The Study to Investigate
the Challenges that face
the Trained Midwives in the Workplace
during the 21st Century in
Ethekwini Region of
KwaZulu-Natal

By

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SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR
THE DEGREE OF M.CUR

NURSING DEPARTMENT
UNIVERSITY OF ZULULAND

SUPERVISOR : PROFESSOR D NZIMAKWE
SUBMITTED : APRIL 2003
DURBAN
The Study to Investigate the Challenges that face the Trained Midwives in the Workplace during the 21st Century in Ethekwini Region of KwaZulu-Natal

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TO WHOM IT MAY CONCERN

EDITING OF DISSERTATION

This is to certify that I have edited the dissertation entitled *The study to investigate the challenges that face the trained midwives in the workplace during the 21st century in Ethekwini region of KwaZulu-Natal* submitted by Mrs ELLEN NOMANDLA MPANTSHA to the best of my ability and declare it free of language errors.

Drs M M SPRUYT

BA Hons MA D.Litt

April 2003
DECLARATION

I, ELLEN NOMANDLA MPANTSHA (née Pepeta) declare that

The Study to Investigate the Challenges that Face the Trained Midwives in the Workplace during the 21st Century in the Ethekwini Region of KwaZulu-Natal.

is my own work, and that all sources used or quoted, have been indicated and acknowledged by means of complete references.

E.N. MPANTSHA
DEDICATION

This work is dedicated to the following:

- My late mother and father who continuously instilled in me a spirit of learning from childhood to adulthood.

- My loving, caring husband, MANDLAKAYISE TEMPLETON MPANTSHA for his undivided support, encouragement and patience.

- My loving children MONDE, SIYABONGA, NOSIPHO and MELUSI for their support and encouragement.
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ACKNOWLEDGEMENTS

I express my sincere gratitude to the following people:

➢ Professor D. Nzimakwe, my supervisor, for her motivation, support, guidance, mentoring and patience during the process of mentorship.

➢ The Heads of Department of Health (both at Provincial and Regional levels) for allowing me to conduct this study at their hospitals and clinics.

➢ The Superintendent of King Edward Hospital for granting me the permission to conduct the research study at the institution.

➢ The nursing managers-in-charge of Prince Mshiyeni Memorial Hospital, Inanda Newtown A and C clinics, KwaMashu Polyclinic and Umlazi D clinic.

➢ The practising midwives of the hospitals and clinics, who participated in the research study.

➢ Mrs Val van Rooyen for her dedication and tireless work with typing of this dissertation, which contributed to my success.

➢ Finally, I would like to thank the “ALMIGHTY” for knowledge and perseverance I was able to complete this research study as the He sustained me during collection of data from different clinical settings.
ABSTRACT

The purpose of the research study was to explore the knowledge of the trained midwives regarding the problems and challenges that face them in the 21st century workplace.

Aim of the Study

The aim of the study was to explore the perceptions of the practising midwives regarding the challenges they face in their practice, with the intention of identifying them and implementing a system whereby these challenges can be addressed.

Objectives of the study

The objectives of the study were:

➢ To explore the knowledge of midwives regarding the problems which occur in their practice.

➢ To identify the challenges that are being faced by the trained midwives in their practice during the 21st century from their own perspective.

➢ To develop guidelines regarding the solutions that can be implemented so as to address the midwifery challenges of the 21st century.
Sample and sampling

The sample of the study was ninety trained midwives working at the two hospitals and four comprehensive health care clinics in the Ethekwini region of KwaZulu-Natal.

Both convenient and purposive samplings were used in the selection of the subjects for the study.

Both descriptive and qualitative research methods were used in collection of data.

Findings of the study

Findings of the study were:

➢ A problem of lack of specification regarding the number of pregnancies terminated by the client has an impact on the government’s finance, taxpayers’ money (including the midwife’s).

➢ The impact of both free maternal and child health services and government grant for single mothers contribute to increased teenage pregnancy rates, whilst the practising midwives are already short-staffed.

➢ Health projects that have been added to practising midwives’ tasks without additional staff contribute to substandard care often leading to clients laying charges against the midwives.

➢ Respondents felt that they are practising under poor working conditions.
The midwifery scope of practice limits the functioning of the current midwives faced with the problems of 21st century, while there is no such scope available for an advanced midwife.

The poor communication due to the attitudes of doctors at the referral hospitals that impacts on both the lives of the mother and the foetus, have legal implications for the practising midwives.

Overworked midwives suffer from burnout syndrome, which impacts on interactions between them and relevant stakeholders in the midwifery practice.

A number of inexperienced midwives allocated in labour wards do not understand partograph.

Some of the Four Year Comprehensive Course qualifiers feel that the six months’ midwifery module in the third year of training leaves them with limited skills.

The slow progress in implementation of the Perinatal Education Programme in the Ethekwini region also contributes to inefficiency of the midwives.

Lack of well equipped skills laboratories at the colleges impacts on the competencies of the qualifiers as they also lack mentorship.

Lack of student accompaniment by the nurse educators impacts on the qualifiers’ competencies, as the experienced professional nurses are currently limited in the workplace.

The respondents in this study were all computer illiterate.
➤ Violence in the community has an impact on the functioning of the health care facility.

➤ The brain drain of experienced midwives for greener pastures contributes to substandard care in the clinical settings.

➤ Unawareness of the public about the time and the type of services rendered by their health care facility impacts on both the lives of the mother and the foetus.

➤ The problem of confidentiality about HIV-positive mothers included in the Nevirapine project impacts on the mode of feeding the babies, leading to diarrhoea.

➤ Midwives feel that some HIV-positive mothers are confused about the action of Nevirapine.

➤ Midwives practising in labour ward are scared of getting infected with HIV/AIDS.

➤ Administration of a Maternity Department by the midwife without advanced midwifery competencies leads to both administrative and obstetric problems.

➤ Ignorance of traditional birth attendants contributes to increased maternal mortality rate.

➤ The attitude of practising midwives towards conducting research projects in their workplace impacts on midwifery practice.
Recommendations

Based on the findings of the study the following recommendations were proposed by the researcher:

➢ The obstetric matrons should mix the experienced midwives allocated in labour wards with a few inexperienced ones for better mentoring in order to prevent substandard care.

➢ Male students that are doing the Four Year Comprehensive Course should be allowed choices of modules, especially midwifery, as they have a negative attitude towards it, hence only 2% of male respondents were included in this study.

➢ An advanced midwifery trained person to promote an effective maternal and child health service to the clients must head the obstetric department.

➢ Rotational placement of trained midwives working in hospitals with those working in the clinics can improve midwives' competencies.

➢ Re-introduction of home visits is essential for rendering a holistic maternal and child health service to the community, thus reducing an influx at the clinical settings.

➢ Inclusion of the trained midwives and key community figures is essential when administrators are developing policies for better cooperation.

➢ Government must ensure safety of trained midwives allocated at the clinics as their lives are often at risk due to crime.
➢ The government must improve working conditions through provision of better salaries, crèches within the clinical settings, and empowering midwives with computer literacy. Supervisors should decentralise some powers to the unit nursing managers for better cooperation and to boost their morale. Career advancement is essential through continuing education, attending seminars, workshops, etc. especially in view of the prevalence of HIV/AIDS and the other “Big Five killers”.

➢ Revamping of the current midwifery curriculum is essential in order to address the health needs of the mother and child in the 21st century.

➢ Revamping of the current midwives’ scope of practice is essential as it is obsolete.

➢ Training of traditional birth attendants by the trained midwives is essential, in accordance with guidelines from National Health Department.

➢ Trained midwives must educate the public about accessing the termination of pregnancy facility.

➢ Confidentiality regarding the HIV-positive status of a pregnant woman who is part of the Nevirapine study has to be addressed as it impacts on the cooperation of these clients regarding feeding of their babies in the puerperal period.

