parts in Tanzania. The findings revealed that ostrich is a source of human food, clothing, ornaments and cosmetics (Magige & Røskaft, 2017:2). Therefore, even though the use of ostrich egg is not documented yet, the practice exists. The CIG reported that the mixtures are intended to quicken the labour process, but unfortunately it is risky and threatens the safety of both the women and their unborn babies.

The CIG highlighted that unfortunately at times these practices result in negative effects like precipitated labour. Precipitated labour refers to the extremely quick process of giving birth to a baby, which lasts for about three hours only and result in extremely strong uterine contractions (Suzuki, 2015:150). The above definition is supported by the CIG s' description of precipitous labour as well as its maternal complications like post-partum haemorrhage, severe perineal lacerations with increased ALOS (Suzuki, 2015:153). On the other side, midwives are worried about the increased use of cultural concoctions. Panganai and Shumba (2016:1) mention that even though women may not be familiar with these, they believe and have faith in them. Additionally, it is noted that cultural practices of birth are instilled in these women, and as such it might be hard for them to discontinue the practices. The CIG indicated their unsuccessful encounters with women when encouraged to abandon the practices. Notably, the practices emanate from the teachings of old women who are trusted as sources for survival during the dire moments of childbirth. Panganai and Shumba (2016:3) concur that it is a common belief that mothers who fail to advise their daughters on childbirth

remedies are regarded as 'useless fools'. Therefore, mothers feel obliged to fulfil the parental role of educating their daughters regarding childbirth matters.

The findings further disclosed forms of gender-based discrimination on accoucheurs or male midwives by some women around the chosen setting. The CIG reported blatant refusal of some women's to be cared for by male final year midwifery students. The findings further indicated that these women openly disapprove and/or become unco-operative and refuse to be attended to by males despite pleas for their co-operation. Similar findings were revealed through a Ugandan study by Ntozi and Katusiime-Kabazeyo (2014) when women boldly declared their increased choice to deliver at home than in hospitals was that they stood a greater chance to be delivered by males. The women added that according to their culture, being delivered by males is a taboo and an immoral act, which meets disapproval of the community they live in. In support, Oyetunde and Nkwonta (2014:44) pointed out that issues of culture contributed to the exclusion of males from nurse training in countries like Nigeria.

The subtheme encourages midwives to learn and appreciate the importance of the cultures of the admitted women. Eventually, they might possess cultural competence and know-how, which, in turn, might improve their cultural awareness and sensitivity towards the women they care for. The midwives' cultural sensitivity might turn childbirth into a positive and self-fulfilling memorable event for women visiting the hospital for midwifery care.

6.4 CONCLUSION

This chapter addressed the discussion of the findings of phase three of the study, which are supported through the relevant literature. The themes, subthemes and quotes directed the discussion and the literature control and assisted the researcher to maintain the focus of the study. The discussion of the findings supported the CIG The belief regarding the promotion of professional value-driven midwifery care. On completion of the writing up of the chapter, the researcher re-visited the maternity ward for member checking. The researcher described the process followed, and the CIG accepted the efforts taken. In addition, the linkages of the findings of this study to other studies with specific references to the similarities and differences are pointed out in 6.2. The next chapter addresses the development of a program that will eventually direct midwives regarding the promotion of professional value-driven midwifery care in the maternity ward.

CHAPTER 7
THE DEVELOPMENT OF STRATEGIES TO EMPOWER MIDWIVES TOWARDS THE PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE

7.1 INTRODUCTION

The previous chapter addressed the discussion of the findings and literature control of the second phase of the study. Chapter seven focused on the development of specific strategies that should guide midwives towards the attainment of professional value-driven midwifery care in a public hospital in the Mpumalanga province of South Africa.

As already explained the cooperative inquiry was conducted in the form of gatherings and meetings organised by the researcher with the CIG as a “cooperative”. The cooperative attended seven meetings altogether. In this study, meetings refer to any gathering, which was attended for planning purposes for the next step to be taken, and these include teaching/workshops conducted for the group. The term meeting was used to distinguish meetings from sessions, which meant the actual participation in the research.

The embracement of the bottom-up approach encouraged the CIG, and they regarded themselves as valuable assets to the cooperative. This approach allowed the CIG to lead the sessions without any imposition from the researcher as the strategies were to be used to improve the care rendered in the maternity ward. One characteristic of a Cooperative Inquiry (CI) is the increase of knowledge of those who take part in it. McNiff and Whitehead (2010:17) assert that as a Participatory Action Research, CI should focus on the improvement of learning and new knowledge creation. The use of the bottom-up approach motivated the participants as the CIG and was suitable for the development phase of the study (Larrison; 1999:68) and McDermott, Hamel, Steel, Flood & McKee (2015). This approach allowed the CIG to be fully

involved in the formulation of strategies, which will empower them to render professional value-driven midwifery care. In addition, the CIG appreciated the bottom-up approach. According to its unique nature, the bottom-up approach created no room for oppressive traditional top-down approaches. The CIG was not channelled to conform to any top-down approach with no tangible benefits. The CIG in this CI continuously appreciated the bottom-up approach and openly declared the resultant sense of self-worth, pride and motivation to participate in the research endeavour. Notably, the approach led to improved retention of the CIG as a cooperative.

7.2 AN OVERVIEW OF THE DEVELOPMENT OF STRATEGIES IN MIDWIFERY

This study was conducted in four phases namely, the Introductory, the Planning, Action and the Observation phases.

A brief summary of the phases of the study are reflected below:

7.2.1 The Introductory phase

Phase one, the Introductory phase was divided into three parts namely, the Pre-entry phase, (Stage 1), the Reflection phase, (Stage 2), the Hand Diagram figure exercise and the Reflection phase, (Stage 3), the Nominal group technique.

7.2.2 The Planning phase

The second phase was the creation stage. The objective of the phase was '*to explore and describe midwives' views regarding professional value-driven midwifery care".* The CIG of this phase were only midwives. This is where three focus group discussions were conducted. The findings of the Planning phase comprised of five themes of providing quality midwifery care to women during childbirth, preserving the holistic well-being of women who undergo childbirth, upholding professional practice to improve midwifery, maintaining ethical midwifery throughout childbirth and barriers to professional value driven midwifery care.

7.2.3 The Action phase

The action phase involved the development of strategies to empower the midwives regarding professional value-driven midwifery care during childbirth. The cooperative felt that the whole Introductory phase which comprised of the pre-entry phase, (stage 1), the Reflection phase, the Hand Diagram figure exercise (stage 2) and the Reflection phase, the Nominal Group Technique (stage 3) should not form part of the development of the strategies. The reasons thereof were that the three stages were meant to introduce the study to stakeholders only, to promote teamwork and acceptance of the individual CIG members unique values. As a result, only the findings of Phase 2, which comprised of the focus group discussions were included in the development of the strategies. For details of the findings of the focus group discussions, see chapter 5, table 5.1 as a summary of the findings, major themes and subthemes.

7.2.4 The Observation phase

The observation phase involved the CIG' reflection on the results from previous year's accreditation by the National Core Standards, which had been a problem and scored them low in two successive years. For the sake of logic in the development of the phases of this study, this item was elaborated upon in chapter 8, as 8.7.2 on the development of an assessment tool. For details on the presentation and interpretation of the Observation phase refer to chapter 4, table 4.7. The Observation phase was discussed in detail in chapter 3, item 3.6.4 which outlined its actual development process in 3.6.4.3.1.

7.3 THE PROCESS OF DEVELOPING THE STRATEGIES

The cooperative came up with a plan to follow during the formulation of the strategies. The plan entailed the following:

7.3.1 Initial plans to develop the strategies

The plan to hold a meeting to develop the strategies to empower the midwives stemmed from the preparations from the previous meeting. The CIG took a resolution to use the findings of the study to develop strategies to empower midwives to regarding professional value-driven midwifery care. The cooperative worked together and tasked all its members to each search for relevant literature for utilisation in developing the strategies in order manage time

effectively in the next meeting. They further stressed the need for acting responsibly in order to come up with good strategies, which should be a core of the study, which they should be proud and accountable for at the end.

7.3.1.1 The meeting for developing strategies

Eight CIG members attended the meeting; an attendance register was circulated, signed and kept. The research organiser opened the meeting with a warm welcome. The purpose of the meeting was stated. The sequence of the activities of the meeting was indicated as the setting of the ground rules, conducting a mini-workshop and the development of the strategies to empower midwives to render value-driven midwifery care.

- **Establishing ground rules**

Due to the notion that people function better and produce good work in a relaxed environment, the Cooperative started by setting ground rules. Since the Cooperative comprised of the same CIG members who participated from the beginning of the study, their participation was based on co-operation, collaboration and joint decision making which included the following:

- Equal; active participation and interaction.
- transfer and exchange of ideas among the Cooperative.
- reliance on each other.
- having feelings of positive interdependency.
- the awareness of the group's social responsibility, commitment accountability towards the development of quality strategies to be utilised during childbirth.
- open and constructive criticism, one person to speak at a time, not allowing interruptions and respect of ideas by others.

7.3.2 The approach followed to develop the strategies

A Cooperative Inquiry was followed and Cooperative leaning took place. Focus group discussions were used to collect data for the third phase. Refer to 3.6.3 for details of the phase.

7.3.2.1 The mini-workshop

The meeting was opened with a mini-workshop on the type of participation required to develop the strategies. The mini-workshop was aimed at reinforcing the collaborative, equal and mutual decision making the type of participation required from the cooperative. See Annexure F, for details of meetings held.

After the mini-workshop, the CIG and the researcher did the homework of searching for suitable literature, read a lot and brought suitable sources for discussion to support the act of developing the strategies.

The criteria for the choice of the literature was the aspect of development of human resources with an intention to improve quality of nursing and midwifery care as follows:

The WHO progress report on health workforce education 2013-2015 had a special aim to educate the healthcare human resources. Its main objectives were to provide sound and technical guidance regarding pre-service education for healthcare human resources. Specific to midwifery, WHO, (2013-2015) intended to uplift continuous professional development and scale-up midwifery education to promote improved midwifery care.

The Executive report (WHO, 2015) reflected on the realisation that healthcare workers are a core of healthcare and therefore prioritised their development. The strategy prioritised different aspects like education, management, retention, incentives and more.

The European strategic directions for strengthening nursing and midwifery towards health 2020 goals (WHO, 2015) was also read by the cooperative. It prioritised scale-up of and the transformation of midwifery education and training, workforce planning and optimising skill mix, promoting positive midwifery environments as well as prioritising evidence-based practice and innovation.

After a joint effort by the cooperative to scrutinise and compare the available literature, a mutual agreement was reached to summarise the contents of the Global strategic directions for strengthening nursing and midwifery 2016-2020 by the WHO, (2016). The choice was made due to the general feeling that it provided a strong foundation for the development of the intended strategies.

7.4 AN OVERVIEW OF THE GLOBAL STRATEGIC DIRECTIONS FOR STRENGTHENING NURSING AND MIDWIFERY 2016-2020

The WHO's (2016-2020) Global strategy was found to be a reliable source for application in the development of the strategies.

Finally, the cooperative, after scrutinising the Global strategic directions for strengthening nursing and midwifery 2016-2020 (WHO, 2016) took a decision to utilise it to guide the development the strategies to empower midwives to uplift the level of quality care in midwifery.

7.4.1 A brief description of the global strategic directions for strengthening nursing and midwifery 2016-2020

The WHO's Global strategic directions for strengthening nursing and midwifery 2016-2020 represent the World Health Organisation's framework which was developed to implement and evaluate midwifery accomplishments globally. The strategic directions further required midwives to portray commitment, accountability and report progress on essential elements of care. The vision of the framework entailed the provision of accessible, available, acceptable quality cost-effective nursing and midwifery care for all, based on population needs, be it at national, regional and international levels.

7.5 GUIDING PRINCIPLES THAT REINFORCE THE DEVELOPMENT OF STRATEGIES IN THIS STUDY

WHO's (2016) Global strategic directions served as an essential guide for the nursing and midwifery fraternity. The strategic directions were recommended for use by individuals and groups in different healthcare contexts for a five-year period. These strategic directions added to the "Every new-born action plan to end preventable deaths". The strategies stressed that

the survival of newborn babies serves as a yardstick to measure the efforts of health systems that actually care for their womenfolk.

On the date of the meeting the cooperative read and shared contents of the global strategic directions by WHO (2016). The cooperative's realisation of the aim of the global strategic directions to strengthen, transform and address matters of education and training with regard to necessary and preventable deaths in midwifery sparked enthusiasm in them. The cooperative discussed the global strategic directions and deemed them relevant to address the challenges they experience with. Finally, they agreed to apply the strategic directions during the development of the strategies of this study, which intended to capacitate midwives in order to contribute to the scaling-up of their knowledge and skills. The principles that guided the formulation of the strategies of this study were derived from WHO (2016:14) and are quality, partnership, relevance, ethical action and ownership.

7.6 THE ALIGNMENT OF THE PRINCIPLES OF WHO (2016) TO THE DEVELOPMENT OF THE STRATEGIES

The five principles of the WHO (2016:14) were aligned with the five major findings of the study.

7.6.1 Principle of quality and the findings of the study

Quality care according to WHO (2017) refers to the extend to which health care services rendered to individuals and population improve the health outcome desired. According to WHO (2016:14), quality care denotes adopting mechanisms and standards based on evidence for best practice, promote relevant education and research as well as best practices.

In this study, quality care emerged from a concern about unsafe, ineffective and inappropriate, risks and harm which may pose challenges that may place women's lives in danger during childbirth. The major finding is related to providing quality midwifery care to women during childbirth emerged. The finding was supported by sub-findings of understanding the concept of quality and creating a risk and harm-free midwifery environment. These findings were reflected in chapter 5, table 5.1 as a summary of findings, major themes and subthemes. The discussion of the findings was supported with relevant literature to render them as evidence

of best practice in order to address the aspect of professional value-driven midwifery care. As a result, the suggested care correlated with the contents of the principle of quality as reflected in WHO (2016:14). See table 7.1 for details. The cooperative maintained that the global strategic directions for nursing and midwifery were relevant. Therefore, the belief rendered the strategic directions suitable for the development of strategies suggested by the Cooperative. For the actual strategies developed, see chapter 7, figure 7.1.

7.6.2 Principle of partnership and the findings of the study

Larkan, Uduma, Lawal and van Bavel (2016:1) refer to the term partnership as a form of peer collaboration with increased sharing of knowledge and development of an attitude to share information within a specific environment. WHO (2016:14) indicates that partnership is a principle that allows working respectively together on common objectives, acting collaboratively with relevant stakeholders and supporting each other's efforts which was the case in this study. The major finding of this study that supported the principle of partnership was about preserving the holistic well-being of the women during childbirth. The findings included addressing the women's physically safe midwifery care, addressing the women's psychological aspect of care during midwifery care and treating every woman as social being in need of support. The composition of the partnership comprised of women who are admitted for childbirth, their families and the society around the hospital. As such, the CIG' realisation of the importance of a close partnership with the aforementioned stakeholders was important in order to change the perception of midwives who worked in the maternity ward. See figure 7.1 in which strategies were developed from the linkage of the WHO's (2016) principle of partnership and the study's finding of the study of preserving holistic well-being substituted the second goal of the strategy development.

7.6.3 Principle of relevance and the findings of the study

The term relevance according to Pehcevski and Larsen (2007:2) refer to pertinent information connected to or applicable to the matter at hand. WHO's (2016:14) principle of relevance means developing nursing and midwifery education programs, research, services and systems guided by health needs and strategic priorities. The relatedness of the principle of relevance by WHO (2016) and the findings of the study was reflected in the study finding of upholding the professional practice to improve midwifery care. The finding further revealed that in order to improve the professional value-driven midwifery care there was a need to

recruit skilled and knowledgeable midwives, conducting in-service training, applying compassionate and committed care and portraying acts worthy of a professional image while caring during childbirth. The relevance of the findings of upholding the professional practice to improve midwifery care requires the development of nursing and midwifery education programmes and research. As a result, the strategies were developed with an intention to develop the midwives to improve the quality of care required during childbirth. Refer to figure 7.1 for the strategy developed and it's relationship to WHO's principle of relevance and the finding of the study.

7.6.4 Principle of ethical action and the findings of the study

Ethics is a division of science and art that allow health care professionals to determine acceptable health care practices leading to rational decision making to resolve ethical dilemmas that may affect the society's welfare (Martin, 2015:324). According to WHO (2016:14), ethical action refers to planning, providing and advocating for safe, accountable high-quality healthcare services based on equity, integrity, fairness and respectful practices, in the context of gender and human rights. In this study, the aspect of ethical action was applied as an approach to care that intended to understand, analyse and distinguish between issues of right or wrong. The principle of ethical action by the WHO (2016) was regarded as a good choice since it covered the finding of maintaining ethical midwifery care throughout childbirth. The finding revealed challenges of lack of beneficence, disrespectful and unjust acts, human rights violation and perceived lack of commitment. The finding of maintaining ethical midwifery care and its sub findings intended to provide safe, fairness, respect, human rights, individual commitment and more which eventually resulted in midwifery strategies intended to improve childbirth. Refer to strategies developed under the fourth finding of the study as reflected in chapter 7, figure 7.1.

7.6.5 Principle of ownership and the findings of the study

Ownership is the right of one to own or possess something (Conti, 2015:1). The WHO (2016:14) refers to the principle of ownership as the ability to adopt a flexible approach that ensures effective leadership, management and capacity-building with active ownership, accountability mechanisms, engagement and involvement of all beneficiaries in all the aspects of the collaboration. The principle of ownership applied to the fifth finding of barriers towards professional value-driven midwifery care. The finding revealed obvious hindrances towards

the attainment of professional value-driven midwifery care during childbirth like lack of resources and cultural practices. See chapter 5, table 5.1 on a summary of the findings as major themes and subthemes. The CIG's exact words pointed a blaming finger at the failure of the broad system. It became clear that no accountability mechanisms were instituted on the side of the CIG as an expectation by the applicable principle of ownership. Conversely, the sub findings as reflected in chapter 5, table 5.1 reflected the Cooperative's intentions to address the identified problem. Usually, when applied correctly, the outcomes of the principle of ownership as displayed in this phase should result in increased care benefits for women and midwives who work in close collaboration during childbirth. The principle and the related findings became a good source for the development of strategies, which intended to promote professional value-driven midwifery care during childbirth.

7.7 PHASE 3: STRATEGIES TO EMPOWER THE MIDWIVES IN A MATERNITY WARD

The process followed in the development of the strategies was according to WHO (2014) and followed the pattern of the name, aim, scope, the structure, the description, rigour, review and updating, the implementation and sharing of the strategies. For details on the aforementioned subtopics refer to the discussions hereunder:

7.7.1 The name of the strategies

The strategies were named: *"Strategies to facilitate professional value-driven midwifery care in a maternity ward in the Mpumalanga province of South Africa".* These strategies came into being due to a need for midwives to practice professional value-driven midwifery care in order to uplift quality care in a maternity ward in one district of Mpumalanga province.

7.7.2 The aim of the strategies

The aim of the strategy was to engage, equip and enhance the midwives' necessary skills to implement the professional value-driven midwifery. The knowledge gained from the strategies should promote the midwives' understanding of the ways through which professional value-driven midwifery care should be applied in order to satisfy the needs of every woman who is admitted for childbirth.