➢ A common platform for all health professionals, traditional healers and community is essential in order to combat the “Big Five killers”.
The researcher recommends the adoption of the AIPAP model in order to fight AIDS.

Government should implement progressive strategies of training midwives in forensic nursing as they deal with victims of abuse.

Conclusion

Resulting from the results of the study it can be concluded that all practising midwives should strive for a safe midwifery practice and should possess competencies which are professional, ethical and legal and maintain a professional image. To achieve this goal they need support from the employer and the community, as well as the government.
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CHAPTER 1

1.1 INTRODUCTION

Midwifery practice is a component of the nursing discipline guided by the South African Nursing Act, Act No. 50 of 1978, regulation 2598. Regulations governing the midwifery practice in South Africa (SANC R1886 of October 1974, as amended by R2488 of October 1990) confer provision for midwives to carry out certain clinical skills and/or procedures either independently or under supervision of an obstetrician (Dolan, Fitzpatrick & Hermann, 1983:78).

Under the South African Nursing Council regulations, midwives deal mainly with normal aspects of midwifery care with limited abnormal aspects. However, the midwifery curriculum does not equip midwives with most of the skills necessary to deal with the number of complicated cases at the clinic level. The midwives are responsible for assisting all women during childbirth and as this is a most precarious experience for both the mother and the midwife, a single mistake can lead to lifetime disability of the baby or the mother, or even death. Therefore, extensive empowerment of the midwives with knowledge and skills of advanced technology is essential (Sellers (Vol. 1), 1997:xxxiii).

Women are the pillars of strength of their families, society and the country, with multiple roles as health care-givers, mothers and wives; yet they suffer from abuse and ill-health, while some of the midwives become infected with HIV, with detrimental results. Cultural practices also determine the lifestyles and habits of both stakeholders, i.e. midwives and health care consumers (Mhlanga, 1999:12).
Currently the midwives are faced with an increased maternal mortality rate of approximately 90% of 585 000 women who give birth every year (Mhlanga, 1999:12). In South Africa the "Big Five killers" were the main causes of maternal deaths in 1999, which are reflected as follows:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Cause</th>
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<tbody>
<tr>
<td>29%</td>
<td>due to AIDS</td>
</tr>
<tr>
<td>19%</td>
<td>due to complications of hypertension in pregnancy</td>
</tr>
<tr>
<td>15.4%</td>
<td>due to obstetric haemorrhage</td>
</tr>
<tr>
<td>13.9%</td>
<td>due to pregnancy related sepsis, which includes septic abortions and puerperal sepsis</td>
</tr>
<tr>
<td>7.9%</td>
<td>due to pre-existing maternal diseases, mainly cardiac diseases (The South African Second Interim Report on maternal deaths, 1999:3).</td>
</tr>
</tbody>
</table>

According to Mhlanga (1999:12) all these problems have an impact on the health status of the mother and child resulting in the increase of maternal and infant mortality rates. It is therefore imperative that attention be given to midwives' challenges regarding their experiences encountered in the clinical settings so as to improve the standard of care of pregnant women as well as the needs of the midwives. Hence in this study the researcher will discuss the challenges that face the midwives in the 21st century workplace, from the midwives' point of view.

1.2 BACKGROUND OF THE STUDY

Historically the midwives played supportive or assisting roles during the delivery of the women without interference of doctors' medical care (Dolan et al., 1983:78). Delivery of the baby was perceived as a basically natural process, not as a complicated
event as it is today, demanding appropriate referral systems for immediate medical intervention.

According to Mellish (1984:119) most of the practising midwives were not licensed, but worked mainly as birth attendants, until Dr James Prince acknowledged that midwifery training was essential, hence Sister Henrietta Stockdale was trained, although she never qualified. Later midwifery nursing was recognised as a profession of vital importance to the health of the nation and qualified midwives were registered with a statutory body, the South African Nursing Council (SANC), to ensure a quality health-care service. This indicates that midwives have a professional commitment and accountability to pregnant women, their families, and the nation holistically, regarding their actions and omissions.

Currently midwifery training is incorporated in the four-year comprehensive course, leading to the registration as a midwife (R425, as amended, and Mellish, 1984:123). Midwifery practice involves dealing with two lives (woman and foetus) as midwives function as independent practitioners in the peripheral clinics. Six (6) months training provides limited skills in clinical exposure, while limited expertise of qualifiers puts the life of pregnant women at risk.

1.3 MOTIVATION

The researcher is a registered nurse educator in the midwifery department, and a full-time employee at King Edward VIII Campus, situated within the Ethekwini Region of KwaZulu-Natal. Whilst conducting student accompaniment of all categories of midwives on training and during in-service education of midwifery nursing staff in the wards, the researcher developed an interest in
investigating the awareness of midwives with regard to challenges that are facing them during the 21st century, stemming from the observations of the researcher regarding the following:

➢ An increase in morbidity and maternal mortality rate.

➢ High risk of exposure to HIV/AIDS.

➢ Challenges in the legislation, like the Constitution of South Africa with the emphasis on the rights of the clients, which at times lead to litigation being brought against the practising midwives.

➢ Focus on awareness of midwives with regard to their challenges because the identified problems have an impact on quality care.

The quality of patient care is regarded as an important factor in preservation of life thus decreasing maternal morbidity and mortality rates.

1.4 DELIMITATION OF THE STUDY

The research will be limited to the practising midwives within the Ethekwini Region of KwaZulu-Natal, which might not be representative of the population of midwives employed by the KwaZulu-Natal Department of Health.

1.5 PROBLEM STATEMENT

The registered midwives practising within the Ethekwini Region are faced with complicated deliveries which impact on maternal
and neonatal deaths, concomitant ethical issues and issues of malpractice.

1.6 AIM OF THE STUDY

➢ To explore the perceptions of the practising midwives regarding challenges they face in their practice, with the intention of identifying them and implementing a system whereby these challenges can be addressed.

1.7 OBJECTIVES OF THE STUDY

➢ To explore the knowledge of midwives regarding the problems which occur in their practice.

➢ To identify the challenges that are faced by the midwives in their practice from their own perspective or point of view.

➢ To develop guidelines regarding solutions that can be implemented as to address the health challenges of the 21st century.

1.8 VALUE OF THE RESEARCH STUDY

➢ The research findings should reveal the challenges being faced by the midwives in the clinical setting, and recommendations will be made, based on the study.

➢ The status of the midwife will be improved, as she will be recognised as a member of a multi-disciplinary team.
The researcher anticipates dissemination of the research findings through publications, incorporation into the midwifery curriculum, presentations at seminars, etc.

1.9 THE SIGNIFICANCE OF THE PROBLEM

According to the Second Interim National Report on Confidential Enquiries into Maternal Deaths (1999) the “Big Five killers” are the cause of increased maternal deaths i.e. pregnancy related sepsis, non-pregnancy related sepsis, deaths due to AIDS and pre-existing maternal diseases.

The “Big Five killers” accounts for 85.8% of the maternal mortality rate. The increase in the maternal mortality rate is one of the greatest challenges that face the midwives, especially in KwaZulu-Natal. Findings show that when comparing the HIV prevalence of nine provinces of South Africa, KwaZulu was the highest, 32.5%, followed by the Free State, 27.9% and Gauteng 23.9% (Second Interim Report on Confidential Enquiries in Maternal Deaths in South Africa, 1999:14).

An increase in the formal education of the public has brought about public awareness of their constitutional rights, which have serious legal implications for the midwifery practice since there are two lives involved, i.e. that of the mother and the foetus (Chirwa, 2000). The question arises as to whether the midwives are equipped with the necessary knowledge and skills to manage complications of a pregnancy in the absence of the obstetrician.
1.10 DEFINITION OF TERMS

Midwifery
Midwifery is not just a service but also an art, being scientific, as well as a humanitarian discipline with a holistic viewpoint based on fundamental ethics of caring for mother and child families, and communities (Beischer & Mackay, 1988:721).