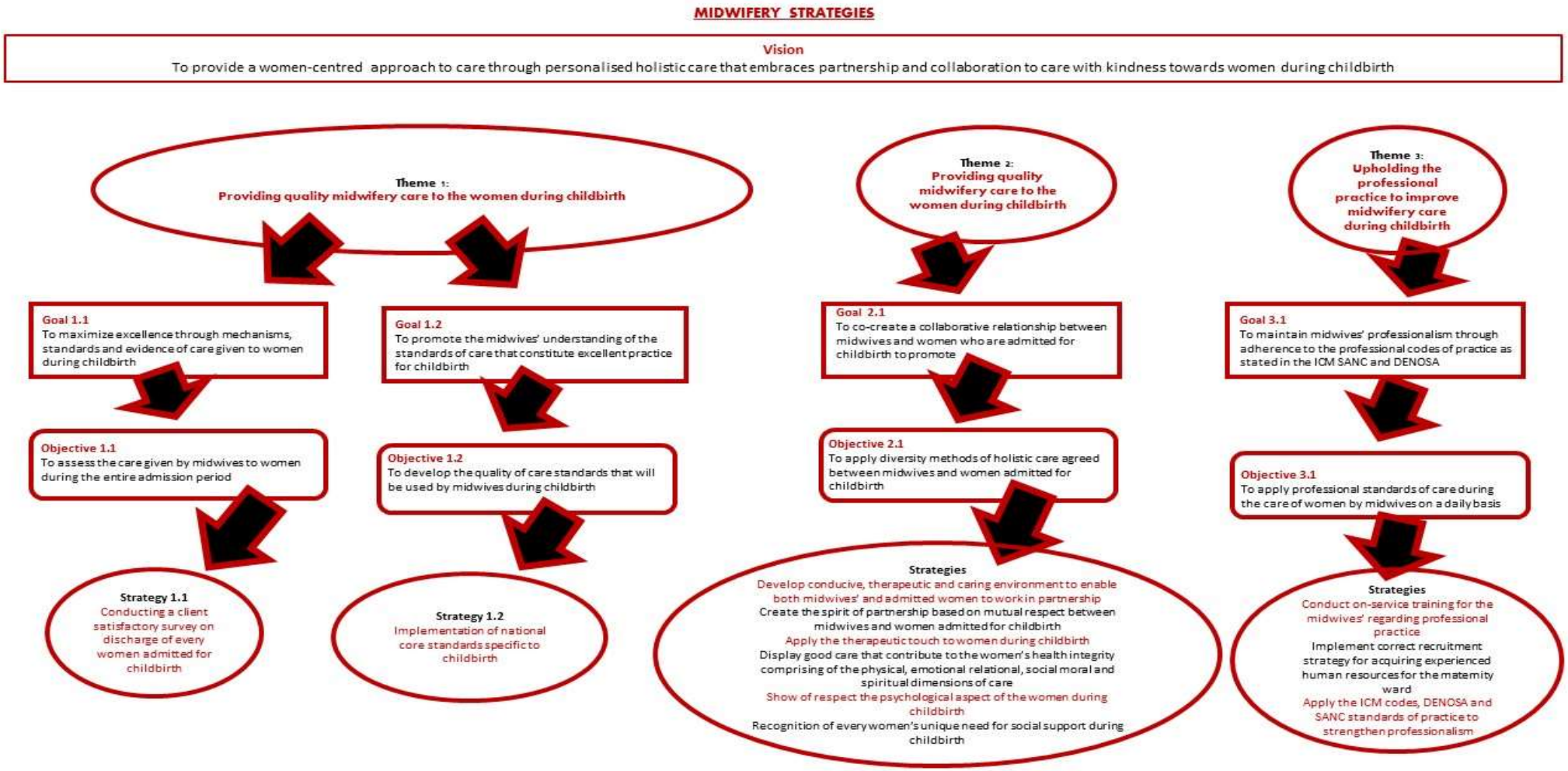
7.7.3 The scope of the strategies

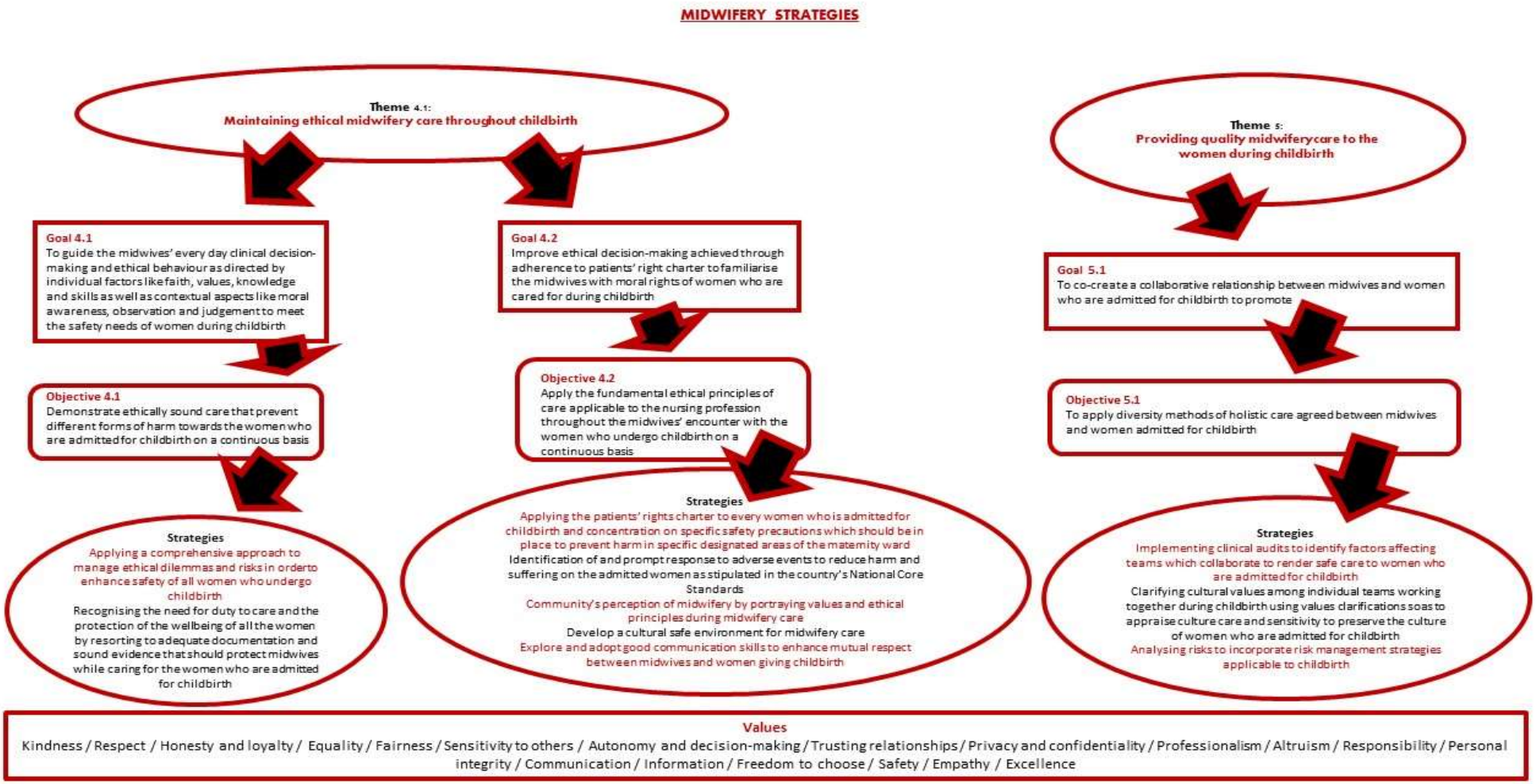
According to WHO (2012:10) any developmental material should cover the related practice area, policy and the people who will be affected by the recommendations of the study. The scope of the strategies covers the aspect of who should use the developed strategies. The aim of the study was to develop strategies to empower midwives regarding professional value-driven midwifery care to improve childbirth using a cooperative inquiry research approach. The study also aims to engage, enhance and equip midwives with necessary skills to implement the value-driven care. The scope of the strategies will cover the midwives from the Maternity ward. Due to the development intentions of these strategies, the scope may be extended to 24 hours service rendering health care centres and 8 hour clinics which transfer women to the chosen Maternity ward for management of complicated cases.

7.7.4 Description and the structure of the strategies

The strategies were guided by the five broad themes and a broad goal. Specific objectives were developed for each theme and goal. The amount of strategies for each theme differed based on the scope of each theme. For details of the developed strategies see figure 7.1 on strategies to empower midwives regarding professional value-driven midwifery care in a maternity ward.

FIGURE 7.1: STRATEGIES TO EMPOWER MIDWIVES REGARDING PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE




MIDWIFERY STRATEGIES
Theme 4.1:
Maintaining ethical midwifery care throughout childbirth
Goal 4.1
To guide the midwives' every day clinical decision-making and ethical behaviour as directed by individual factors like faith, values, knowledge and skills as well as contextual aspects like moral awareness, observation and judgement to meet the safety needs of women during childbirth
Objective 4.1
Demonstrate ethically sound care that prevent different forms of harm towards the women who are admitted for childbirth on a continuous basis
Strategies
Applying a comprehensive approach to manage ethical dilemmas and risks in order to enhance safety of all women who undergo childbirth
Recognising the need for duty to care and the protection of the wellbeing of all the women by resorting to adequate documentation and sound evidence that should protect midwives while caring for the women who are admitted for childbirth
Goal 4.2
Improve ethical decision-making achieved through adherence to patients' right charter to familiarise the midwives with moral rights of women who are cared for during childbirth
Objective 4.2
Apply the fundamental ethical principles of care applicable to the nursing profession throughout the midwives' encounter with the women who undergo childbirth on a continuous basis
Strategies
Applying the patients' rights charter to every women who is admitted for childbirth and concentration on specific safety precautions which should be in place to prevent harm in specific designated areas of the maternity ward
Identification of and prompt response to adverse events to reduce harm and suffering on the admitted women as stipulated in the country's National Core Standards
Community's perception of midwifery by portraying values and ethical principles during midwifery care
Develop a cultural safe environment for midwifery care
Explore and adopt good communication skills to enhance mutual respect between midwives and women giving childbirth
Theme 5:
Providing quality midwiferycare to the women during childbirth
Goal 5.1
To co-create a collaborative relationship between midwives and women who are admitted for childbirth to promote
Objective 5.1
To apply diversity methods of holistic care agreed between midwives and women admitted for childbirth
Strategies
Implementing clinical audits to identify factors affecting teams which collaborate to render safe care to women who are admitted for childbirth
Clarifying cultural values among individual teams working together during childbirth using values clarifications soas to appraise culture care and sensitivity to preserve the culture of women who are admitted for childbirth
Analysing risks to incorporate risk management strategies applicable to childbirth
Values
Kindness / Respect / Honesty and loyalty / Equality / Fairness / Sensitivity to others / Autonomy and decision-making / Trusting relationships / Privacy and confidentiality / Professionalism / Altruism / Responsibility / Personal integrity / Communication / Information / Freedom to choose / Safety / Empathy / Excellence

7.8 MAINTAINING RIGOUR DURING THE DEVELOPMENT OF STRATEGIES

Rigour during the developed strategies was maintained through the strategy of appropriateness. Regular interaction with the CIG and regular interactive processes were briefly described hereunder.

7.8.1 Appropriateness of the strategies

Validation of the developed strategies occurred as highlighted by Waterman, Tillen, Dickson and de Koning (2001:10). The strategies were developed by a Cooperative who comprised of midwives who realised the need to be involved, to sustain their participation throughout and openly declared their readiness to resolve the challenges that they faced during service delivery. In addition, the strategies were discussed with all staff members of the Maternity ward who could not participate in the study to gain their buy-in and ownership of the product.

7.8.2 Regular interaction of the CIG

The research organiser who had the status of an insider-outsider and an experienced nursing manager, lecturer and researcher maintained prolonged engagement by spending time with the CIG through the reflection and plenary meetings, research sessions and mini-workshops. The CIG got used to the research organiser and as a result attended the strategies development meetings at free will. All members of the CIG presented their inputs openly and with confidence.

7.8.3 Regular consultative process

The research organiser frequently consulted for feedback from supervisors, met with the CIG and used the comments to refine the strategies further.

7.9 REVIEW OF AND UPDATING OF THE STRATEGIES

Strategies are not permanent. Therefore, they should be periodically reviewed in order to establish their ability to achieve their intentions. The CIG agreed on a two-year review period. They understood that any time length that goes beyond two years might render the strategies invalid due to the dynamic nature of midwifery and constant improvement of midwifery care.

7.10 IMPLEMENTING AND SHARING OF THE STRATEGIES

The Operational Manager of the Maternity ward revealed interest to utilise the strategies internally and externally in local Community Health Centres and the 8-hour clinics. The sharing will be limited to those facilities which use the Maternity ward as a referral centre for complicated cases to empower the midwives with an intention to improve the quality of care rendered during childbirth. An official implementation of the study will take place during the researcher's post-doctoral studies where she and the co-researchers will develop strategic objectives and tactics to implement the strategies. In that way, the cooperatives will be equipped with the implementation skills as reflected in the second aim of the study.

7.11 CONCLUSION

This chapter presented the formulation and development of strategies to empower midwives regarding professional value-driven midwifery care in a maternity ward in a hospital in Mpumalanga province of South Africa. In this chapter, the CIG managed to develop strategies based on the themes and subthemes of the study. Notably, the CIG believed that the strategies should assist them to provide professional value-driven midwifery care. The next chapter addressed the summary of the study findings, recommendations, implications, limitations and conclusions.

CHAPTER 8
SUMMARY OF THE STUDY FINDINGS, RECOMMENDATIONS, IMPLICATIONS, LIMITATIONS AND CONCLUSIONS

8.1 INTRODUCTION

The last chapter addressed the formulation and development of strategies through the actual engagement, to equip and enhance the midwives' necessary skills to implement the professional value-driven midwifery care. This chapter addressed the summary of the study findings, the recommendations, implications, limitations and the final conclusion of the study.

8.2 AN OVERVIEW OF THE STUDY AND SUMMARY OF THE FINDINGS

The study comprised of four phases. A brief discussion of the findings was given according to different stages as follows:

8.2.1 The Findings of Phase 1: The Introductory Phase

The findings of phase 1 are briefly discussed in three separate stages that were consolidated to form a single whole:

8.2.1.1 Phase 1, Stage 1: The Preparatory phase

The objective of phase 1 stage 1, the Preparatory phase was:

"T*o establish a supportive and trusting relationship with the leadership of the chosen setting"*.

During this stage, the leaders acknowledged the challenges related to the decline in nursing values, ethics and norms in the maternity ward. A report was given about attitude of the nurses, which affected the care that is rendered. In addition, the CIG expressed their wish for positive value-driven midwifery care and a changed maternity ward where workers will perform their duties despite the material and human resource challenges.

8.2.1.2 Phase 1, Stage 2: the 1st Reflection phase of the Values clarification exercise no.1

The objective of phase 1, stage 2, the 1st Reflection phase was:

"To identify the CIG' values that contribute to teamwork".

The CIG in this phase comprised of Midwives who reported for duty on that particular day. The CIG acknowledged the challenges that disturb the smooth rendering of care in the maternity ward and they felt that it was important to address the problems they were faced with in order to return to the normal and trusted midwifery environment. The Hand Diagram figure exercise was carried out by interested midwives as a team-building exercise. See chapter 4, figure 4.1 on the data collected through the Hand Diagram exercise.

The findings of the Hand Diagram figure exercise revealed three categories after the CIG consolidated the findings according to their likeliness. The categories were classified into clusters, which indicated varying values, by members. The classifications were meant to demonstrate awareness with regards to individuals and teamwork. See table 4. 4, which is about the findings of the Hand Diagram image exercise, values clarification exercise 1.

8.2.1.3 Phase 1, Stage 3: The 2nd Reflection phase: Values clarification Exercise no. 2

The objective of phase 1, stage 2, the Reflection phase of Values Clarifications was:

"To prioritise specific values that contribute to midwives' professional values applicable to child birth".

The CIG at this stage comprised of only midwives. The midwives engaged in a Cooperative, collaborative and collegial manner during NGT. For more details see figure 4.1. The findings of the NGT are presented using a Likert scale/value continuum sheet. The findings were divided into two broad categories namely; the individual values which are inherent to midwives and values which can instil a sense of caring and respect towards the admitted woman. Refer to chapter 4, table 4.6 on the rankings of the findings of the NGT, values clarification exercise 2. The findings of the two values clarification exercises were intended to introduce the values clarification to the CIG.

8.2.2 Phase 2: The Planning phase

The objective of the planning phase was:

"*To explore and describe the midwives' views regarding professional value-driven midwifery care".*

The population in this phase was the midwives. Three focus group discussions (FGDs) were used to collect data in this phase and gave rise to five themes.

8.2.2.1 Theme 1: Providing quality midwifery care to women during childbirth

The CIG strongly felt a need for providing professional value-driven midwifery care with resultant quality care during childbirth. The themes gave rise to three subthemes, which supported the identified need. The emerged subthemes increased the understanding of the concept of 'quality midwifery care'. As a result, the findings revealed the importance of creating a risk and harm-free midwifery environment as well as the enhancement of safer childbirth initiatives. Notably, the findings revealed the CIG' belief that adherence to the findings may promote professional value-driven midwifery care. See chapter 5, table 5.1 on the details of the emerged subthemes.

8.2.2.2 Theme 2: Preserving the holistic well-being of women who undergo childbirth

According to the CIG, professional value-driven midwifery care would be realised if midwives view individual women as a unified whole with needs. The participation revealed the necessity of holistic care, which may be realised when midwives observe the physically safe midwifery care for every woman admitted for childbirth. In addition, a need for addressing the women's psychological care needs and treating every woman as a social being who need support during childbirth. Refer to chapter 5, table 5.1 on the summary of findings, major themes and subthemes for more information.

8.2.2.3 Theme 3: Upholding the professional practice to improve patient care

The CIG showed increased understanding of the importance of upholding the professional practice throughout the care given to the women who are admitted for childbirth. They reinforced this theme by highlighting the need for recruitment of skilled and knowledgeable midwives and continuous in-service training for midwives. For details about the afore-reflected finding refer to chapter 5 table 5.1 and the discussion thereof in chapter 6, subsection 6.3.3 on upholding professional practice to improve midwifery care.

8.2.2.4 Theme 4: Maintaining ethical midwifery care throughout childbirth

The CIG demonstrated their awareness of the need for ethical midwifery care as a contribution to professional value-driven midwifery care. The findings revealed that the CIG were totally against acts of harm and abusive midwifery care, which reflects disrespect, unacceptable and undignified acts of humiliation. The findings referred to these humiliating acts as elements of poor quality care and suggested that they should be discontinued. Examples of the unwarranted, undignified acts such as neglect of those who are in need of care, actual intentional and vengeful ways are reflected in Chapter 5, table 5.1.

8.2.2.5 Theme 5: Outlining barriers towards professional value-driven midwifery care

The CIG mentioned hindrances that prevented them from rendering adequate midwifery care. The findings further revealed that these deterrents contribute to compromised safety for women and violation of the women's right to dignified care. The deterrents are mostly systems related and usually result in challenges towards offering quality midwifery care. An example of these challenges was inadequate human and medical resources, which eventually render midwives incompetent and uncaring while also putting them and patients at risk. Details of the discussions are in chapter 6, subsection 6.3.5 which reflected kinds of barriers that prevent the rendering of professional value-driven midwifery care.

8.2.3 Phase 3: The Action phase

The objective of the Action phase was:

"*To develop strategies to empower midwives to promote professional value-driven midwifery care to improve childbirth".*

In this phase strategies to promote professional value-driven midwifery care were formulated by the Cooperative. The CIG comprised of only midwives. Five themes of providing quality midwifery care namely: preserving the holistic well-being of the women who undergo childbirth, upholding professional midwifery care, maintaining ethical midwifery care and outlining barriers towards professional value-driven midwifery care were used as a departure point for the development of strategies.

For the sake of logic of this Chapter, the observation phase could not be addressed after the planning phase. The item was highlighted since it is addressed in detail under the contribution to midwifery body of knowledge in 8.7.2 as the development of an assessment tool. More details on the item are reflected in Chapter 3, as 3.6.4, the observation phase. In addition, 3.6.4.3.1 as the audit tool development and table 4.7, which is on the actual developed tool.

8.3 DEVELOPMENT OF STRATEGIES TO EMPOWER THE MIDWIVES REGARDING THE PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE IN A MATERNITY WARD

The development of the strategies for empowering midwives with regards to professional value-driven midwifery care followed an emerging process that started in chapter three when the CIG collaborated and co-operated through the reflection phases of the 'Hand Diagram figure exercise and the Nominal Group Technique. Ultimately, the process unfolded into the planning phase, which was achieved by conducting focus group discussions. Finally, the Action phase led to the development of the strategies to empower midwives regarding professional value-driven midwifery care.

8.3.1 Methodology for developing the strategies

The Introductory phase was not included in the formulation of strategies since the phase was done only to introduce the study to stakeholders. The development of strategies was determined by the Planning phase of the study.

8.3.1.1 Population of phase 3: The Action phase

The population of the Action phase was midwives only. The number of the CIG who represented the CIG were seven. They comprised of an Operational manager, two shift leaders, two midwives and one community service registered nurses and the researcher.

8.3.1.2 Data collection and analysis

A Cooperative Inquiry approach continued. The CIG felt the 'Circle of speakers' (Jacobs 2004:4) was suitable for a sitting arrangement of choice due to its ability to bring members closer to each other to work in close proximity to each other. The method channelled the CIG to divide into two equal parts. FGDs were used for collecting data and Cooperative Inquiry data analysis was used to analyse

the data in this phase. For more details on methods followed for strategy development, see table 7.1, under 7.7.4 on the description and the structure of the strategies.

8.3.2 The development of strategies in midwifery

The development of strategies was based on the findings of phase 2, the planning phase. These findings were first aligned with the principles of the global strategic directions by WHO (2016) as discussed in chapter 7, subsection 7.6.1–7.6.5. In addition, the Cooperative came up with five categories of strategies derived from the themes of the study see chapter 7, figure 7.1.

8.3.2.1 The aim of the strategies

The aim of the strategies strategy was to engage, equip and enhance the midwives' necessary skills to implement the professional value-driven midwifery care.

8.3.2.2 The name and the scope of the strategies

The developed strategies were named "*Strategies to empower midwives regarding professional value-driven midwifery care in order to promote quality care in a maternity ward in Mpumalanga province*".

The topic falls under the Maternal and Child Health program, which cover the three tier aspects of pregnancy, labour and postnatal. Therefore, the scope of the strategies will cover midwives who function under the aforementioned levels of childbirth.

8.3.2.3 The structure of the strategies

The strategies were developed in a sequential manner according to theme, goal, objective and strategy. For details of the strategies refer to table 8.1 as follows:

TABLE 8.1: A SUMMARY OF THE DEVELOPED STRATEGIES

GOAL	STRATEGIES
Theme 1: Providing quality midwifery care to women during childbirth.	**Strategy 1**: Conducting **a** client satisfactory survey on discharge of every woman admitted for childbirth **Strategy 2**: Implementation of National Core Standards specific to childbirth
Theme 2: Preserving the holistic well-being of women who undergo childbirth.	**Strategy 3:** Develop a conducive, therapeutic and caring environment to enable both midwives and the admitted women to work in partnership **Strategy 4**: Create the spirit of partnership based on mutual respect between midwives and the women who are admitted for childbirth **Strategy 5**: Apply the therapeutic touch to women during childbirth **Strategy 6:** Display good care that contributes to the women's integrity comprising of the physical, emotional, relational, social, moral and spiritual dimensions of care **Strategy 7**: Show respect to the of the women's psychological aspect of the women during childbirth **Strategy 8**: Recognition of every woman's unique need for social support during childbirth
Theme 3: Upholding professional practice to improve midwifery care.	**Strategy 9**: Conducting in-service training for the midwives regarding professional practice

	Strategy 10: Implement correct recruitment strategy for acquiring correct human resources for the maternity ward **Strategy 11:** Apply the ICM codes, DENOSA and SANC standards of practice to strengthen professionalism
Theme 4: Maintaining ethical midwifery care throughout childbirth.	**Strategy 12**: Applying a comprehensive approach to manage ethical dilemmas and risk in order to enhance safety of all the women who undergo childbirth **Strategy *13*:** Recognising a need for duty to care and the protection of the wellbeing of all the women by resorting to adequate documentation and sound evidence that should protect the midwives while caring for the women who are admitted for childbirth **Strategy *14*:** Applying the patients' right charter to every woman who is admitted for childbirth and concentration on specific safety precautions which should be in place to prevent harm in specific designated areas of the maternity ward **Strategy 15**: Identification of and prompt response to adverse events to reduce harm and suffering on the admitted women as stipulated in the county's National Core Standards **Strategy 16:** Improve the community perception of midwifery by portraying values and ethical principles during midwifery care **Strategy 17:** Develop a culturally safe environment for midwifery care **Strategy 18:** Explore and adopt a good communication skills to enhance mutual respect between midwives and women giving childbirth

Theme 5: Outlining barriers towards professional value-driven midwifery	**Strategy 19:** Implementing clinical audits to identify factors affecting teams which collaborate to render safe care to the women who are admitted for childbirth **Strategy 20**: Clarifying clinical values among individual teams working together during childbirth using values clarifications so as to appraise culture care and sensitivity to preserve the culture of women who are admitted for childbirth **Strategy 21**: Appraising risks to incorporate risk management strategies to applicable to childbirth

Table 8.1 shows the summary of the developed strategies. Each strategy was divided into theme, goal, objective and strategy.

8.4 RECOMMENDATIONS OF THE STUDY

The CIG made relevant recommendations regarding the study so as to improve the quality of midwifery care rendered in the maternity ward. The recommendations in this study were directed toward future research and service delivery improvement and are as follows:

8.4.1 Recommendations for future research

The study gave the CIG a chance to make several suggestions to conduct more research specific to problem areas in the maternity ward. Based on the developed strategies the following recommendations for further research were made:

- Explore and describe the outcomes of a shortage of midwives and forced a choice in prioritising activities during midwifery care.
- The exploration and description of the midwives' attitudes towards prolonged allocation to the maternity ward.
- The perceptions of midwives regarding voluntary prolonged post-graduate study leave by non-recommended midwives who do not meet the requirements.
- The influence of cultural practices on women who are admitted to the maternity ward.

The CIG again raised a recommendation, which was not derived from the gaps of the study as follows:

- Conducting similar studies in other hospitals which experience increased complaints with regards to dissatisfaction about the rendered midwifery care.
- Conduct midwifery care problem-based research to solve problems experienced during the provision of professional value-driven midwifery care.
- Conduct more research on the factors that may enhance the positive environment that may improve the satisfaction of midwives in order to promote job satisfaction with resultant quality midwifery care in the maternity ward.
- Conduct similar studies in other hospitals in the province so as to share experience and realise similar problems like dissatisfaction, unsafe practices, disrespectful treatment received by women and come up with better initiatives and policies to enhance professional value-driven midwifery care in maternity wards.

8.4.2 Recommendations for service delivery improvement

Based on the findings of this study the following recommendations were made:

- To device a specific plan of action to apply the developed strategies so as to meet the needs and improve the satisfaction of women admitted for childbirth.
- Promote continuous monitoring and evaluation of the activities, which are aimed at promoting professional value-driven care in order to sustain good practices.
- Conduct in-service training to assist midwives to share experiences with peers and professional groups as that may improve their sense of duty.
- Provide adequate staffing in order to promote a supportive environment that motivates the retention of midwives.
- Revise staff allocation policy in order to promote fair placement of midwives with increased employee satisfaction in the maternity ward.
- Provide a dedicated area for the doula/companionship better birth initiative so as ensure better support for admitted women.
- Conduct awareness campaigns to educate communities about the dangers of oral ingestion of mixtures that are not scientifically tested so as to prevent risks to women and their unborn babies.

8.5 IMPLICATIONS OF THE STUDY

The findings of this study have three-fold implications for Midwifery practice, the Department of Health and Nursing Education.

8.5.1 For midwifery practice

- The consistent application of the strategies should assist midwives to improve midwifery care with resultant satisfaction for admitted women.
- The developed strategies should direct other maternity wards, which are in the same situation to develop their own strategies.
- The strategies could be used to uplift the professionalism in midwifery.
- The strategies should assist midwives to realise the need to treat the admitted women as holistic-beings.
- The strategies should help midwives to improve the quality of care given to women during childbirth.
- The strategies should assist midwives to provide ethically sound midwifery care that protects women from risky childbirth care.

8.5.2 For the Department of Health

The National Core Standards goes all out to ensure that quality care is rendered in all healthcare facilities in the country. Despite the effort, challenges are still experienced when rendering care, especially in midwifery.

As a result, the following recommendation was made:

- Prioritise the recruitment of midwives in order to improve the staffing needs to promote staff adequacy and uplift the standard of care in maternity wards.

8.5.3 For nursing education

- The Nursing Education and Training policy should consider the inclusion of Transcultural Nursing care in the Midwifery curriculum. As a new field of study, Transcultural nursing should uplift cultural sensitivity care as an important determinant of professional value-driven care.
- The Midwifery curriculum should prioritise and allocate a certain number of credits to values clarification necessary in nursing and in particular midwifery.

- The new Midwifery training should increase the number of Midwifery students undergoing training so as to cover-up for the increased demands that outweighs the availability of midwives.
- Nursing Education policy should expand its scope by adding a module on value-driven midwifery for the maternity wards. Even though prescripts are available for example, the National Core Standards, the actual value-driven Midwifery care principles are not adhered to.

8.6 LIMITATIONS

The limitations of this study are as follows:

- The study was contextualised to a specific setting, which is a community hospital in one district in the Mpumalanga province.
- The staffing in the maternity ward was not adequate. Therefore, the agreed upon study time-schedules could not be adhered to. At times, the CIG were delayed to attend the study sessions due to the extremely busy schedules in the maternity ward.
- The study was conducted in the maternity ward. The issue of space was also a challenge in the maternity ward. The identified room was not spacious enough. The CIG used the Nurses' bay in most occasions since it was the only available spacious area were most activities could be performed.
- The implementation phase of this study may be delayed due to a severe shortage of midwives. In most instances, Operational Managers usually divert roles to cover-up for the shortages, and that may disturb the concentration to implement the strategies developed.
- An observation of midwives would have been conducted through a checklist to evaluate their actions but the CIG failed to do so and that was a limitation to the study.
- The CIG's failure to conduct an interview of the midwifery clients in the research that involved them led to a limitation since their voices were important for diverse perspectives on the matter under discussion.

8.7 CONTRIBUTION TO THE EXISTING BODY OF MIDWIFERY KNOWLEDGE

The study evolved into a dual contribution to the body of knowledge as reflected in the brief discussions, which are divided into the development of strategies to empower midwives to render professional value-driven midwifery care so as to improve the quality of care. In addition, the study contributed to the development of an assessment tool to assist midwives in improving care rendered.

A brief description of the developed strategies and the assessment tool is provided below on 8.7.1 and 8.7.2.

8.7.1 The development of strategies to empower midwives to render professional value-driven midwifery care so as to improve quality care during childbirth

Phase 3 resulted in strategies to empower the midwives to promote professional value-driven midwifery care in the maternity ward. The findings of phase two were linked to the strategic directions of the WHO (2016), and thereafter specific strategies were developed in table 7.1 as **"**Strategies to empower midwives regarding professional value-driven midwifery care". As result, the CIG believed that the strategies will assist them to transform the care they render into quality care. Refer to chapter 7, subsection 7.1 for the details of the developed strategies.

8.7.2 The development of an Assessment Tool

The cooperative developed a tool to assist them in improving care which may improve the National Core Standards' QIP scores during the next national accreditations. See chapter 4, table 4.2 for aspects of the QIP with low scores, which led to the development of the tool. The actual tool can be found in chapter 4, table 4.7. The cooperative felt it did justice by developing the assessment tool since it should assist them to attain professional value-driven midwifery care. The tool is contextualised to the specified maternity ward in a district in one province. However, it can be replicated to improve the caring and respectful midwifery care in other maternity wards in Mpumalanga and elsewhere. The implementation and evaluation stage of the tool will be addressed during the post-doctoral stage of this study.

8.8 FINAL CONCLUSION

The study followed a PAR design, and the approach followed was CI. The nature of the CI allowed the CIG to openly co-operate and collaborate with the researcher during all the stages from the beginning to end**.** Notably, midwives' active participation in the entire processes, the mutual decision-making, the collaborative activities for developing the strategies and the assessment tool became a learning opportunity for all. At the end of the study, the CIG were fully exposed to the proceedings of the research, the application of different methodologies, working together as a cohesive team, acceptance of each other and the development of lasting relationships and partnerships.

The CIG benefited since they became empowered in terms of the research methodology, professional values, the development of an assessment tool and strategies. Strategies were developed in order to improve the knowledge base of midwives since evidence-based professional value-driven care will be rendered. Evidence-based midwifery care should direct the performance of safe midwifery care. Therefore, quality midwifery care will prevail with increased satisfaction by women who are admitted for childbirth.

The participatory nature of the study managed to engage, enhance and equip midwives with the necessary skills to implement the professional value-driven care. The study further empowered midwives to develop an assessment tool to assess professional value-driven midwifery care in the ward.

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ANNEXURE A 1

INFORMATION LEAFLET AND CONSENT TO PARTICIPATE IN A RESEARCH STUDY

INFORMATION LEAFLET AND CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Principal Investigator: PM Jiyane

Institution: University of Pretoria

DAY, TIME AND AFTER HOURS TELEPHONE NUMBER(S):

Daytime numbers: 012 354 2127 or 0834162608

Afterhours: 0834162608

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

Day	**Month**	**Year**	**Time**

TITLE OF STUDY: **TOWARDS PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE: A COOPERATIVE INQUIRY RESEARCH APPROACH**

Dear CIG member

1. INTRODUCTION

You are invited to volunteer for a research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved in this study. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the researcher Jiyane PM, on the following office telephone: 012 354 2127 or cell-phone number 083 416 2608

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 explore the professional values in midwifery practice in the selected hospital. In this study you and the researcher will work as partners who join efforts in order to achieve the goals you set as a group for the study. You will be motivated to participate freely in an environment that maintains equal status and poses no threats to all of you including the researcher.

No members will receive special care than others thus fair treatment will be given to all of you within the group.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

Your agreement to participate in this study will make you part of a group with 8-15 members. The researcher and the midwives who agree to participate in the study will combine to form a Cooperative Inquiry Group (CIG). As a group member you will rotate roles as there will be instances where the group of the CIG will conduct the research together as “co-researchers”. Alternatively, the group members will be the CIG who are referred to as co-the CIG of the study. The purpose of this group is to make a contribution to midwifery care in the chosen hospital.

Members of the group are required to attend meetings. These meetings will be held in a venue of your choice within the chosen facility. The meeting program (dates and time) will be compiled by the group.

During these meetings, the group will engage in formulating the goals and objectives of the research study.

At the end of the research study the researcher will compile a report and the group will evaluate the success of the study. A report of the study will be given to the hospital management, the district office and the Mpumalanga provincial government.

4. RISK AND DISCOMFORT INVOLVED

The only possible risk and discomfort involved is some of the questions asked which may contribute to you feeling uncomfortable but you need not answer them if you don’t want to do so. Each meeting you will attend will take approximately two hours of your time - more or less 24 hours over a period of five months. The total number of meetings will be approximately twelve.

5. POSSIBLE BENEFITS OF THIS STUDY

Although you will not benefit directly from the study, you may develop research skills, improve your informed decision-making skills and personal empowerment. The above mentioned benefits will increase your knowledge and will allow the group to directly deal with the existing problem in your own workplace. The results of the study may contribute to an improvement in-service delivery, specifically an improvement of the quality of services in the maternity ward.

6. WHAT ARE YOUR RIGHTS AS A THE CIG?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the Cooperative Inquiry research without giving any reason. Your withdrawal will not affect you in any way.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study received written approval from the CEO of your hospital, the district office and the Mpumalanga provincial Department of Health. Copies of the approval letters are available if you wish to have one. This Protocol was submitted to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, telephone numbers 012 3541677 / 012 3541330 and written approval has been granted by that committee. The study has been structured in accordance with the Declaration of Helsinki (last update: October 2013), which deals with the recommendations guiding doctors in biomedical research involving human/subjects. A copy of the Declaration may be obtained from the investigator should you wish to review it.

8. INFORMATION AND CONTACT PERSON

The contact person for this study is Mrs Jiyane. If you have any questions about the study please contact her at the following office telephone 012 354 2127 or the following cell-phone: 083 416 2608

Alternatively you may contact the supervisor in this study Dr Peu, at the following telephone 012 354 2133 or her cell-phone 0825344245.

9. COMPENSATION

Your participation is voluntary. No compensation will be given for your participation in this study.

10. CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once we have analysed the information, no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or your hospital.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports.

I am participating willingly. I had time to ask questions and have no objection to participate in the study.

I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.

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

The CIG's Name				**(Please print)**
The COG's Signature		**Date**		
Investigator's Name				**(Please print)**
Investigator's Signature		**Date**		
Witness's Name				**(Please print)**
Witness's Signature		**Date**		

VERBAL INFORMED CONSENT

I, the undersigned, have read and have fully explained to the CIG, named …….. the CIG information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the CIG whom I have asked to participate in the study.

The CIG indicated that she/he understands that the results of the study, including personal details regarding the Cooperative Inquiry will be anonymously processed into a research report.

The CIG indicated that she /he has had time to ask questions and has no objection to participate in the Cooperative Inquiry. She/he understands that there is no penalty should she/he wish to discontinue with the study and his/her withdrawal will not affect him/her in any way.

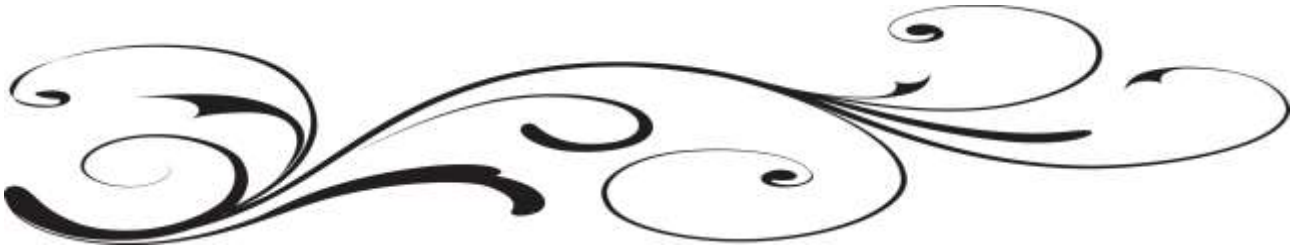
I hereby certify that the client has agreed to participate in this study.