Midwife
According to several authors (Beischer & Mackay, 1988; Catalano, 1996; Sellars, 1997; Brucker, 2001 and Potgieter, 2002) a midwife is a trained woman both in science and the arts registered with the South African Nursing Council under Nursing Act 50 of 1978 and practise within a prescribed scope of practice. In this regard midwives should be committed to their work in order to fulfil their professional responsibility with integrity and protect their clients, families and communities through a holistic approach.

Advanced midwife
An advanced midwife is a midwife who is a clinical nurse specialist in midwifery, who has furthered her studies after the basic qualification of general nurse and midwife, registered with the South African Nursing Council (SANC R212 of February 1993, as amended by R74 of January 1998). This category of midwives is in demand in maternal and child health care services especially in rural areas where there is a shortage of doctors.

Traditional birth attendant
According to Nolte (1998:64) a traditional birth attendant is a middle-aged or elderly lady with no formal training, who acquired her skills through experience. She attends to women during antenatal periods, but being an untrained midwife she may fail to
identify signs of complications leading to an increase in maternal deaths.

**Doula**
A Greek word meaning a woman who helps women and who may touch, hold and support the labouring woman (Johnson & Johnson, 1996:13); MIDIRS, March 2002, 12:1).

**Private midwife**
A private midwife is a qualified midwife, registered with the South African Nursing Council as private practitioner. The interaction between the midwife and client is rewarding because of the relationship that develops, resulting in mutual understanding between the midwife and the client (Birthing Hands S6 – us4 html: 1 of 2 & 2 of 2).

**Reproductive health**
Reproductive health means making efforts to ensure that each pregnancy is carried out through to a successful outcome, i.e. a healthy and wanted child born to a healthy mother. For this to happen effective maternal and child health care services must be available, equitable and accessible to all women who need the service.

**Challenge**
A challenge is a demanding task in need of a solution (Fowler & Fowler, 1995:217). In this research study practising midwives are faced with stimulating, difficult tasks regarding 21st century maternal and child health issues which demand to be addressed by the midwives, employer and the public/clients.
21st century
According to Fowler and Fowler (1995:213) century is a period of one hundred years, reckoned from the birth of Christ hence the 21st century is equivalent to 2001–2101. In this regard the nursing profession is faced with indirect challenges like globalisation, empowerment and orchestration of technology indirectly, as midwifery practice is a component of the nursing profession.

Clinical setting
According to Fowler et al. (1995:246) a clinical setting is an area for treatment of clients or patients. In this study clinical setting is either the hospital or the clinic where the midwives as the population of the study, are practising.

Maternal death
Maternal death is death of a woman occurring any time from conception to six weeks post-delivery, including abortions, ectopic pregnancies, gestational trophoblastic disease and deaths non-related to pregnancy, e.g. motor vehicle accidents, other trauma and suicide (Pattison, 1997:8-11).

Levels of clinical settings
Primary: clinic or health centre manned by midwives without a doctor, but they consult the doctor at the referral hospital when problems arise.
Level 1 hospital: a hospital run by doctors generally with some visiting specialists.

Level 2 hospitals: the hospital has specialists that are always available and there may be intensive care facilities, which include ventilation.

Level 3 hospitals: the hospital has sub-specialists and full intensive care facilities (Pattison, 1997:849).

Batho Pele

Batho Pele is a Lesotho term that means "people first", the name given to the government's initiative to improve the delivery of public health services by ensuring that the first and foremost priority of the public servant is to serve all the citizens of South Africa. In this study midwives are public servants who have to meet this challenge through implementation of the principles of Batho Pele, which includes consultations, service standards, access, courtesy, information, openness and transparency, redress and value for money (Tshabalala-Msimang, 2002:18-19).

Domiciliary unit

In a holistic sense this refers to home confinements as ideal, since only normal deliveries are conducted at home and these are highly screened. There are obstetricians who avail themselves to screen these clients and if complications arise during pregnancy, labour
or puerperium, the midwives summon the doctors. In home confinements both midwife and pregnant women gain the satisfaction of care right through pregnancy and labour for as long as the mother requires the midwife's services in the puerperium. The private midwife qualifies for this service (Sellars, 1995:xxxiv, Birthing Hands S6 1 of 2 – ns4.html).

**Primary care in midwifery nursing**

According to Stanhope and Lancaster (1996:36) primary health care is essential health care made available universally to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and country can afford. It forms an integral part of the client, family and community health status. In this study the definition of Primary Health Care by the World Health Organization reinforces the necessity for its inclusion, as well as transcultural nursing, in the midwifery curriculum, to ensure that midwifery qualifiers deliver maternal and child health services that meet the needs of women, families and the country in order to reduce the increasing number of maternal deaths.

**Health promotion**

Behaviour or actions, which directly or indirectly influence the health of others, may include preventing ill-health of others, maintaining positive health, raising public awareness of health issues and protecting the public from sickness, by promoting healthy lifestyles. In this study health promotion for women is the challenge for midwives so as to address the increasing maternal
mortality rate and morbidity (MIDIRS Midwifery Digest, 2000:10(4))

1.11 THEORETICAL FRAMEWORK

King's theory of goal attainment will be utilized in this research study as it contains the interpersonal systems which are relevant to midwifery practice. This theory comprises the following concepts:

- Interaction
- Communication
- Transaction
- Role
- Stress.

King's theory of goal attainment which will be utilized in this study, which will be based on its hypotheses, which are as follows:

- Communication increases mutual goal setting between nurses and clients thus leading to satisfaction of both.
Goal attainment addresses stress and anxiety in the nursing situation.

Role conflict experienced by the patients, nurses, or both, decrease transaction in nurse-patient interaction (George, 1985:236-245).

1.12 RESEARCH QUESTIONS

What are the experiences and problems of the midwives in the clinical settings?

What measures can be applied to deal with such problems?

What is the impact of these problems on the midwifery practice, patients and communities?

1.13 PILOT STUDY

Six advanced student midwives who have just commenced advanced midwifery and the neonatal nursing science course will be selected for the pilot study.
The pilot study will facilitate finding out if the instrument tests what the researcher intends testing and will be done to detect operational problems of the questionnaire, tests for feasibility of the study and reliability of the instrument.

1.14 METHODOLOGY

1.14.1 Research design

This will be a descriptive, qualitative study to assess the views of the midwives regarding challenges that are facing them in their clinical settings in the 21st century.

1.14.2 Area of study

The population of the study will include all midwives practising at the clinics and hospitals of the Ethekwini region in KwaZulu-Natal, within the following boundaries:

- Tongaat in the north,
- Umkomaas River in the South,
- Camperdown in the West, and
- the sea in the East.
1.14.3 **Sampling**

Purposive random sampling will be implemented in selecting the midwives registered with the South African Nursing Council and practising at the clinics and hospitals in the Ethekwini region in KwaZulu-Natal.

1.14.4 **Ethical consideration**

➤ The permission for conducting the research study will be obtained from health authorities and relevant heads of the institutions by means of mailed letters.

➤ Respondents participating in the research study will be informed that participation is voluntary.

➤ Confidentiality will be maintained, names of the participants will not be written down, and coloured stickers will used to identify institutions and clinics.

1.14.5 **Data collection**

➤ Data will be collected from trained midwives, by means of questionnaires with both open- and closed-ended questions.
Where subjects fail to provide in-depth knowledge of their challenges in the workplace, focus group interviewing will be conducted using the same questions as the questionnaires.

- The purpose of the study will be explained to the participants by the researcher prior to distribution of questionnaires, also assuring them that participation is voluntary, and that collected information will be treated in confidence. The researcher will, where possible, distribute some of the questionnaires physically.

1.14.6 **Data presentation and analysis**

- Respondents will answer research questions from questionnaires provided and a summary of how data was collected and analysed, will be provided to the supervisor of the study.