The CIG's Name			**(Please print)**
Person seeking consent			**(Please print)**
Signature		**Date**	
Witness's Name		**Date**	
Signature		**Date**	

ANNEXURE A 2

CIG SPECIFIC INFORMATION DOCUMENT

TITLE: TOWARDS PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE: A COOPERATIVE INQUIRY RESEARCH APPROACH



ANNEXURE: A (2): CIG SPECIFIC INFORMATION DOCUMENT

TITLE: TOWARDS PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE: A COOPERATIVE INQUIRY RESEARCH APPROACH

Dear CIG (s)

1. INTRODUCTION

Cooperative Inquiry requires a special information which differs from that of the general research. It contains specific issues which should be attended to in order to ensure that critical aspects related to the Cooperative Inquiry research approach are handled. The CIG are advised to read and understand the contents of this document well in order to achieve a successful inquiry. Any unclear statements which are not answered by the document should be forwarded to the researcher, Priscilla Mmatholo Jiyane.

2. THE NATURE AND PURPOSE OF THE CIG SPECIFIC INQUIRY

The purpose of the study is to facilitate professional value-driven midwifery care using a Co-operative Inquiry in a district in Mpumalanga. A Cooperative Inquiry is characterised through the CIG who are co-researchers and co-the CIG of the study. The CIG take a collective effort to research on a topic of interest to them all in order to create new knowledge which they utilize to change service delivery.

As a research scholar, I will be will be expected to write an academic thesis since that is a requirement for me as a student at the University of Pretoria. There is a need to use a digital recorder throughout the study and I wish to indicate that I need your permission to allow me to do so. This additional information document is meant to provide you with full understanding of some specific aspects related to Cooperative Inquiry in order to encourage collective and successful inquiry process. The problem that led to the choice of the topic might be classified under sensitive topics also referred to as difficult topics. This is topic might be emotionally–laden which might trigger individual emotions and might result in crisis and stress (Dickson Swift,)

This is topic might be emotionally–laden which might trigger individual emotions and might result in crisis and stress (Dickson Swift,

James & Liumputtong, (n.y):2). Therefore, the researcher felt a need to attend to issues involving emotions of the the CIG which is also referred to as emotion work.

3. IMPACT OF EMOTION WORK ON THE RESEARCHER AND NURSES

Emotion work means an effort, which is conscious or unconscious, which aims at dealing with one's feelings or emotions. This means that the researcher should implement measures which should suppress the triggering of emotions in the CIG. Obviously, the study relates to declined values in midwifery practice which may trigger the emotions of the researcher and the CIG since it bears negative connotation on the image of the nurses as a whole. The researcher is a midwife too who will be researching from internally and not an outside environment.

The management of emotion work and the management thereof will be discussed as indicated below:

3.1 Building of rapport

The involved research is about entering into the lives of individuals. By agreeing to participate, you as the CIG allow the researcher into your personal lives which is a hard step to take.

As the CIG you are advised not feel the researcher has visited to grab the information from you but you should see her as a colleague who has come to "*work with*" you in order to resolve the existing problem. The researcher will stay a little bit longer after in the department in order to understand your socially acceptable ways of living.

The research topic is classified under sensitive topics since it involves entering into human lives in times of stress or crisis, and expecting their full participation in the topic under discussion. This may involve the discovery process involving deep-seated emotions of the CIG.

Eventually, the CIG may end up experiencing the effects of sensitive research for which arrangements are already made with relevant specialists for in case of need.

From the onset of the initial meeting I will ensure that your recruitment to participate in the research occur wilfully.

3.2 Comfort of the CIG

The medium of communication will be English since all of us as nurses know the language well. Your mother-tongue may be used only where you stress a point which is easily definable in English. Equity and power-sharing will be promoted throughout the inquiry.

3.3 Maintaining boundaries:

The researcher will work within boundaries of maintaining researcher role throughout the research.

3.4 Self-disclosure by the CIG

This research requires the CIG disclosure. A relationship which is different from that of traditional researches will be adopted. An equal relationship in which mutual sharing of stories between the CIG and the researcher will be maintained. The researcher will direct discussions in order to elicit focused discussions to ensure that only relevant information is derived from the discussions and to prevent over disclosure by the CIG. The researcher will always acknowledge your contributions to uplift your sense of worth, sense of belonging and feelings of motivation to further stay in the group (Dickson-Swift, James & Liumputtong, 2007: 332).

3.5 Reflexivity

Critical self-evaluation about the my own biases, preferences, and preconceptions will be dealt with and throughout the study for example, not allowing my own interests and position to influence the research in any way.

Conversations will be entirely led by us as a group. No researcher dominance of the discussions will take place throughout the study (Dickson-Swift, James & Liumputtong, 2007: 334).

3.6 Reciprocity

The process involves the reciprocal sharing of the co-researchers which is seen as a fair exchange. It promotes quality of the given data. It reduces the hierarchical nature of this research and therefore, the principle of “Ubuntu” will be enhanced throughout the interviews. This indicates that there will be mutual respect between the researcher and the CIG. The CIG as unique human beings will be shown respect at all times (Dickson-Swift, James & Liumputtong, 2007: 334).

4. Additional ethical aspects specific to consider during a Cooperative Inquiry

The success of this Cooperative Inquiry will depend on the maintenance of ethical considerations specific to CI as highlighted by Mash (2014) which will be discussed below as follows:

- **Choosing the venue for meetings**

The CIG will choose a venue for attending the meetings in order to ensure that it suits all of them and will not inconvenience any of them in any way. Venues will not be imposed by the researcher but should be as joint decision making.

- **Attendance and schedule**

As co-researchers you will decide on the times suitable to you and will draw a schedule which you will agree to as a collective to reinforce commitment of each one of you.

- **Respect for one another**

Any contribution by each and every member of the group is of utmost importance of to the study. Issues of equity and power-sharing will be addressed with no one who should be viewed as more important than others. As individual members, you will be expected to indicate your preferred name and a wish as to how you should be addressed.

Active participation

As co-researchers, you will be expected to participate actively as a collective in a collaborative manner and should show openness towards each other while in the study.

Aspects of importance to a CIG inquiry which lead to the retention of the group which may result in the success of the study which the CIG should fully understand are as listed and discussed.

- **Transparency**

The gate-keepers will be updated on the progress of the research and their suggestions will be appreciated since they are expected to bless the involvement of the staff members in the inquiry. All the staff members in this hospital will be made aware of the existence of the CIG within the premises of the this hospital so that they easily support you as colleagues who will be expected to leave service delivery to attend the Co-operative inquiry meetings.

- **Choosing the venue for meetings**

As the CIG, you are allowed to choose a venue for attending meetings in order to ensure that it suits all of them and will not inconvenience any of you in any way. Aspects of importance to a CIG inquiry which lead to the retention of the group which may result in the success of the study which the CIG should fully understand are as listed and discussed.

Joint Undertaking by the CIG

By signing the UP's consent to participate and information leaflet the following are confirmed:

- Collective agreement to participate as members of a Cooperative Inquiry Group in the research study indicated above.
- Full individually understanding of the contents of the CI specific information document. All my questions have been sufficiently answered. I also understand that should I decide to discontinue with the study no punitive measures will be taken against me.

ANNEXURE B 1 (1)

ETHICS LETTER: UNIVERSITY OF PRETORIA

ETHICS LETTER: UNIVERSITY OF PRETORIA

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 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.: 232/2015

Title: Towards professional value-driven midwifery care: A Cooperative Inquiry research approach.

Dear Ms Priscilla Jiyane

The **New Application** as supported by documents specified in your cover letter dated 22/06/2015 for your research received on the 22/06/2015, 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 4 years
- Please remember to use your protocol number (**232/2015**) 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; MBChB; MMed (Int); MPharMed.
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 🖷 0866516047 deepeka.behari@up.ac.za http://www.healthethics.up.co.za
✉ Private Bag X323, Arcadia, 0007 - 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Gezina, Pretoria

ANNEXURE B 1 (2)

COPY OF REC APPROVAL FOR EXTENSION

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

26/07/2018

Ms Priscilla Jiyane
Department of Nursing Science
University of Pretoria

Dear Ms Priscilla Jiyane

RE.: 232/2015 – Letter dated 12 June 2018

Protocol Number	**232/2015**
Protocol Title	Towards value-driven midwifery care: A Cooperative Inquiry research approach.
Principal Investigator	Ms Priscilla Jiyane **Tel:** 0834162608 **Email:** priscilla.jiyane@up.ac.za **Dept:** Nursing Science

We hereby acknowledge receipt of the following document:

- Extension until end of July 2019.

which has been approved at 25 July 2018 meeting.

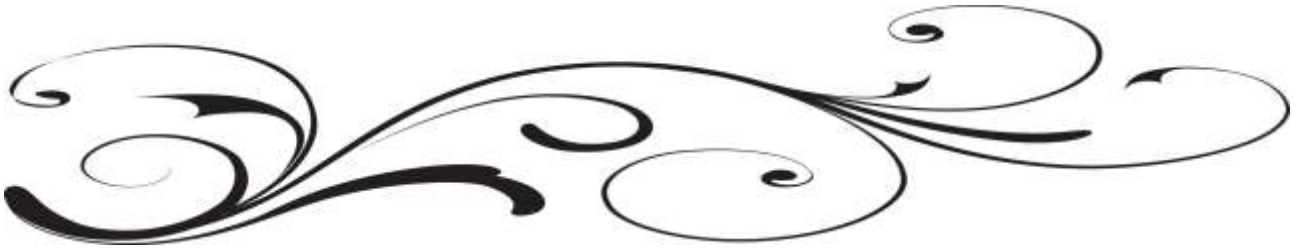
With regards

Dr R Sommers; MBChB; MMed (Int); MPharMed; PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

☎ 012 356 3085 fhsethics.up.ac.za http://www.up.ac.za/healthethics
Private Bag X323, Arcadia, 0007 - Tswelopele Building, Level 4-59, Gezina, Pretoria

ANNEXURE B 2 (1)

COPY OF REC APPROVAL BY MPUMALANGA



Department of Health
Mpumalanga Provincial Government

Building No. 3, No. 7 Government Boulevard, Riverside Park Extension 2, Mbombela, 1200, Mpumalanga
Private Bag X 11285, Mbombela 1200, Tel: 013 766 3429, int: +27 13 766 3429, Fax: 013 766 3459, int: +27 13 766 3459

Litiko Letemphilo | Umnyango WezaMaphilo | Departement van Gesondheid

Enquiries: Themba Mulungo (013) 766 3511

01 September 2015

Ms. Pricilla Mmatholo
25147
Gezina
0031

Dear Ms. Pricilla Mmatholo

APPLICATION FOR RESEARCH & ETHICS APPROVAL: TOWARDS PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE: A COOPERATE INQUIRY RESEARCH APPROACH

The Provincial Health Research and Ethics Committee has approved your research proposal in the latest format that you sent.

PHREC REF: MP_2015RP6_154

Kindly ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

MR. JERRY SIGUDLA
RESEARCH AND EPIDEMIOLOGY

MPUMALANGA PROVINCE
DEPARTMENT OF HEALTH
PLANNING & INFORMATION
2015 -09- 01
DATE
PRIVATE BAG X 11285
NELSPRUIT 1200

MPUMALANGA
THE PLACE OF THE RISING SUN

ANNEXURE B 2 (2)

COPY OF APPROVAL BY MPUMALANGA RESEARCH

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

No.3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel I: +27 (13) 766 3429, Fax: +27 (13) 766 3458

Litiko Letemphilo Departement van Gesondheid UmNyango WezeMaphilo

Enquiries: Themba Mulungo (013) 766 3511

Ms. Priscilla Jiyane
P O Box 25147
Gezina
0031

Dear Ms. Priscilla Jiyane

APPLICATION FOR RESEARCH & ETHICS APPROVAL: TOWARDS PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE: A COOPERATE INQUIRY RESEARCH APPROACH (amended)

The provincial health research committee has approved your research proposal in the latest format you sent.

- Approval Ref Number: MP_2015RP6_154
- ***Period: 06/07/2018 to 09/08/2018***
- Facilities: KwaMhlanga Hospital

Kindly ensure that the study is conducted with minimal disruption and impact on our staff, and also ensure that you provide us with the soft or hard copy of the report once your research project has been completed.

Kind regards

MS. T.Z MADONSELA
MPUMALANGA PHRC

DATE 2018/7/6

MPUMALANGA
THE PLACE OF THE RISING SUN

ANNEXURE B 3

COPY OF REC APPROVAL BY MPUMALANGA

COPY OF REC APPROVAL BY MPUMALANGA

Department of Health
Mpumalanga Provincial Government

Building No. 3, No. 7 Government Boulevard, Riverside Park Extension 2, Mbombela, 1200, Mpumalanga
Private Bag X 11285, Mbombela 1200, Tel: 013 766 3429, int: +27 13 766 3429, Fax: 013 766 3459, int: +27 13 766 3459

Litiko Letemphilo | Umnyango WezaMaphilo | Departement van Gesondheid

Enquiries: Themba Mulungo (013) 766 3511

01 September 2015

Ms. Pricilla Mmatholo
25147
Gezina
0031

Dear Ms. Pricilla Mmatholo

APPLICATION FOR RESEARCH & ETHICS APPROVAL: TOWARDS PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE: A COOPERATE INQUIRY RESEARCH APPROACH

The Provincial Health Research and Ethics Committee has approved your research proposal in the latest format that you sent.

PHREC REF: MP_2015RP6_154

Kindly ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

MR. JERRY SIGUDLA
RESEARCH AND EPIDEMIOLOGY

MPUMALANGA PROVINCE
DEPARTMENT OF HEALTH
PLANNING & INFORMATION
2015 -09- 01
DATE
PRIVATE BAG X 11285
NELSPRUIT 1200

MPUMALANGA
THE PLACE OF THE RISING SUN

ANNEXURE C

COPY OF APPROVAL BY THE HOSPITAL CEO

COPY OF APPROVAL BY THE HOSPITAL CEO

Permission to access Records / Files / Data base at the Kwamhlanga Hospital

To: Chief Executive Officer Kwamhlanga Hospital

From: The Investigator

Jiyane Priscilla Mmatholo

Mr Mangena PM Mrs Jiyane

Re: Permission to do research at Kwamhlanga Hospital

Lecturer Priscilla Mmatholo Jiyane is a researcher working at the Faculty of Health Sciences , Department of Nursing at University of Pretoria. I am requesting permission to conduct a study on the premises of Kwamhlanga Hospital grounds that involves access to patient records.

The request is lodged with you in terms of the requirements of the Promotion of Access to Information Act. No. 2 of 2000.

The title of the study is: Towards professional value-driven midwifery care: A Cooperative Inquiry research approach.

The researcher request access to the following information:

Access to the clinical files, record book and the data base.

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.

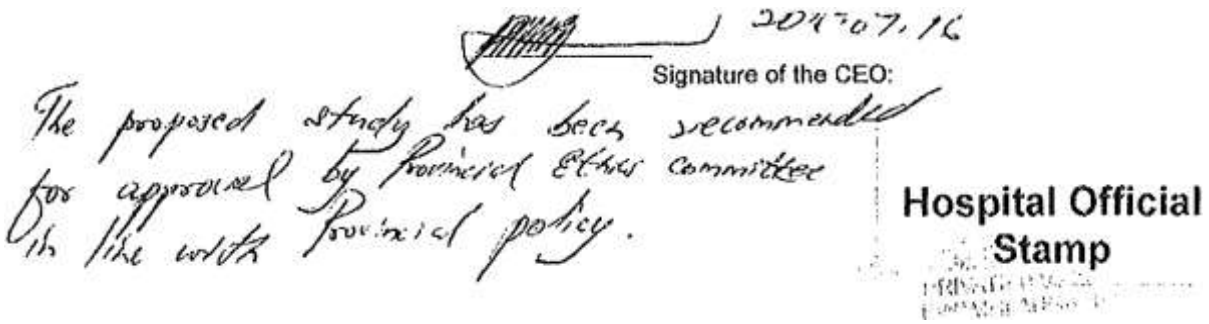
I intend to protect the personal Identity of the patients by assigning each patient a random code number.

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

Signature of the Principal investigator

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

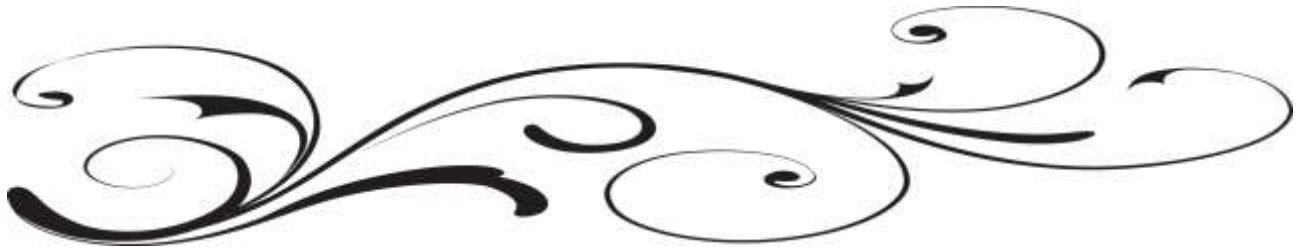
Chief Executive Officer
Kwamhlanga ….Hospital
Mr./'1/Mangcna



ANNEXURE D 1

CONFIDENTIALITY CLAUSE

RESEARCHER'S CONFIDENTIALITY CLAUSE



CONFIDENTIALITY CLAUSE
RESEARCHER'S CONFIDENTIALLY CLAUSE

Study title: Towards professional value-driven midwifery care: A Cooperative Inquiry Research approach

Promoter: Prof M.D. Peu

Co-Promoter: Prof F.M. Mulaudzi

Co- Promoter: Prof S.S. Moloko-Phiri

Researcher: P.M. Jiyane

Researcher

- I understand that all the material which will be transcribed in this inquiry is confidential.
- I understand that the contents of the tapes or recordings can be discussed with the CIG members and the promoters only.
- I will not allow third parties access to transcripts.

Researcher's name: Jiyane P.M.

Researcher's signature: _____

Comments: I hereby promise to handle the transcripts safely according to the time-frame prescribed as directed by the policies of University of Pretoria.

Adapted from Donald, H. (2012)

ANNEXURE D 2

CONFIDENTIALITY CLAUSE

RESEARCHER'S CONFIDENTIALITY CLAUSE

CONFIDENTIALITY CLAUSE

RESEARCHER'S CONFIDENTIALITY CLAUSE

Study title: Towards professional value-driven midwifery care: A Cooperative Inquiry Research approach

Researcher: Jiyane P.M.

Transcriber No 1

- I understand that all the material which will be transcribed in this inquiry is confidential.
- I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- Iwill not keep any copies of the transcripts
- I will not allow third parties access to transcripts.

Transcriber's name: _____

Transcriber's signature: _____

Transcriber's Contact Details: _____

_____ _____

Signature **Date**

Comments:

(The transcriber's details were omitted to promote the confidentiality aspect of the study).