- Biographical data will be presented in tables and analysis of responses to questionnaire will be presented in themes.

- The research findings will be recorded, and the researcher will draw conclusions and make recommendations at the completion of the research study.
1.15 SUMMARY

The research report will be organized according to the following chapters:

Chapter 1  -  Orientation of the study.
Chapter 2  -  Literature Review
Chapter 3  -  Research Design
Chapter 4  -  Data Analysis
Chapter 5  -  Discussion of Findings, Guidelines, Limitations of the Study, Summary, Recommendations and Conclusion.

1.16 CONCLUSION

An introduction to the study was presented in this chapter. This consisted of a background of the study, motivation of the study, delimitation of the study, problem statement, aims and objectives of the study, value of the study, significance of the problem, definition of terms relevant to the study, theoretical framework and organization of the study.
The next chapter will contain a literature review regarding challenges that face the trained individual in the workplace during 21st century.
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CHAPTER 2

LITERATURE REVIEW

2.1 DEFINITION OF LITERATURE REVIEW

This chapter presents a review of literature related to the challenges that are facing midwives in the workplace during the 21st century within the Ethekwini Region of KwaZulu-Natal.

According to Brink (1996:203) a literature review is a process that involves reading, understanding and forming conclusions about published research and theory on a particular topic.

2.2 INTRODUCTION

According to Polit and Hungler (1999:79, 80) literature review aids in gathering information and learning the current or existing findings from selected research studies. Mashaba and Brink (1994:296) also state that literature research alerts the researcher to unresolved problems or new applications suitable to the selected research study. The purpose of literature review in this study is to provide the researcher with information of what has already been identified as midwifery challenges.

Secondly, identified solutions to midwifery challenges in the 21st century will be brought to the attention of the practising midwives of the Ethekwini Region, in order to combat increased maternal morbidity and mortality rates.

This chapter entails the following: The role of the midwife (both basic and advanced midwife), historical development of midwifery practice, ethical aspects of midwifery practice, aspects of midwifery
education, aspects of midwifery practice (public and private), the theoretical framework (King's theory of goal attainment) and National Health Plan recommendations regarding maternal and Child Health Care Services.

2.3 THE ROLE OF THE REGISTERED (BASIC) MIDWIFE IN SOUTH AFRICA

2.3.1 Professional role

In South Africa all practising midwives register with the South African Nursing Council, thus protecting the public from medico legal hazards that can endanger the lives of mother and baby.

The maintenance of professional excellence, credibility and competence through continuing education remains the midwives' responsibility as they are responsible for their own acts and omissions (SANC Government Notice R425, 15/99:3).

2.3.2 Ethical role

Maintenance of the highest ethical standards in accordance with the ethical code of nurses/midwives is essential to a practising midwife. Therefore midwives must not be influenced by political, religious or racial considerations, e.g. when a client ask for a termination of pregnancy, the client should be granted access to the facility in spite of the midwife's beliefs (SANC, 15/99:2).

2.3.3 Provider/Collaborator/Facilitator role

Provision, management and facilitation of comprehensive maternal and child health services based on the scientific approach in the context of the primary health care approach, to individuals,
families and respective communities are essential. Accordingly the empowerment of midwives with skills on the scientific approach method will lead to insight in understanding of the importance of analysis, documentation, reporting and utilization of all relevant information appropriate to some pregnant women’s lives (SANC, 15/99:3).

The ability to render first aid measures during obstetrical emergencies is essential, even to basic registered midwives, and this competence is also a challenge to practicing midwives of the Ethekwini Region (SANC, 15/99, 1999:2, R2598 as amended by 260, 1991:2 and 3).

Establishment and maintenance of ethical partnership with other health care multidisciplinary members, to provide for collaborative planning and the implementation of integrated health care services to both the mother and the baby are important (SANC 15/99, 1999:2).

2.4 ROLE OF AN ADVANCED MIDWIFE

2.4.1 Role of advanced midwife as clinical specialist

The role of an advanced midwife includes a variety of responsibilities, for instance acting as a consultant at the peripheral clinics, which provide maternal and child health services by liaising with far-off clinics by means of two-way radio communication.

At the level one hospitals (where there is no doctor) the advanced midwife is also responsible for sharing the clinical care of clients in maternal and child health care services, including supervision of the family planning service.
The advanced midwife holds the responsibility of monitoring overall counselling of HIV-positive patients and clients requesting termination of pregnancy (SANC, R212, 1993:18 and 31). In this study the question is: Does the advanced midwifery curriculum equip the students with extensive training of counselling skills (SANC R212, 1993:20)?

As a senior member of staff, the trained advanced midwives conduct perinatal mortality meetings and attend journal clubs for staff development and prevention of the morbidity and maternal mortality rates. An advanced midwife also continues her education as a means of self-empowerment in order to empower others.

2.4.2 **Role of advanced midwife as an educator and trainer**

An advanced midwife also trains members of the staff, patients and doctors during internship according to the demand of their knowledge deficit. She also conducts in-service training of community health workers, traditional birth attendants, and primary health care nurses according to her competence. In this study the question is: Does the advanced midwifery curriculum equip the students with primary health care, in-depth knowledge and skills?

As a senior member of staff, the trained advanced midwives conduct perinatal mortality meetings, clubs for staff development and prevention of the morbidity and maternal mortality rates. The advanced midwife also continues education as means of self-empowerment in order to empower others.
2.4.3 **Role of advanced midwife as an administrator**

The role of the trained advanced midwife includes facilitation of proper functioning of maternal and child health care services through designing protocols and maintaining and monitoring of implementation for effective patient care. The advanced midwife is also responsible for controlling human and material resources and monitoring of both resources including the staffing of the health care clinical setting (SANC R212:19).

2.4.4 **Role of an advanced midwife as a researcher**

The advanced midwife has a responsibility to prioritise the health care needs of the maternal and child health care service under her supervision. An advanced midwife also has the responsibility to conduct situational analysis of her facility, including the community under her health care service in order to identify epidemiological markers like teenage pregnancy, etc.

The advanced midwife also has responsibility to design research protocols. In this study it is the responsibility of an advanced midwife to publicize the findings and utilize them in improving patient care (SANC R212, 1993:20).
3 HISTORICAL SERVICES DEVELOPMENT OF MIDWIFERY

3.1 A GLOBAL OVERVIEW OF THE MIDWIFERY DEVELOPMENT

3.1.1 Pre-Christian era

According to Sellers (1998:19) and Dolan, Fitzpatrick and Herrmann (1983:19) during ancient times old women demonstrated a natural caring concern for human life, from conception to death, as they acted as birth attendants. These women were either from the family or from the community, with experience in childbirth, and they rendered services without payment other than ‘presents’.

To date this practice remains virtually the same except that there are no ‘presents’. The professional midwives are beginning to recognize the importance of the traditional birth attendants, although this is still in its infancy. South African midwives are faced with a challenge of training the traditional birth attendants in order to combat the increase of maternal morbidity and mortality rates.

The Hebrews and Egyptians were the first ones to realize the value of midwifery training, although it was limited to basic knowledge of anatomy, physiology and skills on management of women in labour, like preservation of warmth by using swaddling bands. Today, the Kangaroo method is a challenge for the current practising midwives in South Africa.

Greek laws in which midwives were to summon medical assistance when complications arose governed midwifery practice. The SANC
R2488, 1990 & R2598, as amended, stipulate the same to this day.

3.1.2 Medieval era (Circa 300-1500 AD)

In current midwifery practice there are no indications as to whether the midwives baptise the neonates or summon a minister of religion in pending death of an unbaptised neonate, as was practised during the Medieval era. Ethical obligations were introduced by Soramus to supplant the myths which created confusion among women in the utilization of maternal and child health care services, like the slaughtering of a goat for the ancestors as a method of sterilization. These myths remain as challenges to be addressed by the midwives (Searle, 1988:35; Mellish, 1984:33-37).

Current maternal and child health care practices, including management of obstetrical emergencies like shoulder dystocia, were introduced by Aphasia (the first skilled midwife). In this study the competence of the midwives in the management of obstetrical emergencies is regarded as a challenge, although their scope of practice is limited (Searle, 1988:45).

3.1.3 The Renaissance period

The technology of induction of labour and caesarean section was introduced during this era. Duge was the first midwife to conduct a research project on childbirth through record keeping and statistics. Conducting research studies in the workplace remains a challenge for South African midwives, as they lack this skill (Sellers, 1997:xli).
Midwives had to pass an examination to be licensed to take an oath of office, currently known in South Africa as Nurses' Pledge. This was introduced when the first qualifier in midwifery was appointed. Applications of the Nurses' Pledge in nursing or midwifery practice is at times questioned by the public, with a 'I don't care attitude' that is seen in midwifery practice of today (Mellish, 1984:57-77).

3.1.4 **Pre-Twentieth century**

Semmelweiss (cited in Sellers (1997:xliii) discovered that the cause of puerperal sepsis was the contaminated hands of medical students, which were infected during corpse dissection. Infection was transmitted to puerperal women. The South African Report on Confidential Enquiries in Maternal Deaths (1999) reflects 7,3% of deaths by puerperal sepsis. Semmelweiss’ emphasis was on the washing of hands between procedures to prevent spread of infection. This remains the same even today.

Weaver (1843) cited in Sellers (1997:xliii) was the first person to do urinalysis to exclude proteinuria, which was associated with eclampsia. Proteinuria, which is one of three cardinal signs of pre-eclampsia (Beischer & Mackay, 1988:169), is one of the challenges that face midwives in the workplace, as it increases maternal morbidity and mortality rates.

3.1.5 **Professional Midwifery in South Africa**

19th century Batavian Midwifery

When the British Government took over the Cape from the dissolved Dutch East India Company in 1652 it commenced formal midwifery practices. Leishing recommended that a midwifery school be established, which was only considered in 1808. The
concern was the shortage of qualified midwives for Cape Town and its districts, including the poor standard of midwifery care executed by unlicensed persons. Wehr cited in Sellers (1997:xiv), an approved colonial accoucheur, requested the Supreme Medical Committee to grant him authority to teach midwives thus serving the community. The Supreme Medical Committee approved this request and together they drew up a Plan of Instruction for midwives (Mellish, 1984:97-98 and Sellers, 1997:xiv).

In 1858, hospital beds for midwifery points in Natal were made available for the first time at the Albany hospital and the first non-white was admitted to Greys Hospital in Pietermaritzburg. It has taken time to transform the maternal and child health care service to serve a culturally diverse people. Admission of all the diverse cultural patients in health care services was initiated after 1994 but the knowledge and skills of transcultural nursing remains a challenge for the practising midwives.

3.1.6 The beginning of modern training

Henrietta Stockdale trained at Carnarvon Hospital in Kimberley. Although she never qualified formally, she initiated state registration of nurses and midwives through the Medical and Pharmacy Act, No. 34 of 1891. South Africa became the first country in the world to register midwives.

Until the 20\textsuperscript{th} century training was for whites only due to various social and political reasons. Judson became the first coloured person to be registered as a midwife in 1918. Midwifery training for blacks only started in 1927 at McCords Zulu Hospital in Durban. Beatrice Msimang became the first black woman to be registered as nurse/midwife. Today the education and training of nurses/midwives is multi-racial in South Africa. Currently
midwifery qualifiers have been developed from the following programmes:

(a) Basic courses:

- Four-year comprehensive course, which leads to registration as a nurse (general, psychiatric and community) and as a midwife according to SANC R425.

- One-year midwifery course (post-bridging course) according to SANC R254 as amended.

(b) Post-basic course:

Advanced midwifery and neonatal nursing science lasting for one year.

- Decentralized Advanced Midwifery lasting for eighteen months (Mashaba, 1995:01).

In this study the relevant scope of practice within the above categories of midwives is regarded as essential to prevent professional role conflict and to promote early midwifery intervention when complications arise in the absence of the doctor, thus preventing an increase in maternal mortality rates. However, a limited scope of practice for basic midwives is a concern. There is also no such scope available for Advanced midwives.

According to Sellers (1997:xiviii) the South African Nursing Council took control of midwifery training in 1945 and its major role is to protect the public by ensuring that the practising midwives are licensed and are guided by regulations in their
practice. This role has not been fulfilled adequately if there is currently no scope of practice for practising advanced midwives.

4 REGULATIONS/ACTS

The Legislation For Maternal And Child Health

4.1 PUBLIC HEALTH – THE DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

The Health Act (Act 63 of 1977)

➢ The Child Care Act, No. 74 of 1983, provides conditions for the welfare and protection of children in need (Government Gazette, 22 June, 1983:2).

➢ The Children's Status Act, No. 82 of 1987, stipulates the conditions relating to paternity, guardianship and the status of certain children, and provides for matters relevant to this.

➢ The Birth, Marriages and Death Registration Act, No. 81 of 1963, stipulates the laws relating to the registration of births and deaths (Sellers, 1993:1684).

4.2 CHOICE ON TERMINATION OF PREGNANCY ACT

Act No. 92 of November 1996

The Act states the conditions under which the pregnancy of a woman may be terminated, but it does not specify the number of abortions allowed to each client. This Act is shown to deal with controversial issues like increase in use of termination of pregnancy facility versus family planning facility, its impact on religious beliefs of trained midwives and the social stigma attached to especially the African community.
4.2 LEGAL AND PROFESSIONAL CONTROLS OF THE MIDWIFE AND MIDWIFERY

Legislation in South Africa pertaining to Midwifery Acts

Nursing

The Nursing Act No. 50 of 1978
The Nursing Act of 1978 as amended by Act No. 70 of 1982 has authorized the South African Nursing Council under certain conditions to control midwifery practice, education and training of the midwives in South Africa, thus protecting the reproductive health consumers.

The South African Nursing Council Regulations
➢ R2488, 26 October 1990, amended regulations relating to conditions under which registered midwives and enrolled midwives may execute their professional duties.

➢ R387, 15 February 1985 amended regulations relating to actions or omissions in respect of which the South African Nursing Council may take disciplinary steps.

➢ R866 of 1987 and R2490 of 1990 – The practicing midwife must be familiar with these regulations to retain her/his practicing licence.

The Medicines and Related Substances Act No. 101 of 1965 and the Abuse of Dependence Producing Substances and Rehabilitation Centres Act, No. 41 of 1971 is essential because they govern the control of medicines and drugs. The midwife in private practice must apply for a permit authorizing the handling
of medicines to the Director General of the Department of National Health and Population Development.

In this study the above-mentioned regulations are shown to have limitations on the practicing midwives who deal with complications that arise during absence of doctors in the clinics.

The Mental Health Act stipulates conditions for reception, detention and treatment of mentally ill persons in institutions; including women who suffer from psychiatric disorders in pregnancy (Sellers, 1993: 1683). In this study it is shown to be common in midwifery practice for the trained midwives without psychiatric nursing skills to deal with a patient suffering from psychiatric disorders.

4.4 LABOUR

(1) Workmen’s Compensation Act (Act No. 30 of 1941)

This Act stipulates legalities relating to compensation for disablement due to injury at work or death resulting from injuries or diseases contracted at work, for example needle pricks resulting in HIV/AIDS infection. The midwife must be familiar with the implementation of this regulation.

(2) Unemployment Insurance Act (Act No. 30 of 1966 amended)

The Act states the laws relating to the Unemployment Fund, the payment of benefits to a beneficiary of a deceased employee and the combating of unemployment (Sellers, 1993: 1684).
In this study, currently trained midwives are shown to be overworked due to staff shortages resulting from the brain drain of experienced midwives who are leaving for greener pastures and some who are sick. It is essential for the midwives to have insight regarding the benefits and procedures involved in the Basic Conditions of Employment Act.