Adapted from Donald, H. (2012)

ANNEXURE D (3)

CONFIDENTIALITY CLAUSE

RESEARCH CONFIDENTIALITY CLAUSE

CONFIDENTIALITY CLAUSE

RESEARCH CONFIDENTIALITY CLAUSE

Study title: Towards professional value-driven midwifery care: A Cooperative Inquiry Research approach

Researcher: Jiyane P.M.

Transcriber No 2

- I understand that all the material which will be transcribed in this inquiry is confidential.
- I understand that the contents of the tapes or recordings can be discussed with the researchers.
- I will not keep any copies of the transcripts
- I will not allow third parties access to transcripts.

Transcriber's name: _____

Transcriber's signature: _____

Transcriber's Contact Details: _____

_____ _____

Signature Date

Comments:

(The transcriber's details were omitted to promote the confidentiality aspect of the study).

Adapted from Donald, H. (2012)

ANNEXURE E

COPY OF INTERVIEW GUIDE

COPY OF INTERVIEW GUIDE

Research questions

PHASE 1: REFLECTION PHASE: INTRODUCTORY PHASE

PHASE 1.1

How can gatekeeping be negotiated in a public hospital following a CI research approach?

PHASE 1.2

How should midwives relate professional value-driven midwifery care in the maternity ward?

PHASE 1.3

How can midwives prioritise professional value-driven Midwifery care in order to improve care given during childbirth following a CI research approach?

PHASE 2: PLANNING PHASE

How can midwives promote professional value-driven midwifery are using a Cooperative Inquiry research approach?

PHASE 3: ACTION PHASE

How can midwives utilize knowledge of professional value-driven midwifery care to develop strategies to empower midwives using a CI research approach?

PHASE 4: EVALUATION PHASE

How can midwives evaluate the attainment of caring and respectful midwifery during childbirth using a CI research approach?

ANNEXURE F

PROJECT TIME SCHEDULE

PROJECT TIME SCHEDULE

PROJECT TITLE: TOWARDS PROFESSIONAL VALUE-DRIVEN MIDWIFERY CARE: A COOPERATIVE INQUIRY RESEARCH APPROACH

STARTED	PURPOSE & THE CIG/S	DETAILS AND REPORTING	COMPLETION	SCHEDULED TIMES ADHERED TO: YES/IF NOT PROVIDE REASON
PHASE 1: INTRODUCTORY PHASE				
03/07/2015	**Gatekeeping and rapport** Researcher and CEO	Requesting permission to conduct the study.	03/07/2015	**Yes**
09/10/2015	Leadership and Nursing Management	Meeting with the leadership - Presentation done. - Permission to conduct the study granted.		**Yes**
15/10/2015	Maternity staff	Initial meeting: 1st visit for meeting with the staff of the first shift.	30/10/2015	**No. The hospital underwent a Provincial assessment**
30/10/2015	Midwives Midwifery students Enrolled nursing categories	Introduced the purpose for the visit.	30/10/2015	
16/10/2015		2nd meeting with the staff of the second shift. Introduced the purpose for the visit.		**Yes**
		Meeting the Operational Manager (OPM) for accessing specific ward records.		**No.** **Manager busy with Provincial assessments**

STARTED	PURPOSE & THE CIG/S	DETAILS AND REPORTING	COMPLETION	SCHEDULED TIMES ADHERED TO: YES/IF NOT PROVIDE REASON
30/10/2015		Meeting with the Quality improvement officer for accessing Hospital Quality records.	30/10/2015	**Yes**
08/11/2015	**Rapport building** OPM & shift leaders	Meeting to revisit the project plans. Agreeing on future plans. Acknowledging the need to use the opportunity to cover the CPD requirements by the NDoH.	08/11/2015	**Yes**
16/11/2015 & 17/11/2015	**Rapport and the importance of teamwork.** Maternity staff	Reflection meeting with the staff of the Maternity ward. Presentation on values and values clarification: Values clarification exercises no1 & 2.	17/11/2015	**Yes**
PHASE 2: PLANNING PHASE				
12/01/2016	**Establishing a Cooperative Inquiry Group (CIG).** Midwives & researcher	Meeting the CIG - Setting of ground rules - Assigning specific group roles by the CIG	12/01/2016	**Yes**
12/02/2016	Researcher **Empowerment** Researcher	Involvement of the CIG in the initial plans of the study. Presentation on PAR and its phases Presentation on Cooperative Inquiry	12/02/2016	**Yes**
26.02.2016	Researcher	Presentation on Focus group discussion method.		

STARTED	PURPOSE & THE CIG/S	DETAILS AND REPORTING	COMPLETION	SCHEDULED TIMES ADHERED TO: YES/IF NOT PROVIDE REASON
12.03.2016	**Empowerment through Researching**	**Conducting first focus group discussion sessions.** **Session number one: Focus group 1**	12.03.2016	**Yes**
		No 1: (1st shift day duty) and data analysis	12. 03.2016	**Yes**
15.03.2016		No 2: (2nd shift day duty) and data analysis	21.03.2016	**Yes**
21.03.2016		**Session number two: Focus group 2**		
20.05.2016		**Session number three: Focus group 3**	20.05.2016	**Yes**
28.02.2016			28.05.2016	**Yes**
24.05.2016	**Data analysis** Co-Coder Researcher and CIG representatives	Data analysis commenced Data analysis completed	07.10.2016	**Yes**
4.11.2016	Researcher and CIG representative	Member checking and reflection and plans for writing up	14. 11.2016	**Yes**
20.02.2017	Researcher	Writing up commenced	31.01.2018	**No.** **There were delays on part of the researcher**

STARTED	PURPOSE & THE CIG/S	DETAILS AND REPORTING	COMPLETION	SCHEDULED TIMES ADHERED TO: YES/IF NOT PROVIDE REASON
01.06.2018 20.05.2018		**THE ACTION & OBSERVATION PHASES**		
31.02.2018	Researcher CIG	Member checking and Reflection Plans regarding the collected data	15.03.2018	**Yes**
30.03.2018	CIG	Development of an audit tool	15.04.2018	**Yes**
01.05.2018 -	Researcher CIG	Presentation on collaboration and meaning of "strategies". Development of strategies		
	Researcher and CIG representative	Member checking and Reflection	20.05.2018	**Yes**
01.06.2018	**FINALISING CHAPTERS** Researcher Editor	Writing conclusions Editing of first chapters of the study Final corrections for submission	01.06.2018 30.05.2018	**Yes**

Compiled by Jiyane PM (Researcher/student)

ANNEXURE G

CRITERIA FOR ASSESSMENT OF COOPERATIVE INQUIRY RESEARCH: SELF-ASSESSMENT COOPERATIVE INQUIRY GROUP / COOPERATIVE

CRITERIA FOR ASSESSMENT OF COOPERATIVE INQUIRY RESEARCH: SELF-ASSESSMENT COOPERATIVE INQUIRY GROUP/ COOPERATIVE

ASSESSING ACTION RESEARCH PROPOSALS AND PROJECTS	YES/NO	REFER TO PAGE
1. **Is there a clear statement of the aims and objectives of each stage of the research?**	X	Refer to 1.2 Problem Statement
• The project clearly define the aims and objectives of the project.	X	Refer to Aim of the Study 1.5
• Aims and objectives of the research are appropriate.	X	Refer to table 1.2 List of Objectives
2. Was the action research relevant to practitioners and/or users?		
• The research addressed local issues.	X	Refer to 1.2 Problem Statement
• It contribute something new to *understanding* of the issues.		
• The research was relevant to the experience of those participating in the study.		
• Further research suggested	X	Refer to Point 8.4.1
• The research stated how the action research will influence policy and practice in general.	X	Refer to Point 8.4.2 Refer to 8.5.3 and 8.5.4
3. Were the phases of the project clearly outlined?	Yes	
• A logical process in evidence (or intended) included:	X	Refer to Table 3.2
– problem identification	X	
– planning	X	Refer to Table 3.2
– action (change or intervention that was implemented)	X	Refer to Table 7.1: Strategies to address problems related to childbirth were developed as Figure 7.1

ASSESSING ACTION RESEARCH PROPOSALS AND PROJECTS	YES/NO	REFER TO PAGE
– evaluation	X	Refer to Table 4.7: Presentation of the audited.
• These influence the process and progress of the project.		
4. Were the CIG and stakeholders clearly described and justified?	X	Refer to Table 3.2: summary of the phases of the study.
• The project focus on service users and/or health professionals.	X	Refer to Table 3.2 Health care professionals: Midwives for phases 1, 2, 3, 4 Refer to Points 3.6.1, 3.6.2, 3.6.3, & 3.6.4
• It is stated who was selected and by whom for each phase of the project.	X	Refer to Point 3.6.1.2.4 on voluntary participation from the NGT & onwards.
• It is discussed how the CIG were selected for each phase of the project.	X	Refer to Table 3.2: Sample and sampling methods.
5. Was consideration given to the local context while implementing change?	Yes	
• It is clear which context was selected, and why, for each phase of the project.	X	The Maternity ward was used for all the phases of the study. See Point 3.3 and 3.3.1.
• There's a critical examination of values, beliefs and power relationships.	X	Image 4.2, findings of the NGT page 95
• The context is appropriate for this type of study.	X	Refer to Point 3.3; 3.3.1 – 3.3.3.
6. Was the relationship between researchers and the CIG adequately considered?	Yes	

ASSESSING ACTION RESEARCH PROPOSALS AND PROJECTS	YES/NO	REFER TO PAGE
• The level and extent of participation clearly defined for each stage.	X	Refer to Point: 3.6.1, 3.6.2, 3.6.3 & 3.6.4.
• The types of relationships that evolved over the course of the project acknowledged.	X	
• The researchers and the CIG critically examine their own roles, potential biases and influences, that is, they were reflexive.	X	Refer to Table 3.10.
7. Was the project managed appropriately?	Yes	
• The key persons approached and involved where appropriate.	X	Refer to 3.6.1 – 3.6.1.1.4.
• Those involved appear to have the requisite skills for carrying out the various tasks required to implement change and/or research.	X	Refer to Table 3.10.
• There was a feasible implementation plan that was consistent with the skills, resources and time available.	X	Refer to Table 3.8.
• This was adjusted in response to local events and the CIG.	X	Refer to Table 3.8, point no 1 on meeting and attendance
• There is a clear discussion of the actions taken (the change or the intervention) and the methods used to evaluate them.	X	Refer to Point 3.6.4, the Observation phase, and the presentation thereof as 4.2.6
8. Were ethical issues encountered and how were they dealt with?	Yes	
• Consideration was given to the CIG, researchers and those affected by the action research process	X	Only one the CIG was emotionally affected by past experience of usage of fundal pressure during her past delivery. She was attended by the researcher and unit manager with success. Refer to transcript H(2).
• Consideration was given to underlying professional values, confidentiality and informed consent was addressed.		Refer to 3.6.1.2.4 in page 58

ASSESSING ACTION RESEARCH PROPOSALS AND PROJECTS	YES/NO	REFER TO PAGE
9. Was the study adequately funded/supported?	Yes	By the National Research Foundation, RSA
• Assessments of cost and resources was realistic.	X	
• There were no conflicts of interest.	X	
10. Was the length and timetable of the project realistic?	Yes	
• timetable was given for the project and an indication of where the section being reported fits into the overall timetable.	X	Refer to Annexure F: Project Time Schedule
11. Were data collected in a way that addressed the research issue?	Yes	
• Appropriate research methodologies were used to answer research questions.	X	Refer to Table 3.2: Summary of the phases of the study or 3.61, Introductory phase, 3.6.2, the planning phase, 3.6.3, the action phase & 3.6.4 Observation phase.
• It is clear how data was collected, and why, for each phase of the project.	X	Same as above
• Data collection and record-keeping was systematic • Explanation was provided for methods that were modified during data collection.	X	

ASSESSING ACTION RESEARCH PROPOSALS AND PROJECTS	YES/NO	REFER TO PAGE
12. Were steps taken to promote the rigour of the findings? • Differing perspectives on issues were sought.	Yes	Refer to Point 3.9 on promoting rigor of the study.
• The researchers undertook method and theoretical triangulation.	X	3.8 as maintaining Triangulation of the CI
• Key findings of the project were fed back to the CIG at key stages.	X	Member checking done frequently, refer to the time schedule and Reflection as Annexure J.
• The researcher offered a reflexive account.	X	On engaging the CIG in the reflective stage of the study
13. Were data analyses sufficiently rigorous?	Yes	Refer to Point 3.7 Data Analysis.
• Procedures for analysis were described.	X	
• The analyses was systematic	X	
• The researcher explained how the data presented were selected from the original sample.	X	
• The arguments, themes, concepts and categories were derived from the data.	X	
• Points of tension, contrast or contradiction are identified.	X	
• Competing arguments are presented.	X	
14. Was the study design flexible and responsive?	Yes	
• Findings were used to generate plans and ideas for change.	X	
• The approach was adapted to circumstances and issues of real-life settings: that is, are justifications offered for changes in plan.	X	

ASSESSING ACTION RESEARCH PROPOSALS AND PROJECTS	YES/NO	REFER TO PAGE
15. Are there clear statements of the findings and outcomes of each phase of the study? • The findings and outcomes are presented logically for each phase of the study. • They are explicit and easy to understand. • They are presented systematically and critically – the reader judge the range of evidence/ research being used. • There are discussions of personal and practical developments.	Yes	Table 3.2: Summary of the findings of the study.
16. Do the researchers link the data that are presented to their own commentary and interpretation?	Yes	
• Justifications for methods of reflection are provided.	X	
• There is a discussion of how the CIG were engaged in reflection.	X	Refer to Annexure J
• There is a clear distinction made between the data and their interpretation.	X	Refer to: Chapter 3: Data collection Chapter 4: Presentation and Interpretation of data of the Reflection phase Chapter 5: Presentation and Interpretation of data of the FGDs

ASSESSING ACTION RESEARCH PROPOSALS AND PROJECTS	YES/NO	REFER TO PAGE
17. The connection with an existing body of knowledge made clear? • There is a range of sources of ideas, categories and interpretations.	Yes	Refer to Chapter 6
• Theoretical and ideological insights are offered.	X	Chapter 6
18. Is there discussion of the extent to which aims and objectives were achieved at each stage?	Yes	Refer to table 3.1: areas on objectives and outcomes of each phase
• Action research objectives have been met.	X	Refer to different Chapters 1-8.
• The reasons for successes and failures are analysed.		
19. Are the findings of the study transferable?	Yes	
• The findings could be transferred to other settings.	X	Refer to Point 3.9 Promoting Rigor of the study.
• The context of the study is clearly described.	X	See chapter 3; 3.3.1 - 3.3.3.
20. Have the authors articulated the criteria upon which their own work is to be read/judged?	Yes	
• The authors justified the perspective from which the proposal or report should be interpreted.	X	Refer to point 3.10.

Compiled by the CIG members: A & M

ANNEXURE H

TRANSCRIPTION OF FOCUS GROUP DISCUSSIONS NO 3

TRANSCRIPTION OF FOCUS GROUP DISCUSSIONS NO 3

Title: Towards professional value-driven midwifery: A Cooperative Inquiry research.

Number of the CIG: 10

Venue: Maternity ward

PART ONE: MOTIVATIONAL SESSION

TOPIC 1: READING OF INDIVIDUAL MOTIVATORS (An opening move)

Facilitated by: OPM Maternity ward

Research question: How should the midwives be motivated to succeed during the challenges of childbirth in the Maternity ward?

CIG MEMBER D: Be positive and think positive.
Research organiser: Thank you.
CIG MEMBER A: Yah…it seems as if everything I do does not succeed all the time. It only happens spontaneously and at the end of the day I will not win. Be positive, think positive. Every time you do that thing, tell yourself that the business I'm starting its going to be successful like it or not. You will see miracles. Do not be negative "so and so did this and they were never successful. I just do it because I was advised to". I must tell myself that I will succeed. Say I am going to study for the exams and I am gonna pass like it or not. I am going to make it neh, do not be negative.
CIG MEMBER C: No…do! And be positive.
Research organiser: Let me add a bit. Do not be always negative.

CIG MEMBER A: Because what you will be studying will not be easily internalised because you are already negative.
Research organiser: When I add a bit to that"…you know the maternity ward, as for the males, you know I do not know, how dare they allocate me to such a ward? How will I work with these ones [meaning the female patients]. But if you say you know what? This is a ward just like any other wards, I will be caring for this woman just like any other patient and take away the thing of saying I am a male she is a female yah… And you work wonders, what I know with men is that Sister, at the end they work wonders in the Maternity.
CIG MEMBER A: You'll find the patients continuously saying, they do that neh sister ...yah, we want Bafana (name of a Research organiser: Thanks a lot, what more do we have to say. Research organiser: Thanks a lot, what more do we have to say. final male student) to attend to us because his touch is different".
Research organiser: Thank you. And you are not realising that you are doing something very good.
CIG MEMBER A: They understand you are a calm person. Maybe they even think Sister "D" shouts at them and all that".
CIG MEMBER C: "A man who moves a mountain starts by carrying small stones".
CIG MEMBER A: Exactly Sister, Exactly sister. Little by little we are going forward, neh…
Research organiser: mm…
Research organiser: We begin something by stating from the very beginning, you don't say I want to start up there immediately at the beginning stage. Steady but sure. You need not say I started at the same time with sister… and now she already achieved this and that. Let us go step by step. Take it day by day, mm… one step at a time.
CIG MEMBER A: Be patient, exactly Sister G be patient neh… you will eventually achieve what you intended to. You will be corrected for the mistake today, and again tomorrow and eventually you will reach your goal. One day at a time Bafana.
CIG MEMBER F: Yes sister ,neh
CIG MEMBER A: yah… (laughs) one day at a time because Rome was not built in one day. CIG MEMBER F: Next…
CIG MEMBER G: "**It is hard to beat a person who never gives up".**
Research organiser: It is hard to be…?