5 ASPECTS OF LEGAL ISSUES IN MIDWIFERY PRACTICE

5.1 IMPACT OF POOR WORKING CONDITIONS ON THE MIDWIFE

McGibbon as cited in Sunday Tribune (21/01/1990) highlights the implications of poor working conditions on midwifery practice. A midwife at an understaffed and overcrowded obstetric unit was reprimanded for the incorrect recording of a baby’s sex as a girl instead of a baby boy, because she was too busy with deliveries to fill in the child’s details. Midwives are accountable for their acts and omissions even if they are stressed; the fulfilment of this obligation is a professional necessity.

McGibbon also reports that two midwives were suspended by SANC after they delayed to summon medical assistance when a patient, during labour, showed no sign of labour progress with stillbirth being the end result.

Currently midwives utilize partograph, which easily reflects abnormalities hence. This leaves midwives with no excuse for mistakes, except where tasks are assigned to unskilled midwives or if a telephone facility is not available for communication. The master of knowledge and skills of interpretation of partograph by the midwives remains a challenge for the midwives.
5.2 IMPACT OF VIOLENCE ON THE MIDWIVES PRACTISING AT THE CLINICS

Jackman cited in the Daily News newspaper (26/10/1995) reported that the goal of health care services is to bring these services to the public, but midwives cannot deliver if they are threatened. A group of nineteen (19) health care providers were terrorized by armed thugs for almost two hours at Clare Estate Clinic. This type of experience as well similar occurrences in some primary health care services causes midwives to become the victims of criminals. There are even “No Go Areas” which hinder twenty-four hour health care services, including home visits, and at the end of the day it is the women who suffer. The lack of security in community health care centres may paralyse the future of maternal and child health care services.

Mkhize cited in the Daily News (02/04/1960) also highlights the necessity for elimination of violence, which leads to victimization of nurses and midwives by thugs whilst on duty.

6 ETHICAL ASPECTS OF MIDWIFERY PRACTICE

6.1 POLICY ON ETHICAL CONSIDERATIONS IN MIDWIFERY

> According to SANC (1992) nursing ethics is concerned with the code of conduct for nursing and midwifery practice, aiming at preservation of human life and dignity, yet some midwives at times violate these ethical rights of their clients. The Mercury newspaper (24/11/1997) reported on unprofessional behaviour of the labour ward staff (three nurses) in the clinical setting of the Ethekwini region, who refused to attend to the patient that was in labour because she was not booked with their clinic. Eventually, while they were arguing with the relative, the
patient crawled into the labour ward and delivered the baby without the midwife’s assistance. Midwives are obliged to ensure that patients have access to health care service in a respectful manner, as this is the patient’s right. This study shows that midwives are being challenged about misconduct that damages the image and integrity of the nursing profession (SANC 1992).

A news report on the ‘ETV’ television channel (30/04/2002) announced that a pregnant woman was denied access to health care services at Khayelitsha Hospital in Cape Town because she was not booked with this facility. She had to turn to the police station for help. These are midwives who violate the right of access to maternal and child health care services and destroy the image of the nursing profession. Midwifery is a sub-discipline of nursing hence these ethical problems have legal implications on the midwives concerned. Some midwives apply an “I don’t care attitude” while practising in maternal and child health care services. In this study this “I don’t care attitude” at work remains a challenge to be eradicated by the midwifery administrators.

KaMzolo (2001:15) regards the impact of HIV/AIDS on nurses and midwives as a critical factor to be attended to. The midwives are exposed to HIV/AIDS infected patients, and some of the midwives discriminate against these patients. “As nurses or midwives, every day we deal with HIV-positive people, known and unknown, their blood and other secretions are a threat to us, it is not the patient that exposes nurses to infection, but the content of their secretions that increases the risks and extra precaution need to be taken”. According to Van Wyk (2002:54), the risk of depression and progression of diseases in a midwife who is HIV-positive increases to a higher level due to the “mirror effect” as the midwife
identifies herself with a dying patient. Management has to bridge this gap created by prejudice between the client and health care provider.

**Moonlighting**

Geyer (2001:30) refers to 'moonlighting' as the practice of an employee in accepting employment with another employer outside the normal working hours that form the basis of the employment contract with the primary employer.

According to the Occupational Health and Safety (OHS) Act (No. 85 of 1993) it emphasises the responsibility of the employer to ensure that clients utilizing the health facility have a safe environment. This includes the midwife who must not be overworked as this may lead to unsafe practice.

The midwife has an obligation in terms of Occupational Health and Safety (OHS) Act (Act No. 85 of 1993) to comply with the stipulations of this regulation to avoid unintentional exposure to exhaustion due to lack of rest, resulting in malpractice.

**6.2 ETHICAL OBLIGATION**

A midwife has an ethical obligation to ensure that she is not being overworked, so as to remain faithful to her commitment. If the midwife is exhausted negligence in patient care is possible.

The Basic Conditions of Employment Act (Act No. 75 of 1997) stipulates that the midwife has an ethical responsibility towards self, her family, her employer and the health care consumer under her service. She has to ensure that she has sufficient rest to perform a good day's work. In this study the Nursing Act (No. 50 of 1978) states that a nurse or midwife is responsible and
accountable for her own acts and omissions, therefore any offence or unprofessional conduct due to long working periods may result in the loss of her licence for practicing, which is a challenge to midwives who are moonlighting due to financial constraints.

“Nursing” means a caring profession practiced by persons registered under the Nursing Act (Act No. 50 of 1978), which stipulates that she supports, cares for and treats the individual, ill or well. Nursing covers all stages of life, so as to achieve and maintain health. Where this is not possible, to render health care services with respect and dignity until the death. Hence midwifery is a sub-discipline of the nursing profession. Midwives therefore have an obligation to support and care for women with HIV/AIDS without discrimination (SANC 130/S, 1962:2). According to Nzimande as cited in Human (2001:26) it is nurses’ or midwives’ challenge in South Africa to “Fight war of HIV/AIDS, individually, professionally and boldly, otherwise we shall have no answer to the future generations who will judge us by our own actions of today”.

Catalano (1996:127) states that HIV/AIDS has evoked emotions both in public and in the medical community. Nurses and midwives who have been practicing for years, complying to the ethical principle of treating all patients with no discrimination, have now become biased, because when a midwife is infected by an HIV/AIDS positive patient, she faces a fatal condition, social isolation from colleagues, partners and public, and is even neglected by her profession.

The Mercury newspaper (20/11/1997) reported on a health consumer who was shocked by the uncaring attitude of midwives and the lack of communication between the relatives of a patient admitted to the labour ward by midwives, who waited 35 minutes
to answer a phone call enquiring about the patient. Midwives are obliged to ensure that relatives have access to information about their relatives, as this is the patient's right. In this study this remains a challenge of the practicing midwives.

**Assertive behaviour** is essential if midwives are to act as advocates to patients and their subordinates to ensure consolidation of their rights, ensuring that both interests of patients and subordinates are considered and their rights are protected. Assertiveness facilitates problem identification, problem solving and decision-making, leading to a positive self-image, improved productivity and job satisfaction, which is still lacking in the current generation of midwives. They are at times instructed by doctors with their limited scope of practice, which hinders the midwifery practice, resulting in professional role conflict (Jooste & Troskie, 1995:60).

Midwives have to empower themselves during the 21st century, as there is a demand for assertive midwives to save both mother and baby from unsafe hands of the inexperienced doctors or midwives. This includes socio-cultural contexts (Morrison & Burnard, 1991:52-53).

An International Council of Nurses Report (1976:6) highlights the fact that nurses and midwives often tend to associate themselves with trade unions. Some of these unions have non-professional staff with no insight into the nursing profession or their code of ethics, and this affects the image of the profession with the outcome of substandard care of the patients. In this study it is regarded as relevant to alert the midwives about legal implications involved with substandard care of patients.
7 ASPECTS OF MIDWIFERY EDUCATION

7.1 CURRICULUM FOR MIDWIFERY EDUCATION

A maternal and child health care service is rendered in a complex, culturally diverse clinical setting yet the midwifery curriculum does not cover transcultural congruent care which in turn is based on the principles of knowledge, respect and negotiation. The emphasis is on cultural assessment rather than cultural imposition so as to gain compliance and cooperation of pregnant women (De Villiers & Tjale, 2000:21).

7.2 EMPOWERMENT OF MIDWIVES REGARDING KNOWLEDGE AND SKILLS

Mbananga (2001:44) emphasises the empowerment of midwives with knowledge and skills regarding advanced technology like nursing informatics.

Mbananga (2000) and Reilly and Oermann (1992) define informatics nursing as the multi-disciplinary scientific endeavour of analysing, formalizing and modelling how nurses collect and manage process data into information and knowledge, make knowledge based decisions and inferences for patient care, use this empirical knowledge to broaden their scope of practice and enhance the quality of their professional practice.

Nursing informatics uses the knowledge borrowed from computer science and utilizes this knowledge in the processing and handling of nursing care information by means of computers and other information, thus commanding midwives to be computer literate (Goosen et al., 1996).
Uys (2000:6) at the African consultative meeting on nursing midwifery education held in Durban, proposed that East Africa, West Africa and Southern Africa review current curricula to become community based, in order to meet the needs of the consumers.

7.3 IMPACT OF DOMESTIC VIOLENCE

Sallah (1998:772, 786) states that in South Africa there is limited research on the recognition of the impact of domestic violence on pregnant women. Early identification and management is essential, to prevent increase in perinatal morbidity and mortality rate. Midwives should therefore be trained in this regard and must realize that as members of a multi-disciplinary team, they have an equal responsibility in ensuring high standards of care and positive outcomes of pregnancy. Hence continuing education and being proactive remain the responsibility of the individual practitioner.

7.4 IDEAS ABOUT MIDWIFERY PRACTICE

According to the Daily News (26/11/1996) the fundamental focus of the National Health Plan is the establishment of community-oriented health institutions, with a change of emphasis from the present doctor centred service towards one in which the primary health care adviser takes the initiative. The training of midwives is lacking in this regard, whereas health promotion is the component of primary health care.

> Midwives provide or play a key role in maternal and childcare provision with a greater emphasis on continuity care as well as ability to provide a more holistic approach to care.
Midwives' knowledge and influence can greatly affect the outcome of pregnancy for mother and baby and their role in health surveillance, education and promotion is invaluable. Vulnerable women are the ones who have insufficient financial and social support, poor diet or housing, suffer from drug abuse, have poor access to health care, poor lifestyles and the negative impact of cultural beliefs (Midwifery Digest for March, 2001:11; supplement 1).

Updating of knowledge and skills using current research findings, technology etc. should be a norm.

7.5 MIDWIFERY AND RESEARCH

The SANC R254 states that although one of the purposes of the one-year Midwifery Training Programme is to educate students with skills of implementing scientific principles underlying midwifery as the background to midwifery practice in the workplace, a research component has been omitted in the midwifery curriculum. Sajinwandani (1998) emphasizes that midwives have an obligation to respond positively to capacity building in midwifery practice through nursing research.

Capacity building is defined as the ability of a nation to maximize nationwide efforts to promote health, education and political, economic and social policies for the benefit of all people. Midwifery as a component of nursing discipline is no exception.

According to Champion and Learn (1989), Treece and Treece (1986:508), and Woods and Catanzaro (1988:9-10) nursing research is a systematic and rigorous enquiry for the purpose of generating new knowledge, skills and culture. Once the midwives understand the nature of human behaviour in health and illness,
they can identify or moderate interventions that might be implemented to enhance changes in lifestyle of their clients, especially if the midwives are culturally sensitive.

7.6 EDUCATIONAL ASPECTS REGARDING CLIENT PERSPECTIVE

Kelbitsch (2001:38, 39) states that childbirth education is about getting a clear understanding of what is happening in pregnancy, labour, actual delivery of the baby and early parenthood. Empowerment of couples about childbirth is essential, as there is a dramatic shift from extended families to nuclear families in this era, and even if traditional birth attendants are available, there is an advance in medical technology defining the professional midwives' role.

Kelbitsch insists on the involvement of African male partners in antenatal classes, but as they are still culturally bound, some of them cannot witness their women in labour; neither can they change nappies because these will either bring bad luck or turn him into a weak man. Ignorance about physiological changes occurring in pregnancy, labour and puerperium may have a negative impact on marital relationships leading to separation or extramarital affairs with end results of sexually transmitted diseases, HIV/AIDS and even divorce. This remains a challenge for midwives, as they are the backbone of the country.

According to Matsau (2001:20-21) “unprotected sex is a higher risk than car hijacking, as during year 2000 AIDS killed about 120 000 people, yet car hijacks in South Africa declined. For every infected man there are three women infected by him”. This statement indirectly reflects the challenges facing the committed midwives in the twenty-first century.
Nolte (1998:59) states that the key focus of a maternal and child health policy is improving the health status of women by ensuring that mechanisms are created, to prevent women dying due to herbal intoxication, or inability to access the health services. These mechanisms include training programmes for traditional birth attendants, as they render initial interventions prior to the clients reaching a health care facility. This also promotes the community clinic to be a place for future midwives, but with the brain drain of midwives there is a demand for midwives to train the traditional birth attendants and spell out their roles in maternal and child health care services. Also, to ensure the safety of pregnant women from detrimental interventions which are rendered by traditional birth attendants.

According to Theron (1999:63) the philosophy of the Maternal Care of the Perinatal Education Programme introduced in maternal and child health care services is the promoting of midwives by improving knowledge and skills and the ability to apply that knowledge to rescue the lives of mothers at risk in the absence of the doctor. The following questions arise: Are the midwives in the workplace utilizing these manuals? Does perinatal education have an impact on attitudes of midwives towards their work?

8 ASPECTS OF MIDWIFERY PRACTICE

8.1 THE IMPORTANT ROLE OF MIDWIVES IN HIV/AIDS

Stewart, Di Clemente and Ross (1999:687-688) state that nurses and midwives can play an important role in assessing adolescents’ risks for HIV infection and in promoting preventive behavioural change, if they stop holding negative attitudes about HIV-positive women or fear of becoming infected by an HIV-positive patient.
The Mercury (20/09/2001) reports that hospital figures of HIV/AIDS infections are worse than any holocaust. Coovadia and Trusen, in the same newspaper, state that 5 360 people died of AIDS at King Edward VIII Hospital between 1994 and 2000 whilst in 2001 4.7-million were infected. As mainly women are infected, this heralds immediate attention from the midwife. Morrison and Bernard (1991) emphasize the urgency of empowerment of midwives with interpersonal skills such as counselling to help the victims of HIV/AIDS and assertive skills in order to cope with difficult or grieving clients. As midwives work with other members of different health disciplines, communication skills will also assist midwives when interacting with clients of diverse cultural groups in order to facilitate healthy lifestyles.

Nzimande cited in Human (2001:26) poses a challenge to nurses and midwives of South Africa by stating "Fight the war of HIV/AIDS individually, professionally and boldly, otherwise we will have no answer to the future generations who will judge us by our actions of today".

8.2 THE IMPORTANT ROLE OF MIDWIVES IN TEENAGE PREGNANCY

King (1991) reports on Searle's concern about the increase in teenage pregnancies "with a baby being born every 16 seconds of the day and with 14 percent of the current black community mostly under 19 years of age, midwives have to promote integration of family planning services thus preventing maternal deaths caused by sepsis due to illegal abortions".