CIG MEMBER G: To beat a person who never gives up"
CIG MEMBER A: It is hard to beat a person who never gives up, ne? I want to oppress this one, to make sure he/she does not succeed, neh… I want to show him/her that she will not achieve this goal she/he thinks he will achieve. Tomorrow again I give her 20% for her performance this sister…I want to fix her. Tell yourself that the next day you would like to excel. My aim is to destroy you, but because you do not give up easily the next time you get 60%, the next time 80%. I will not be able to destroy this person who is determined to reach the set goals. Who is next? Sister….
CIG MEMBER E: "You are stronger than you think"
CIG MEMBER A: Exactly. Who should tell you that you are useless? You as a person must tell yourself that everyone has his/her own weaknesses, neh, but there are strong points you do not realize in the same person. I can say what does this and this person know?. Why is she/he doing this and that but you must not look down upon yourself as an individual. You are the best, you are unique. You were created by God for a purpose neh…yes, there may be things you are not good at as I already indicated that we all have our own weaknesses. There is no one who does not have weak points. We all possess some strong points too. No one is perfect. So, take the positive points about yourselves and capitalize on them to shine. No one is useless.
CIG MEMBER F: Don't remind yourself of how tired and weak you feel. You arrive very early in the morning and suddenly utter that you are already tired!!. Even before we start working, so do not remind yourself.
Research organiser: "Thank you"
CIG MEMBER F: you don't try, so don't remind yourself how tired you are. Even if you are studying for your exam just say mm… mm… I am taking a break I am coming back.
Research organiser: "Thank you".
CIG MEMBER I: You will collect certain energy and you'll feel stronger than before.
CIG MEMBER B: Teamwork divide task and multiply the success.
CIG MEMBER G: iyoo… that is very good!
CIG MEMBER I: When we work together as a team, things (meaning work) become simple and success will multiply.
CIG MEMBER A: Because you are working as a team and helping each other, I use to say we work as a team in the Maternity ward neh…so …when sister is still busy do not sit down and say I'm done with

my work. If you lend a hand you will contribute to very good quality. You can make the colleague aware of the foetal heart she forgot to chart down. By reminding her to chart the foetal heart you will be saving the whole ward so that the mistake is not blown out of proportion is it not it? So working as a team is a very good thing and in a team we support each other, we help each other.
CIG MEMBER D: Oh… If you work hard within a team, every time there is something important to be done we think of you before any other person.
Research organiser: mm…
CIG MEMBER A: They'll be saying where is so and so? Just because you are a hard worker. And you are always there in case of need. You are a team worker, you are lucky because even all the secrets of work will be shown to you since you are always there. (They laughed).
CIG MEMBER A: Sister I think you are right…Yes you are. Okay colleagues, just to wrap it up, now we going to talk about how we should communicate with our patients neh… yah. (CIG MEMBER re-arranging themselves)
PART TWO: SESSION 2 **TOPIC TWO: ACTS THAT MAY CONSTITUTE HARM TO THE WOMEN/ PATIENTS IN THE MATERNITY WARD.**
Research question: which are acts which may constitute harm to women during childbirth?
CIG MEMBER A: Okay being a midwife in the Maternity ward you will try to avoid, prevent acts which constitutes harsh or abusive behaviour whilst caring for patients in our maternity ward at all times. I mean we are committing ourselves that all harsh and abusive behaviour, we as maternity staff we are going to avoid harm towards the women at all costs. at all cost neh, psychological harm, verbal harm and physical harm.
CIG MEMBER A: I will start with the physical harm. Let us hear…(No response). Colleagues let us concentrate.
CIG MEMBER D: By physical harm we talk of a midwife refusing to remove a swollen intravenous infusion because the patient is complaining a lot. I want to teach her a lesson. I want her to feel pain. At the end, the patient's limb swells until dressings are prescribed. By the way she came with a maternity problem but now she becomes a surgical patient, do you see. We are not supposed to neh. We should avoid such things at all costs. A midwife slaps a delivering woman ("Open this thighs of yours") slap!!.And let me tell you this, we talked to the students and they heard me that day neh. We said if H and E [names of two nurses nurse were given as an example] beat a patient during the delivery and you are there and keeps quiet and say you are not involved, then you will be perceived as

condoning the action. When we go to the Nursing Council, because the patient indicates that you were present, you kept quiet and did not tell them to stop, during the ruling you go down with her.
CIG MEMBER I: So sister, let us say I call her and advised her to stop the unacceptable act, what next should be said to the patient?
CIG MEMBER D: A patient? Let's say she stops? [meaning the midwife]. She must apologize to the patient for doing that so that is why it is unacceptable. It should never happen even if it is done by somebody else. As you are colleagues you call them to order. If she refuses you report her to the manager. You must know what happened neh. Because at the end of the day immediately the patient starts complaining, it will mean that you also condoned the action and obviously it will mean you did that together.
CIG MEMBER J: a midwife forces a patient to deliver in a bad position. Which bad position can you let a patient deliver?
CIG MEMBER F: a standing position
GROUP OF CIG MEMBERS: (said as group) No.
CIG MEMBER A: so I am talking about such positions. You are not allowed to do that to patients. (CIG MEMBER continuing) Okay what psychological harm can be done to a patient by a midwife? What psychological harm can happen to a woman during childbirth? Give us a practical example.
Research organiser: I agree. We are nurses and we wish to avoid such acts. We do not wish them to continue.
CIG MEMBER G: Ok…instead of requesting her to open her legs you do not talk to her in a good manner.
CIG MEMBER A: Failure to talk politely to her neh… Bafana do you want to add?
CIG MEMBER F: yah… say for instance a woman arrives here and request sister so and so, why did you run to here? You by-passed the clinic to here.
CIG MEMBER D: Exactly, there should be a way of addressing the patients who bypass the clinic neh. Don't shout at her, you tell her politely mama when you don't have identified complications you should start at the clinic. Just now we going to check you but otherwise you should have started at the clinic not in the hospital, in the hospital we attend to complicated cases neh. so you don't shout you address them so that next time they will know, they will learn that this is the way we do things.
CIG MEMBER A: what other psychological harm should we address?

CIG MEMBER F: The thing of not giving them the necessary attention might harm them psychologically. That is abusing a patient psychologically, when a patient calls for attention you go to her and tell her that mama the patients are many in the ward, you have been checked just now so please so we are going to check you maybe after two hours, you explain to her, we are again going to check you after two hours or maybe after four hours if the patient need us. I will check the patient and I will report at the same time if there are abnormalities, so that she's transferred, to safe her and her baby".
CIG MEMBER D: Don't say "you are a nuisance, you want special attention", this and that to patient neh, yah … at the end of the day if something negative happens to that patient like maybe the baby is no longer alive, she will say I called them they ignored and never attended to me and at the end of the day they didn't want to assist me and all those things and it is going to suit the situation that she is presenting at that moment
Research organiser: Can I add?
CIG MEMBER A: yah…
Research organiser: Nowadays people have got their sophisticated cell phones, when I try to talk to her in whatever way, this person switches on her cell phone and records and that is evident enough, so let us try to save our skins.
CIG MEMBER A: mm… Thank you Sister M. What else? What other psychological harm or abuse do you think of, that we should avoid at all cost in this unit.
CIG MEMBER J: Ignoring a patient by just concentrating on the one that came before despite the condition.
CIG MEMBER A: I think we should elaborate in our discussions.
CIG MEMBER J: Every patient that comes to this unit you ask her mama have you been assisted? Meaning when they are still busy) you redress the patient is it? Ya… we are still all held up mama it's not that we don't want to help you is not that we don't want to help you, we are going to help you, you came for this and that isn't it? She should agree then from there we say okay just sit there we are going to attend to you just now neh... Just like this one who just came in for elective Caesarean section tomorrow, I will explain to her… just sit there we are going to attend to you just now neh. Yah… that is how we do it.
CIG MEMBER A: You don't just pass her as if you see no one. It hurts. Just imagine if it was you who needed the service at a specific point and then the staff is there but is just passing with no one is asking you if you have ever been helped they are just talking among themselves ignoring you as a client that

came for service so just take that patient, that pregnant woman, put in her boots and then you will understand what is it that she will be feeling. What more do you have to tell about this topic?
CIG MEMBER I: Err…privacy of a patient. When we attend to a patient you don't have to expose the whole body for her to stay naked for no apparent reason as if one will personally rejoice for that, just expose the only part that you attending to.
Research organiser: Thank you very much. Over to your sister "D".
CIG MEMBER D: Another thing under privacy of a patient is to expose the status of a woman in-front of other patients, you need to respect her privacy and you need to respect other patients because the way we address them and our attitude towards them like a woman who just came and telling her that "haai you have many children", it harm them psychologically. And the way we address them when they come in the ward how we welcome them like when a mother approaches you then you change your face even if she has some pains you can see that the mother…
CIG MEMBER F: She is going to hide it.
CIG MEMBER A: She is going to feel… instead of welcoming her, by greeting her with a smile and ask "can I help you mama"? What brings you here? So for that she can be free. But when I say err… err… "what do you want?". Hey… you left your hospital there at place "X" then came here". You didn't ask her why she is here, maybe she visited and you started doing that so if you can try to treat each patient the way you want to be treated with respect and dignity then I think we will go very far because psychologically, the smile, the greeting can go a long way.
CIG MEMBER A: What else?
CIG MEMBER C: In addition to this one neh, maybe let us say you are admitting a patient and you find that a patient is 43 years old is not right to say "hey you are too old why did you just decided to have your first child at this age", and things like that. You don't know what made her to have children at that age.
CIG MEMBER D: You might find that by the time you are given her history she will never be able to explain to you that she was having miscarriages because of the attitude and the way she was treated.
More than 1 CIG member: Yah, and…yes sister D?
CIG MEMBER D: Another thing is the way we address our patients, like "she is the one with warts". And we call them she is that one with TB or, "did you give that TB her treatment that side?"

CIG MEMBER E: I think we also need to stand up against nepotism where…as… let's take err… a patient approaches you, let us take it that it is my relative or friend. I act fast because this is my friend, the others, we neglect.
CIG MEMBER H: We should treat all of them equally because we have professionals who are coming to visit us at hospitals, we don't know that person's status, professional status then you just start behaving as if she is a layman. Be careful, whatever that you say be careful.
CIG MEMBER A: and what else?
CIG MEMBER H: say err… showing no interest in what the patient is saying.
Research organiser: It is painful neh…?
CIG MEMBER A: Because you are learned, you are a midwife you know everything related to this field, so whatever the patient is saying to me you ignore that neh…, yah…, address it properly neh… It does not mean you should take whatever the patient is saying to you and do it, we don't work like that, we have policies, we are guided by policies, by principles and standards that we work under. So explain to that patient and say no mama you are not supposed to do this. This is going to bring harm to you. This is the way how we work in a hospital. We are guided by principles, policies whatever. Let us say for an example, a patient come to you and I am tired of this pregnancy I want to do a Caesarean section. You explain to here politely like: Mama, " we only do a Caesarean section when there is an indication but never the less I will call the doctor to come and address you neh... and you indicate that to the doctor, Mrs so and so I have explained this to her but she says she wants to come to you first. Let the patients talk to the doctor because we are not doing Caesarean section out of interest, doctors are doing the operation for a medical indication, we don't do a Caesarean without indication neh?
CIG MEMBER I: The issue of verbal abuse should be addressed like having … traditional birth attendants who are believing in whatever they are believing in. We don't allow them to spoil our good practices like we don't allow them to give anything to the patients they are sending to us because as long as the patient is now in our hands it should be handled as such. At home they can do whatever they want to do but not in the hospital set up neh…
CIG MEMBER A: If they come here they and are expecting to see of our patients, you don't shout at them, we don't chase them away saying you don't belong here. Show that we appreciate the role they played but now the patient is in our hands. They should come for the visit alone and nothing more.
Research organiser: Somebody has already touched err… err… the problem of having too many children, having too many children, why don't we want our patients to have many children? Sister "H" what is the danger of having too many kids? Of delivering more than seven more than eight, more than nine what is the danger?

CIG MEMBER H: she won't be able to have normal contraction due to the loss of tone of her uterus. An atonic uterus cannot contract and retract easily. It's muscles become too relaxed and even if you give syntocinon, there is no contraction and she just bleeds, you put up a blood transfusion, "it goes out" [meaning the blood will not be retained] so it is very dangerous.

CIG MEMBER A: If you can look at the lifestyle of today, we drive cars, we no longer walk. We are no longer those strong women of the past. We eat frozen foods like meat portions and no longer eat, mmm…, fresh vegetables from the fields. The only green vegetables we talk about are is only spinach. So even the life style we live doesn't allow us to do to have many kids, it is a health hazard. Even though the maternal deaths happened before maybe it was as a result of maternal related problems like err… multi parities.

Is unlike these days where we have increased litigations. Today if a child [meaning a baby] dies we know that litigations are coming so be very careful in whatever that you are doing. Health education is not forced on anyone it is an advice that is given on a patient and should be very careful. To the patient who come to the hospital early we do not say why did you come early , you should have waited for the pains to be strong because we do not want to monitor the patient, we don't do that neh… if she came too late "you" [meaning the midwives] explain to her the danger. It is dangerous to come too late because she is going to deliver alone she is going to deliver immediately and she may be alone and there is nothing that you can do but if she came earlier, you could pick up issues like foetal distress and things like that neh.

CIG MEMBER F: And then traditional herbs. What can we say about traditional herbs sister? They are really a problem to us…yes, I realised that.

CIG MEMBER D: Educate them about the dangers that can happen to them and the foetus that they can do more harm than good.

CIG MEMBER A: Yah so we don't shout and scold them, explain the dangers neh. Err…for "delivering at home in the past" for example, a woman admitting "I used to deliver/give birth at home in the past" and the midwife shouts at her for that and utter the words "yes, you think you are clever". Please, don't do that. We explain the dangers of delivering at home neh, like " didn't you think of issue of a baby who was born not breathing what were you going to do? (CIG MEMBER continued).

CIG MEMBER A: what else did we leave out? Favouritism we have spoken about that ne, ignoring a patient, okay being charged for a baby's clinic card. People who wanted to be written a bay's clinic approached on hospital worker who stole the card and card and charged them a fifty rand. You are shaking your head with disbelief sister E. People who were doing that in this were stealing the cards and they were charging women at home selling cards to them. One day you will be caught and when you are caught you will lose your job because of a fifty rand note. You will lose your profession because of fifty rand. You will never register with the South African Nursing Council (SANC) because of the behaviour that you did and if the nursing council struck you off the roll for such behaviours you will

never again be reinstated not in South Africa. If it happen that you acquire another certificate from anywhere, that certificate must be checked against the South African Nursing Council. It is not worth it to lose our jobs for just a fifty rand so don't do it as simple as that. Do you have anything thing sister? [meaning the research organiser].
Research organiser: mm… I don't have anything. I think you touched nearly everything, though we can't say we did it fully.
CIG member F: so how do you feel about this "guys"? Raising it and talking about it? We are going to avoid it at all costs ne, call a person to order.
CIG MEMBER B: Don't make it a habit to each and every person you come across, harshness may be applied but use it…
Research organiser: Situationally…?
CIG MEMBER G: yah…just like we can do to the women who do not push in there (pointing at the labour room) we end up being harsh.
Research organiser: what form of "harshness?"
CIG MEMBER F: like shouting "push mama push" (raised her voice, and showed an unpleasant facial expression) see, she starts pushing. I think that is that (the CIG MEMBER laughed).
PART THREE: SESSION 3 Facilitated by the research organiser **TOPIC 3: WOMEN'S CHILDBIRTH RIGHTS** **How should the midwife promote the woman's childbirth rights in the Maternity ward?**
Research organiser: Thank you sister A and thank you for all your contributions. I am going to be very snappy because what I will do is to remind each other. These are the things which we know and at times we may forget but they are the things we know and as we talked here we touched most of them.
Research organiser: I am a South African, are you?
Group of CIG members: (said as group) Yes we are.
Research organiser: Okay… I have my rights do you?
Group of CIG members: Yes we have (said as group).
Research organiser: Okay… does a patient have a right? A woman in the maternity? Is she having rights?

Group of CIG members:: Yes (group member's voices).
Research organiser: She is a human being like you and me right?
Group of CIG members: (group) Yes.
Research organiser: Err… I won't reiterate much on the rights of this woman in the Maternity ward. I will give this over to you because these are the things you know very well. Her rights are like mine. Its only that this time this is a who is admitted for childbirth in the maternity ward. I can be a woman who is admitted for childbirth in the maternity too myself do you agree?
Group of CIG members: Yes (said by a group but a young staff member looked straight into the research organiser's eyes and their faces showed doubts).
Research organiser: At my age… yah… so I would like to hear from you, "which rights do you recognise of a woman who is admitted in the maternity ward? **How should the midwife promote the woman's childbirth rights in the Maternity ward?** Which rights do you recognise, do you still remember any rights of a woman in the maternity ward?
CIG MEMBER F: Right to privacy
Research organiser: Can you elaborate? Let us elaborate and…
Group of CIG members: A woman err… when we talk about privacy we are talking about starting from admission. You admit a woman in a private place since she will have to undress to put on comfortable attire. And again, giving of private information must be done in a private place.
Research organiser: Okay… Thank you. Privacy that is the buzz-word here. What can we say? What more rights do you know or think of or you still remember Bafana?
CIG MEMBER F: Dignity and respect.
Research organiser: Can you elaborate for both?
CIG MEMBER F: Yah… a patient need to be treated with dignity and be respected.
Research organiser: How do you do that? [meaning] treating them with dignity and respect?
CIG MEMBER E: Yah… let me assist. You address a patient by name that shows respect. No not to say " hey…hey, I call you hey…!). Hey you "dwarfy!!". (They all laughed).
CIG MEMBER A: We must address them by their correct names yah… you must show respect. She is a human being neh… don't say "you". You are in a facility, you are a boss here and a patient is going

to hear from you. You are not a boss. The patient is a boss actually because we are here because of a patient so we must render services to a patient isn't it/ you are here because of the patient so address her with dignity, address her politely to preserve that human dignity okay?
Research organiser: What more? I will go this side (meaning that she invited the others to talk too). What about if despite everything, all the information you have given to the patient, she still does not understand the need for your action, what do you do?
CIG MEMBER B: If still she does not understand I will speak to member of family or somebody who will let the family know.
Research organiser: Yes, that becomes evidence that efforts were taken to explain. The presence of a family member will cover us in instances where complication occur? The midwife stands a better chance, of "the woman's voice against yours". Did we talk about everything? Let us hear what more rights is this woman in the Maternity ward having?
CIG MEMBER C: Right to companionship when she is going to deliver.
Research organiser: Is it her right to have a companion while admitted in here?
CIG MEMBER C: Yes.
Research organiser: Okay err… on the issue of the space, if "this gentleman …Yes I understand you (meaning the woman's fiancé/husband) says I would like to be there, to be a companion to my who-ever, what do you do?
Group of CIG members: You create space for privacy.
Research organiser: There is a possibility that in here we won't have any more space. What do I do?
CIG MEMBER G: You explain to her.
Research organiser: Please tell us more. Why? Tell us more. **CIG MEMBER G**: I make the next of kin to put him or herself in my shoes to realise that as much as I know the importance or advantages of having him or her next to the birthing woman as possible, I have limited powers to construct an extra space to serve the purpose. **Research organiser:** Yes, thank you. What more rights does this woman have?

CIG MEMBER B: A woman has **a right to consult any health care facility of her choice and a right to be treated and get the best of the best care.** If she feels like signing out I will be left with no option but to "let go".
Research organiser: That is, the she has those rights we all deserve. She is a human being, she is a South African too. What more can we say?
CIG MEMBER G: **Refusal of treatment.**
Research organiser: "Refusal of treatment" and what do you do in that case?
CIG MEMBER F: She has a right to say "*I refuse to be treated in this ward*" and …but if it happens, I try to show her the importance of staying in hospital. I can even call the family, talk to them and ask her to show her the importance of being here and how her careless decision might harm her and/ or her unborn baby. She may listen to them and change her mind. Otherwise will resort to proper recording of the incident".
Research organiser: Ok…You indicate, in writing because record keeping is an important media to communicate for you. Thank you. What more?
CIG MEMBER B: Ah…I will release her. I cannot keep her even if she is not willing. But it pains at times.
CIG MEMBER A: Yes, of course. O' right…Who can add?
CIG MEMBER E: She has a right to act at **Liberty, with autonomy, self-determination and freedom.**
CIG MEMBER A: Yes…? Please elaborate.
CIG MEMBER E: If a woman does not want to be treated here and she wants to sign a RHT and leave it is her right. I will explain to her the dangers of refusing to be treated and the risk she is putting herself and her baby in immediately she is out of hospital without the doctor's authority. Explaining everything to her before she signs is important. It is her right she can go, but (CIG MEMBER communicated by raising her shoulders).
CIG MEMBER A: Okay, what about equality? **Right to equality**? We talked about that earlier. (They laughed)
CIG MEMBER G: Kusho ukuthi… (It means…)
Research organiser: English please baba (meaning English Mr…reminding the gentleman to talk English)

CIG MEMBER G: We must not discriminate on them regardless the nationality. Everybody deserves to be treated equally. We should not judge them differently based on other things like education or citizenship and so on.
Research organiser: Thanks, so here are the rights, we reiterated on them, they are not new, we can elaborate as much as we can as long as it is in the favour of the admitted woman in the maternity. Now err… the things we said have been "preached" for long… that is why I said what I was about to introduce was already touched upon.
CIG MEMBER A: While we are still there, look at the back of this this document. This is where midwives take this commitment to care. She commit herself and this is a good thing to do as to commit ourselves as to how we going to take care of this woman whose care is entrusted to us.
Research organiser: Sister A, thank you. That is good.
CIG MEMBER A: Thanks. Let's hear.
TOPIC FOUR: COMMITMENT TO THE WOMEN IN THE MATERNITY WARD
Research question: How should the midwife commit to the wellbeing of a woman who visited a Maternity ward for childbirth?
CIG MEMBER D: "**No one can physically abuse me"**
Research organiser: Do you understand what we mean by saying that?
Group of CIG members: (more than one voice) Yes.
Research organiser: What do you think this sentence mean? To whom does this letter that sister A came up with is addressed to?
CIG MEMBER D: To the… it is from the patient to the nurse. That's why I said I wish that we commit ourselves just here Sister. I want this to remind us of this commitment every time we enter the ward.
Research organiser: mm…? is it the patient to the nurse?
CIG MEMBER D: Nurse to patient or you represent the patient that no one should abuse "you". No nurse should abuse a patient.
Research organiser: But now we are in a maternity what do we do here?
CIG MEMBER F: No patient is going to be slapped, no patient is going to be pinched, to me, no procedure is going to be done without any indication. No urinary catheter will be inserted without any medicinal indication.

Research organiser: mm…?
CIG MEMBER F: This goes back to what we said… doing bodily harm…..patients are going to be treated…
Research organiser: Okay let's hear. Here are the statements of these midwives.
CIG MEMBER D: My second statement is, "**no one can force me or do things to me without my knowledge and consent**".
CIG MEMBER C: You can't do anything to a patient without any explanation.
Research organiser: Why are you saying so sister "C".
CIG MEMBER C: Like err… if you perform any surgical procedure to a patient you have to explain first and obtain consent form her, no matter how small it might appear. No matter how useless it might seem, you need to give treatment you explain "this treatment is for … and so on.
Research organiser: Okay let's continue, what can you say further?
CIG MEMBER H: Err… like inserting a catheter, you need to explain to a patient why you are inserting it and ask them to give you a go-ahead to do. **Research organiser:** Give us a practical example. **CIG MEMBER H:** Taking bloods… explain the reason why bloods must be taken and "it is going to be painful" of course it is but you explain that "*we going to draw blood, and it is doctor's orders, you are going to theatre so we need your consent that if maybe in theatre you bleed too much you lose more blood we need to transfuse you… so are you permitting us*?" Because the patient will … maybe be asleep or it will be an emergency so we cannot let the patient sign a consent form in the theatre so explain the procedure while still in the ward so that she gives you this consent.
Research organiser: okay, thank you. What can you further say…?
CIG MEMBER H: Another thing, when delivering a patient I think it is wise for few people to attend the delivery, not everybody.
Research organiser: Why?
CIG MEMBER D: (Senior midwife talking) Let me say there are students and you cannot call them and say "come and see the delivery" and everybody is standing around the patient's bed. It is embarrassing … so let there be a few people attending delivery not everybody like "*go in and feel the cervix is here…, and next*!" They all laughed.

CIG MEMBER A: You are not supposed to do that because you are exposing the patient unnecessarily.
CI: (Junior male nurse uttered) But let me ask if the patient herself says *"no I am fine I am also a nurse?"* I am asking for argument sake… I am not saying it is o' right. I want a correct answer sesi (meaning "sister"). For argument sake the patient says *"how many are you guys 12? It is fine all of you come stand here and watch we have to say no… no… no it is wrong?*
More than 1 CIG Member: (Female nurses' voices) It is wrong, for sure.
CIG MEMBER A: (Senior midwife) Yah … on a patient "*one student one sister*".
Research organiser: are you covered… are you answered?
CIG member I: I just wanted to have clarity. Yes. (They all laughed).
Research organiser: Okay… what more… let us hear.
CIG MEMBER H: "No one can humiliate me**".**
Research organiser: What do you mean?
CIG MEMBER H: Like being told "you have been here last year, you were here last year delivering a child and now you are here again, ah… Is it you o and so …again?)
CIG MEMBER B: Like ah… ah… ah… "*how old are you? Just 22 years?"* No, no, calling others "*hey, come …come and see".*
Research organiser: Okay what more?
CIG MEMBER F: "No one should discriminate against you due to where you come from".
Research organiser: Like?
CIG MEMBER C: "*You are from Nigeria you can sit down*" and attend to a South African a delivery (meaning first priority).
Research organiser: What more can you say? Please add.
CIG MEMBER C: Discrimination due to favouritism, les say that other one is my cousin then I decide to see her first and the others will be seen last.
CIG MEMBER E: Like saying I prefer this one because "*you are a problem*" so I prefer this one, or "*this one is not a problem she can push*". You don't look at the need of a patient.

CIG MEMBER F: You can also discriminate by being judgemental by… by intentionally ignoring the patient due to that she is HIV positive. So by saying "*no, I am not touching that one"*, it is part of discrimination.
Research organiser: discrimination due to condition of this woman, we only touch those that we think are not "positive". That is not right.
CIG MEMBER E: "No one can prevent me from getting the maternity care" in this maternity ward.
CIG MEMBER A: How can we elaborate on that one?
CIG MEMBER E: There are those patients that come without "*something*" written down, before they are referred from the clinic there must be written report which indicates details of her labour progress and take it up from there. Some of them just come here without being referred. They… it is their right to be here. They must be seen even if they did not bring along a referral letter but show her the importance thereof.
CIG MEMBER A: Okay… are you saying you will allow her to be seen? You will attend to this woman at the same time you educate her? **CIG MEMBER B & E:** Yes (said simultaneously)
CIG MEMBER D: The other thing is that we are not the ones who should tell her that "*you are still a child what do you want in here*" or "*you are aged what are you doing among the younger women?"* We are not deciding for the woman which one must get booked and which one must not.
Research organiser: Thank you. Have we exhausted all the points? Lets hear.
CIG MEMBER G: The last one…"**no one can detain me here in hospital because I just want to go".**
Research organiser: if a woman is not yet discharged and she insists on going does that mean that you are just going to allow this woman who insist to leave to go? She is not yet ready to be discharged but she forces to go due to various reasons. Do you mean you will allow her to go even if it is not good timing for her to go?
CIG MEMBER D: I will sit her down and explain to her the reasons why there is a need for her to be kept in hospital. That is, I will make her understand why she is not yet ready for a discharge and will pinpoint the dangers she may expect. If she insists I will notify her doctor to talk to her. Should she be adamant we will still give her the medications to use at home but indicate the other critical treatment which she will miss like continuous monitoring of her vital signs. I will indicate that the doors of the ward are still opened for her. I will indicate that she will have to sign in our records as evidence of being released before time.

Research organiser: Thank you. Okay. Thanks for all of you for participating. Who can wrap-up regarding what we were saying?
CIG MEMBER F: (a senior midwifery student) I can say thanks this was very important especially to us as the incoming professionals and midwives. You have given us a lot of information not only for the Maternity ward but for general work-life since the topic of the rights of a patient does not apply only here in the Maternity ward.
Research organiser: Who else can add?
CIG MEMBER D: (a senior midwife added) I can add that it took us back to our pledge.
Research organiser: mm…?
CIG MEMBER D: When we said that we are going to give our patients quality care by treating them with respect and dignity and I think this session was an added in-service training to lead us back to basics, reminding us the reason why we are here… is for the patients. The patient's quality care…and respecting patients. Our attitude has changed since err… back then, now we use to think that our patients are our enemies and now our patients are our first priority while we are here. It teaches us that patients come first.
Research organiser: Thank you for the contribution. Wrap up?
CIG MEMBER E: As a midwife be alert and not be trapped in to danger.
Research organiser: "*Be alert and not be trapped into danger*". Can you elaborate?
CIG MEMBER D: All women… all pregnant women coming through that door because they are carrying lives they must go back home happy about our service.
Research organiser: Due to lack of time I wish to thank you all. Sister please thank them for us.
The end

ANNEXURE I (1)

XXX HOSPITAL MATERNITY IN-WARD POLICY

XXX HOSPITAL MATERNITY IN-WARD POLICY

Policy Classification: Mother and child

Department: Maternity Ward

Policy Name: Treating the women in a caring and respectful manner by the staff during childbirth

1. Introduction: The aim of this policy is to strengthen the importance of adherence to customer care towards the women who are admitted for childbirth in the Maternity ward.

2. Aim: The aim of the policy is to allow the staff to promote a caring and respectful treatment of the women who are admitted for childbirth by staff with specific consideration to the appropriate values and attitude throughout childbirth.

To provide the midwives with the domains of caring and respectful Maternity care for the women during childbirth.

2.1 The adherence to the following 12 domains of caring and respectful Maternity care for women during childbirth

- Engaging in effective communication.
- Being free from harm and mistreatment.
- Providing equitable Maternity care.
- Preserving the women's dignity.
- Availability of competent and motivated human resources.
- Respecting women's choices that strengthens their capability to give birth.
- Enhancing quality of the physical environment and resources.
- Ensuring continuous access to family and community support.
- Prospective provision of information and seeking informed consent.
- Continuity of care.

- Maintaining privacy and confidentiality,
- Provision of efficient and effective care

Active Date: 2017/12/30

Review date: 2019/12/30

Signature: A, B, C, D, E, F, G, H, I, J, K & L.

Policy document: 1 Mat: 04/2018

Adapted from WHO. Shakibazadeh et al. (2017). Creative Commons Attribution

ANNEXURE J 1 (1)

REFLECTIVE DIARIES

GROUP REFLECTION

VERBAL GROUP REFLECTION ON THE FIRST PHASE AND INTRODUCTION OF THE NEXT PLAN

REFLECTIVE DIARIES

ANNEXURE J1: GROUP REFLECTION

J 1 (1) VERBAL GROUP REFLECTION ON THE FIRST PHASE AND INTRODUCTION OF THE NEXT PLAN

Intentions: To introduce Phase 2, the planning phase.

Researcher: Eh…, Yes I would like to continue from where sister D ended, as she indicates that there is something I will like to share with you. My role now is to identify or to talk about the next step we are going to take. Is it not it we did the hand diagram exercise and we did the nominal group technique, and now we are going to do focus group discussions and most of our findings will depend on the focus group discussions. The focus group discussion method is the one which will head the study…, I mean the study will be based or its findings or the foundation of the study will be the focus group discussions. That is why it is very important for me to share what focus group discussions are. Err… a Focus group is a form of interview, Let me say, yes, it is derived from interviews but this is where the CIG work in a group. They attend together, they discuss together in one room at the same time. They will be answering one question at a time, if ever there are 3 questions they will together deal with the first question until they reach the last question. Focus group discussion allow the researcher to ask open ended questions. An open ended question is a question that gives the CIG a chance to elaborate on a subject matter that is being discussed. When we do focus group discussions, the CIG are not channelled in anyway to discuss in a certain form, you give your views the way you have them. You pour your chest out; it is not a rigid method but it is flexible. Yes you are allowed to "*go to town*" …err… Sister F, when we say go to I mean you can talk as much as you can as long as you are on the right track.

Thank you, focus group discussions is far differentiated from a one-one interview. During a one-one interview you'll find that even if you can be a group of the CIG you will be entering the room where the research is conducted being alone and arriving there you will be asked questions yourself as an individual , and when the other one comes, she will be asked the same questions as the previous ones but you will be answering alone. Now when using focus group discussion all the other the CIG who are with you as the person who is answering, have the right to say something by adding on to what you are saying or they also have a right to disagree to argue and say no is not supposed to be that, or it's supposed to be this way. In a focus group discussion you work as a team and you own the findings together. Is it clear?

The CIG: (as a group) Yes,

The CIG: Yes, it is clear.

Researcher: Mm... Sister A, by the way you said you did quantitative research?

The CIG 1: Yes I did.

Researcher: For now, focus group discussion is a qualitative data collection method. When we talk about qualitative data collection, we mean, the data collection method whereby individuals (clearing throat) whereby err… you talk through words; you give verbal response to what is being asked, that is why it is far different from quantitative method in which you will be expected to use numbers to respond to the questions which are being asked. In hospital researches we mostly use quantitative research when you are expected to rate the events or the care that is being rendered. What can you add sister A?

The CIG A: mm… the quantitative research…err… a survey?
Researcher: mm… Yes, it can be a in a form of a survey. Do you have any survey in a hospital which the patients are allowed to rate the care rendered?
The CIG C: I know of a discharge summary.
Researcher: Is it…sister?. Are you using it in the maternity ward?
The CIG 2: Yes, we do use it.
Researcher: In a qualitative form the patients will not rate but they will talk and voice their feelings or experiences regarding the care rendered and the results will undergo an analysis and be classified at the end. Do you see how totally different that will be?
The CIG D: mm…We will be learned at the end. We will be led by you neh sister? What else do you have to ask from Sister? (The CIG were quiet).
The CIG A: Thank you Sister Jiyane (M).

ANNEXURE J 1 (2)

VERBAL GROUP REFLECTION AND MEMBER CHECKING: POST DATA ANALYSIS

VERBAL GROUP REFLECTION AND MEMBER CHECKING: POST DATA ANALYSIS

Intentions: To acknowledge the CIG who involved in the data collection, importance of the data collected and the findings of the phase.
Researcher: Good afternoon, how are you?
The CIG: (as a group uttered) we are fine.
Researcher: I am fine thank you. The last time when I was here we had the raw data that we collected through the focus group discussions, and you gave us, me, sister A and sister D, sister… yes we were 3, you assigned the responsibility to see to it that the data is analysed, and that was done successfully. The data gave us the following 5 themes. We will be mentioning the themes individually, together with their subthemes, and these themes are the ones which will be used to derive the strategies which we intend to derive for the study. The first theme read as providing quality midwifery care to the woman during childbirth. These was derived from your verbatim of actual words whereby you indicated that you think quality care should be given and the following were the subthemes which are derived from the data, from these theme like First one is understanding the concept of quality in midwife care, because quality can be in many ways depending on what subject is being discussed. They included creating a risk and harm free midwifery environment, whereby we intend that no woman should be exposed to any risk or harm while admitted in the maternity ward. The third one under the theme of quality is the enhancement of safer child birth initiatives. This is where you indicated that every woman who is admitted in this ward should be cared for according to the better birth initiatives, whereby they sustain no harm while they are under our care. Theme 2 – preserving the holistic wellbeing of woman who undergoes childbirth. This is where we indicated that all the women who are admitted to the maternity ward should be physically safe while under our care, you agreeing with this?
The CIG: (The response from a group of people) Yes.
Researcher: OK. You indicated that the environment hygiene is very important. You also came up with therapeutic touch that the woman who is being touched therapeutically by me as a midwife will feel safe, and that is part of the holistic wellbeing of a woman. The provisioning of health education was indicated as very important by you to this woman who has been admitted in the maternity and OK, the next one is addressing the physiological aspect of care during child birth whereby you indicate we should guard our tongues when we talk to this women, we should not talk anyhow, we should not insult them, we should not harm them emotionally because when we talk bad things they will be affected emotionally. The third one is visualizing the woman as part of the family, no woman is born from isolation each and every woman who is being admitted is part of a certain family and that is why it is important for us to involve the family the woman leaves with in the care of the woman we are taking care of. Developing effective interpersonal skills just means that we should have harmonious relationship with the woman who we admit to the Maternity ward. Consideration of women as unique beings was highlighted. That is, we should not treat one woman the same as the other since no one is the same as the other. We should consider that

everybody is like herself in the Maternity ward and that is why we should try to hear from each and every individual as to how he or she expects to be cared for while she's under our care in the Maternity ward. Upholding professional practice to improve midwifery care also came up. We should make sure that as midwives we make ourselves as skilled as possible by making sure that we are empowered while we are rendering care to the women during childbirth. This can happen in a form of in-service training through workshops, seminars and conferences and so on. Applying companionate care also came up. That is, we should make sure that the emotions of every admitted woman are taken care of, we should empathize and sympathize with them. Is it what you said colleagues?
The CIG: (others Laughing) yes
Researcher: OK portraying acts worthy of professional image indicated that as midwife we should try to at all times we should try to as all times ….err… Sister "A" "you are disturbing me" (said jokingly).
The CIG: (group) laughing.
Researcher: OK, Through companionate care we sympathize with these women for example, a woman who is under stress. Let me just say that maybe it happened that the baby is no more alive, we should put ourselves in the shoes of this woman, and we should understand what she is going through and treat her appropriately. And then, the forth one is maintaining ethical midwifery care throughout childbirth by promoting beneficence. We indicated that beneficence, means "*doing no harm*". By the way what type of harm can we do to the women while they are in our ward, while they are admitted under our care?
The CIG A: We can, we can shout at them and beat them.
Researcher: yes according to sister A's report that says some women were physically assaulted. (researcher laughing). Yes, the report says women are clapped while delivering in the Maternity ward. Shouting at them is not ethically allowed because you injure them physically. Another form is by portraying respect towards birthing women, how can we show respect? … how can we show respect towards them? You indicated these during the interviews.
The CIG D: Like by not discriminating against them.
The CIG C: You treat them with gentleness.
The CIG F: And also comfort her like…
Researcher: You give comfort to them? Comfort in which way?
The CIG B: Maybe if the person feels pain you give them pain medication.
Researcher: Thank you. That is what you said, what more?
The CIG B: Privacy.
Researcher: Huh! What can you say about it?
The CIG B: Maybe if the person needs privacy and like… eh…
Researcher: OK, like If she says "*I will like to be alone for now*"

The CIG E: Exactly.
Researcher: You respect that and then what happens? What more can we say? What about the screens, the curtains? "*I am in here naked*?"
The CIG E: We don't expose them.
Researcher: We promote acts of justice. That is where discrimination came in and encouraging women child birth rights, we know that all women have rights and we respect those rights. We addressed issues of commitment to provide ethical midwife care all times. We make sure that we give care that is ethically allowed. Then number 5, barriers towards professional value driven midwifery care. You indicated that you experience lack of resources like what, what lack of resources you are experiencing?
The CIG B: Shortage of staff.
Researcher: And you said that it makes your work tiresome and very stressful if there is no staff.
The CIG F: Equipment.
Researcher: You indicated issues of equipment, issues of medication. Thank you. Barriers towards professional value-driven midwifery care also came up like aspect on companionship whereby you indicated that a woman has a right to have someone next to her while she is giving birth, it can the partner or it can be sibling it can be even be the parent.
The CIG: Yes (more than one the CIG)
Researcher: I am tired of talking who can take over from me? (Silence). (Researcher continued). OK, the role of culture. You indicted that human beings or the women who are admitted in the maternity ward belong to specific culture, which is different from one women to the other, and as such that forms barriers. You indicated that some barriers occur where women come to the maternity with problems like what? (no the CIG' responses and she continued). Ok… problems like having ingested herbal medication with effects that becomes a problem to you. This are the findings. (A comment from the researcher). "*You seem to be very tired today?*

The CIG: Yes. (Said by more than one the CIG) The CIG B: Yes, it has been a long day.
Researcher: I agree. This is what we did the four of us. We sat down and at the end we came up with these themes and their subthemes. We will hear from you as to how to address the chapter on the presentation and the discussion of the findings of the study. I thank you for everything.
The CIG E: Thank you.
Researcher: Sister A, sister D, you seem to be very tired today but thank you.

ANNEXURE J 1 (3)

REFLECTIONS POST THE ACTION PHASE LEADING TO THE DEVELOPMENT OF THE AUDIT TOOL

REFLECTIONS POST THE ACTION PHASE LEADING TO THE DEVELOPMENT OF THE AUDIT TOOL

The CIG D: OK colleagues, before we close chapter 3, mm… I realize that the QIP standard 1.1.1 page 87 which is a problem to us during accreditation has not been addressed as a stand-alone item and this is my concern. We suggest to use the contents of the QIP which led to our underscoring during the National core standards to address the problem. Due to the issue of time since I can see that mm… time is not on our side. I request each of you to go and list items that you think will address the item fully, bring your views back to me before the end of next week. We will handle your inputs and will give report at the end of the next meeting and we will take it up from there mm…? I think that will be the best way to approach it do you agree colleagues?
The CIG: (as a group) Yes.
Researcher: Ok… sister A, Err… Sister are you saying we should address it individually and then we submit the comments to you?
The CIG D: Yes, I think it will be best for everyone. It's like you can go home and write those items down. Yes.
Researcher: OK .Thank you Sister A.
The CIG A: Thank You.

ANNEXURE J 1 (3) 1

INDIVIDUAL WRITTEN REFLECTIONS

INDIVIDUAL WRITTEN REFLECTIONS

REFLECTIVE DIARY PHASE 1:

Name: [redacted] **Position:** ITE

Topic: **Towards professional value-driven midwifery care: a Cooperative Inquiry research approach**

Instruction: Based on the verbal discussions to clarify the analysed data you are requested to reflect on the items listed below.

1. I was involved in the planning of the project

Describe/elaborate

- The project was explained clearly to me and consent was obtained before it started.
- I was given time to ask question before signing the consent form.
- I was told the reason of my involvement in the project

2. As part of the focus group I found the interviews to be:

Describe/elaborate

- educational and straight to the point
- eye opening and reminding me of my professional ve
- encouraging and promote effective balance towards the patients and colleques!

3. The time management disturbed /did not disturb my normal working hours

Describe/elaborate

- My work was not disturbed because proper planning was do
- I was told in time so I can arrange my programm
- Time frame was managed effectively.

4. Thoughtfully analyse the interviews: how were your feelings regarding the phase/ are they a true picture of the interview proceedings?

Describe/elaborate

- It was a true picture because it tackled my daily act
- Most of the things are my daily duties and it helped me to rectify my mistakes along the way.
- It reliabilitate and remind me of my Professional Pledge.
- It helps me to remember patients rights first before my mem

5. Based on the analysed data, use the given themes to elaborate and reflect on the categories which emerged.

* Ensure physical well-being and ~~the~~ Psychological well being

1. I always promote and provide health education to my patients
2. Re-assurance and give good care Spiritual and Psychologically.
3. I always listen Carefully and give patients good feedback about their well being.
4. I am always respectfull and treat every patient equally
5. Good interaction between patients and built long term relationship.
6. I always ask consent and ~~(illegible)~~ acknowledge their culture
7. I always maintain professional secrecy by not disclosing their Status or discuss their attitude with other people
8. Ensure patients safety in all the spheres
9. I am always preventing infection by maintaining Standard precautions
10. Report any faulty and fixing good Care of working equipment.
11. Use myself as a healing tool therapeutically by touching and re-assurance.

Signature: _____ Date: 29/03/16.

Researcher's signature: _____ Date: 29/03/2016

Manager's signature: _____ Date: _____

Reflection: Phase one Date: May 2016

Here's what. So what? Now what?

Data Discussion Protocol

1. Here's what. (5 minutes)

Factual statements

SAFE - EFFECTIVE CARE
There is a malpractice ongoing - especially with emphasis to neonates. They need care so the feeling is that there is no enough care given to=quality.
INFECTION CONTROL = is not practiced

2. So what? (5 Minutes)

Interpretations of the data.

X1 nurse - even if registered - cannot in a practical situation - nurse more than 12 neonates alone - it means somewhere there no quality of care given. The space is congested, you cannot nurse neonates in a small congested space - with different diagnosis - there is a high rate of infection coming in babies who are fed - neglect - needs time to be given attention - so if you are alone you can't do everything

3. Now what? (5 minutes)

Action Plan

① INFRASTRUCTURE = Nursery on its own is a need need to have a real structure for nursery.
② Human Resource: There organization to hire more staff - it has long been pleaded with that - If in real we need quality of care.
③ Workshops + In service Trainings: We need them but because of shortage of staff most nurses misses them also as a result you end up with a nurse that does not know what they are doing

Name/number [redacted] Date: 12 May 2016

ANNEXURE J 1 (4) 1

REFLECTIONS OF THE PLANNING PHASE, PHASE 2 (AFTER MEMBER CHECKING)

REFLECTION OF THE PLANNING PHASE, PHASE 2

(AFTER MEMBER CHECKING)

Researcher: Good morning colleagues. How are you? Good morning colleagues. How are you?
The CIG: Fine thanks. How are you? (In numbers)
Researcher: I am fine thank you. It's a pleasure for me to meet you. To you I'd like to say please continue to be free, there is nothing new. We will be dealing with reflection of what we did in phase two. When we reflect by looking back at what we did and we as questions like what is it that we did, how did we do it and what was the purpose of doing what we did. Are you with me? According to the plan you came up with after phase one, you said in order to make people aware of what we have been up to, we need to come up with workshops or use our teaching programs. Since we did not follow the route of going out, we agreed that it will be done in the maternity due to constrains we are experiencing. **What is it that you can say you benefited from the presentations?**
The CIG C: I can say partnership.
Researcher: What can you say about partnership, sister? Please elaborate further.
The CIG E: I benefited professional values and I also learned to work together with my colleagues.
Researcher: Since you worked together with the staff from University of Pretoria you benefited a lot. What more can you say you benefited from the presentations?
The CIG D: Taking care of the woman is very important, handling and communication with her during the delivery process is also important.
Researcher: Tell us how and why it is important to communicate with the patient during labour.
The CIG C: It is important because she must be involved in the decision-making during the process, and when there are any complications you tell her so she can know what is happening and reassured that the problem has been solved.
Researcher: I hear you when you say the patient must be reassured of the situation has been solved. You also work together during the process you don't say the task was not assigned for you.

The CIG C: Involvement of the patient during decision-making in delivery in case she won't allow you to take her blood and to reject injectable. You need to explain to her that it is procedure and indicate why you need to take her blood.
Researcher: Thank you for your contribution. Today's session is very short but very important. We will tackle the other topic next time when I come back. **Researcher:** Thank you for your contribution. Today's session is very short but very important. We will tackle the other topic next time when I come back.

ANNEXURE J 1 (4) 2

REFLECTION OF THE PLANNING PHASE, PHASE 2 (AFTER MEMBER CHECKING)

REFLECTION OF THE PLANNING PHASE, PHASE 2 (AFTER MEMBER CHECKING)

Researcher: Good morning colleagues. How are you? Good morning colleagues. How are you?
The CIG: Fine thanks. How are you? (In numbers)
Researcher: I am fine thank you. It's a pleasure for me to meet you. To you I'd like to say please continue to be free, there is nothing new. We will be dealing with reflection of what we did in phase two. When we reflect by looking back at what we did and we as questions like what is it that we did, how did we do it and what was the purpose of doing what we did. Are you with me? According to the plan you came up with after phase one, you said in order to make people aware of what we have been up to, we need to come up with workshops or use our teaching programs. Since we did not follow the route of going out, we agreed that it will be done in the maternity due to constrains we are experiencing. **What is it that you can say you benefited from the presentations?**
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ANNEXURE K

COPIES OF CIG DEVELOPMENTAL SESSIONS

COPIES OF CIG DEVELOPMENTAL SESSIONS

2018/11/02

DEVELOPMENT SESSION 1

Topic: Participatory Action Research.

Participatory Action Research.

- Develops the participants' critical thinking and problem solving skills, while
- advancing their professional development

Participatory Action Research.

- It is particularly suited to the care contexts
- - its nature to working with communities who are involved to improve clinical
- practice.
- - it is well suited to bridging the gap between evidence and practice.
- - it will provide you as participants with the opportunity to learn through critical (and
- self-critical) collaborative inquiry.
- -

- THE END

Participatory Action Research.

- Participants will come up with processes that encourage self -evaluation and
- - engage in participatory problem solving.
- They will identify and quantify problems, to then devise effective solutions so as to resolve the existing problem on their own.

1

DEVELOPMENT SESSION 2

Topic: Values clarification

Values clarification process

3. ACTS:

6. **Make the choice part of one's behaviour**
7. **Repeats** the choice.

Values clarification

1. CHOOSES

1. **Choose** and prioritize alternatives AND be open to alternatives.
2. **Careful consideration of the consequences** .
3. **Communicate** why you made such a choice to your colleagues.

References

- Uustal, D.B. 1978. Values clarification in Nursing. Application to practice. The American *Journal of Nursing*, 78(12), 258-263.

Values clarification

2 PRIZES:

4. Are you **proud of and happy with the choice.**
5. Are you willing to **affirm the choice publicly.**

1

ANNEXURE L

COPY OF DECLARATION FOR DATA STORAGE

COPY OF DECLARATION FOR DATA STORAGE

Protocol No 232/2015

No 11: Principal Investigator(s) Declaration for the storage of research data and/or documents

I, the Principal Investigator: Jiyane PM
of the following study titled : **Towards professional value-driven midwifery care: A Cooperative Inquiry research approach.**

will be storing all the research data and/or documents referring to the above mentioned study at the following address: Faculty of Health Sciences, Nursing Department, 8th Floor.

I understand that the storage for the abovementioned data and/or documents must be maintained for a minimum of 15 years from the commencement of this study.

START DATE OF STUDY: 30 August 2012

END DATE OF STUDY: 30 August 2016

UNTIL WHICH YEAR WILL DATA WILL BE STORED: 2031

Name: Priscilla Mmatholo Jiyane

Signature: 

Date: 26/06/2015

COMMITMENTS AND RESPONSIBILITIES OF SUB- INVESTIGATORS
REQUIRED FOR RESEARCH THROUGH THE FACULTY OF HEALTH SCIENCES RESEARCH ETHICS COMMITTEE, UNIVERSITY OF PRETORIA

DECLARATION BY INVESTIGATOR:

I agree to **personally** conduct or supervise the described investigation.

I understand as sub-investigator that I **am totally responsible** for aspects of the study delegated to me by the Principal Investigator and am legally bound by the contract signed with the sponsor and **will not inappropriately delegate** my responsibilities to the rest of my study team.

I have read and understand the information in the investigator's brochure, including the potential risks and side effects of the drug.

I agree **to ensure** that all associates, colleagues, and employees assisting in the conduct of the study are informed about their obligations in meeting the above commitments, without relinquishing my **total** responsibility for the study.

I confirm that I am **suitably qualified and experienced** to perform and/or supervise the study proposed.
I agree to conduct the study in accordance with the relevant, current protocol and will make changes in the protocol only after approval by the sponsor and the Ethics Committee, except when urgently necessary to protect the safety, rights, or welfare of subjects.

I agree to inform any patients, or any persons used as controls, that the drugs are being used for investigational purposes and **I will ensure that the ICH GCP Guidelines and Ethics Committee requirements relating to obtaining informed consent are met.**

I agree to timeously reporting to the sponsor and Ethics Committee adverse experiences that occur in the course of the investigation according to the time requirements adopted by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

I agree to maintain **adequate and accurate** records and to make those records available for inspection by the appropriate authorized agents, be it EC, FDA or sponsor agents.

I agree to comply with all other requirements regarding the obligations of clinical investigators and all other pertinent requirements in the Declaration of Helsinki and South African and ICH GCP Guidelines and am conversant with these guidelines.

I agree to inform the Ethics Committee in advance should I go on leave together with an agreed plan of action regarding an alternate principal investigator or sub-investigator to take responsibility in my absence.

I understand that the study may be audited at any time and that deviation from the principles in this declaration will be put before the Ethics Committee for action, which may include disqualification as an investigator and rehabilitation before being accepted as an investigator in other studies.

I confirm that there is no conflict of interest whatsoever in my participation in this study. I have no shares in the sponsoring company and my participation and interests are as defined in the financial agreement.

NAME (Printed)	SIGNATURE OF PRINCIPAL INVESTIGATOR	10/07/2015 DATE
NAME (Printed)	SIGNATURE OF SUB-INVESTIGATOR	DATE

7

ANNEXURE M

EXTRACT OF XXX HOSPITAL QUALITY IMPROVEMENT PLAN (QIP) 2015

ANNEXURE M: EXTRACT OF XXX HOSPITAL QUALITY IMPROVEMENT PLAN (QIP) 2015

Risk Rating: V Standard: 7.4.1 **The buildings and grounds are kept clean and hygienic to maximise safety and comfort** Measure: 7.4.1.2.1 Cleaning materials cloths / dusters / scourers and chemicals and equipment are available and stored in an appropriate safe lockable area / with clear labels for equipment used internally and externally Notes: 16/23	Identify a lockable cupboards to store cleaning materials	OPM and Cleaners	September 2015	**Not yet closed**
Risk Rating: E **Standard: 1.1.1 Patient are treated in a caring and respectful manner by staff with the appropriate values and attitudes** **Measure: 1.1.1.1.1 Patients are interviewed to assess whether they feel that they have** **been treated in a respectful and caring manner** Notes: 9/15	**Strengthen the importance and adherence to customer care policies**	OPM and HRD	August 2015	Awaiting schedule from HRD
Risk Rating: E **Standard: 2.4.2 The care rendered to patients with special needs contributes to their recovery and well-being** Measure: 2.4.2.6.2 In units where children are cared for	Ensure acceptable water temperature and the rest are not applicable in maternity	OPM and maintenance	September 2015	**Awaiting maintenance people**

specific safety precautions are in place to prevent harm e.g. covers on power points/barriers/cotsides/child resistant cupboards/safe water temperature/doors with high handle/window safety catch Notes: Only newborns				
Risk Rating: E Standard: 2.6.4 Strict infection control practices are observed in the designated feed preparation areas to prevent infection Measure: 2.6.4.1.2 Personnel working in the feed preparation area wear protective clothing including gowns/plastic aprons/ gloves/ masks and hair protection Notes: No evidence	Discuss the milk room challenge with management	OPM, corporate	September 2015	The CEO requested the OPM in Maternity to order all the required equipment for the Milk room

ANNEXURE N

HOSPITAL XXX SCENARIO, A MODIFIED ESMOE DRILL

ANNEXURE N: HOSPITAL XXX SCENARIO, A MODIFIED ESMOE DRILL

Maternity ward

The following patient arrives in the Maternity ward wheeled by a porter. On her arrival in the ward you realise that she was pushed hurriedly because she told the porter that something was "coming out of her private area".

Two midwives received her, pushed her to the labour room and started preparing immediately. While they were busy they realised the following:

- She is young, a primi-gravida and was un-booked.
- Spent less than thirty minutes at the Casualty where the doctor's notes revealed that she thought she will get a chance to go home to deliver there following her **family traditions and practices.** The notes also highlighted her other concerns as follows: "Will you give me a **remedy" to lessen the pain**? The notes further revealed that her belongings had **an old piece of half split river-bank reed** which she kept as an instrument to clip the baby's cord. She verbalised that the reed is passed on to any next female member of her household who give birth and the reason thereof is that it protects bleeding from the baby's cord as that may lead to the baby's death. Her final plea was to **be given the placenta** since that is important for her future **deliveries.**

The young woman cooperated well with the midwives in the Maternity ward and had a normal verted deliver but unfortunately had a retained placenta. Indicate how you will manage this woman based on the following:

- physical wellbeing
- Psychological wellbeing and the
- Spiritual wellbeing.

The responses of the midwives put in simpler and understandable terms

Health education: physiologic natural cleansing of the woman's uterus (different stages of lochia).

- Suturing of the area which was cut during the delivery.
- Sitting in slightly warm water that contain any healing solution like Dettol, Savlon and even table salt.
- Frequent pad changes.
- Early movement by walking around.
- Health education: Breastfeeding, baby care and pain management.
- Record keeping with the woman or the family member's signature.

Psychological wellbeing

Reassurance: Reassurance that all is well and congratulated her for doing well throughout the delivery.

Cultural-Spiritual wellbeing

- Indication that cultural practices and beliefs are acceptable as long as they do not put her life and that of her baby in danger.
- Advice the woman that the usage of all equipment which are brought from home is not acceptable due their unsterile nature which might cause poisoning of the baby's blood.

Compiled by CIG representatives

ANNEXURE 0

RECORD DEPICTING DECREASED PROFESSIONAL VALUE-DRIVEN MIDWIFERY

RECORD DEPICTING DECREASED PROFESSIONAL VALUE-DRIVEN MIDWIFERY

XXX DISTRICT-COMPLAINTS PROFILE

FACILITY: XXX HOSPITAL, MATERNITY WARD

PERIOD: NOVEMBER 2014

CLASSIFICATION OF COMPLAINTS

1. Hospitality/Hotel services
2. Staff (incudes attitude
3. Clinical
4. Environmental /Infrastructure
5. Communication/ Information
6. **Advocacy**

NATURE OF COMPLAINTS	DATE RECEIVED	MEASURE TO RESOLVE	RESOLVED YES/NO	REFERRED TO NSM'S OFFICE YES/NO	DATE
Assault of patient by staff. The client identified certain nurses who assaulted her during the delivery at night and she even lost her baby.	13/11/2014	Offence indicated to them if really committed as the patient indicated	No	Yes	17/11/2014

Compiled by: ---------- **Date:** ----------

ANNEXURE 0 1

RECORDS DEPICTING DECREASED PROFESSIONAL VALUE-DRIVEN MIDWIFERY

RECORDS DEPICTING DECREASED PROFESSIONAL VALUE-DRIVEN MIDWIFERY

NKANGALA DISTRICT-COMPLAINTS PROFILE

FACILITY: XXX HOSPITAL, MATERNITY WARD

PERIOD: JANUARY 2012

CLASSIFICATION OF COMPLAINTS

1. Hospitality/Hotel services
2. **Staff (incudes attitude**
3. Clinical
4. Environmental /Infrastructure
5. Communication/ Information
6. Advocacy

NATURE OF COMPLAINTS	DATE RECEIVED	MEASURE TO RESOLVE	RESOLVED YES/NO	REFERRED TO NSM'S OFFICE YES/NO	DATE
Staff attitude	27/01/2012	Discussion held with relatives who were complaining about the attitude from the night staff and they promised that the matter will be rectified with the relevant staff members.	No	Yes	27/01/2012

Compiled by: ---------- **Date: ----------**