Searle as cited in the Mercury (20/08/1984) also emphasises the importance of utilization of family planning services to combat the
extraordinary high fertility rate in the black community with the emphasis on community involvement in the health services issues.

Selelo-Kupe cited in the Daily News (27/11/2000) emphasises the urgency of overcoming obstacles that could hinder the World Health Organization to enhance the health promotion to mother and child, families and communities.

Attitudes affect the success in collecting cultural data because of midwives' acculturation to midwifery and biomedicine. A positive approach through self-understanding, self-control, respect of cultural diversity and compromise may lead to adequate health care delivery (Khanyile, 1999:23, De Villiers & Tjale, 2000:21).

According to the Nursing Update (September, 2001) “Nurses leave the country because of economic pressures, thus resulting to staff shortage especially experienced midwives, whilst the remaining midwives are overworked yet faced by litigations from diverse cultural clients and patients in the workplace”.

Ramukumba (2001:28-29) states that cultural diversity in the workplace, cultural differences and expectations of midwife to midwife/multi-disciplinary members or clients has an indirect impact on patient care. Diversity may be due to race, culture, disability, national origin, sexual orientation, communication styles and language, speed of learning or comprehension. This may have a negative influence on the enhancement of the health of the nation.
8.3 THE ROLE OF THE MIDWIVES IN HEALTH PROMOTION
AND IN PROPOSED LIMITED LOW RISK ANC VISITS

In the MIDIRS Midwifery Digest (December, 2000) the emphasis is on health promotion as an integral part of the midwife’s role. Midwifery is a component of stakeholders to be involved in saving lives of individuals, families and communities to achieve the goal of a healthy nation. Midwives have to be committed in working towards achieving this goal. The potential health benefits of a midwife’s work will be untenable unless health promotion is clearly defined, audited and published, securing greater interests and investments by major health stakeholders. Midwives are faced with the challenge of changing the client’s behaviour and lifestyle, and to develop strategies to improve socio-economic conditions that affect the health of the consumer or empower women to make healthy lifestyle choices within the context of their socio-economic circumstances. Reinforcement of health promotion will promote the possibility of changing the current traditional schedule of antenatal visits to low obstetric risk clients, the challenge being open-door communication between the client at home and the midwife at the health care centre (MIDIRS, June 2000:169-170). Therefore the idea of providing low risk pregnant women with increased flexibility over the number and timing of their antenatal visits remains a challenge of South African midwives.

Safe motherhood implies that every child should be a planned and wanted child, therefore women need to be encouraged to delay the first pregnancies until they are physically and emotionally mature to have a baby. The increased number of teenage pregnancies and the termination of pregnancy clients reflect that motivation of the public to utilize family planning services remains a challenge for midwives.
8.4 ASPECTS OF MIDWIFERY PRIVATE PRACTICE

Historically midwives hold a philosophical belief of considering pregnancy as a healthy, natural process of early development of a human being. This belief guides the manner in which the midwives practise in private practice as prescribed by the South African Nursing Council’s scope of practice (R2488, 26 October 1990 as amended, chapter 2).

The registered private midwife is able to provide holistic maternal and child health care services to women in their home settings, with their loved ones around them. Friendly supportive relationships between the midwife and the pregnant woman build up with subsequent antenatal visits on a one-to-one basis. This includes labour and puerperium.

If the South African Nursing Council regulation 2488 (26 October 1990 as amended, Chapter 2) is implemented successfully by the midwives, complications beyond their scope of practice are referred to the relevant obstetricians, but a limited scope of practice becomes problematic when the midwife is faced with complicated labour.

This practice allows midwives to learn more about the culture of their clients and develop flexibility and sensitivity to diverse cultural needs. Some midwives choose to practice in specific clinical areas like lactation consultants, etc. (MIPPS www.capers bookstore page 1 of 2). In South Africa midwifery private practice is in its infancy, and it therefore remains a challenge for the current practising midwives.
9 THEORETICAL FRAMEWORK

9.1 DEFINITION OF THEORY

According to Brink (2000:25) and Polit and Hungler (1993:37) theory is the ultimate aim of science, which transcends the specifics of a particular time, place and group of people (midwives) aiming at identifying regularities in the relationships among variables. The use of this framework in this study will help the researcher to organize the study and provide a context in which to examine a problem (midwives' challenges at the workplace), and to gather and analyse data. It is anticipated that this will have broad significance and utility in maternal and child health care services.

9.2 INTRODUCTION OF KING'S THEORY OF GOAL ATTAINMENT

The choice of King's theory of Goal Attainment has originated from King's thoughts in which the researcher has identified that she acknowledges the vast amount of knowledge available to nurses/midwives, and the difficulty this presents to the individual nurse/midwife in choosing the facts and concepts relevant to a given situation.

George (1995:217) highlights that the core of King's theory of goal attainment is seen in the interpersonal systems in which two persons, who are not familiar to each other, come together in a clinical setting as a strategy to seek help from the midwife and maintain a status that promotes functioning in her life's roles.
9.3 DISCUSSION OF KING'S THEORY OF GOAL ATTAINMENT

King's theory of goal attainment entails the external boundary criteria known as:

➢ Firstly, interactions in a two-person group which are the midwife and the client, her family or community, with diverse lifestyles or cultural beliefs.

➢ Secondly, the interaction is only limited to qualified nurses/midwives currently registered with the SANC, and to women in need of relevant maternal and child health services according to this study.

➢ Thirdly, interactions are taking place in environments like hospitals or clinics where midwives are placed. There is mutual interaction between midwife and the client. There is a need for identification of the unique needs of the client in order to facilitate establishment and achievement through health promotion.

Her beliefs, lifestyle, her family, her religion, cultural beliefs, level of education, work system and peer groups, especially in the case of teenagers, influence the interpersonal system of both the midwife and the woman. Concepts of King's theory of goal attainment will be integrated in this research study; hence the relevance of each is outlined as follows:

9.3.1 Interaction

Interaction is defined as a process of perception and communication between the client and environment, between the midwife and the client; and between the midwife and multi-
disciplinary team members either through verbal or non-verbal communication resulting in goal directed behaviours of healthy pregnancy, safe delivery and a healthy baby. This interaction aids in prevention of increased maternal morbidity and mortality rates as the stakeholders are involved (George, 1995:214).

9.3.2 Perception

Perception is defined as each person’s representation of reality and this involves both the midwife and client. The perception of an individual is affected by her personal and professional philosophy (George, 1995:211). In this study the manner in which midwives perceive challenges in their workplace will also be determined by their individual and professional philosophy, which have an impact on their practice.

9.3.3 Communication

Communication is a process whereby information is passed on from one person to another, in this study from the midwife to the client either directly in face-to-face meeting (antenatal classes), or indirectly through mass media or pamphlets or booklets (George, 1995:214).

9.3.4 Transaction

Transaction is defined as observable interaction of people within their environment. It entails bargaining, negotiating and social exchange. In this study the midwives must negotiate with their clients, families and communities for cultural preservation and cultural restructuring of detrimental health lifestyles. Transaction leads to goal attainment, satisfaction, effective health care service

9.3.5 **Role**

Role is defined as a set of behaviours expected of a person occupying a position in a social system. Rules define the roles of each member or stakeholder must be clearly stated. Rules that define the patients' rights and ethical or professional obligations of midwives in their clinical practice, as the scope of practice limits their independent practices (George, 1995:214).

King cited in George (1995:218) highlights that the roles must be clearly defined to prevent professional role conflict, for example roles of advanced midwife and a doctor, basic midwife and advanced midwife or client.

9.3.6 **Growth and development**

Growth and development is defined as the continuous changes in persons at early developmental stages of life and behavioural levels of activities. In this study professional development of the midwife with knowledge and skills is essential in order to adapt to current changes of advanced technology. Personal and professional achievements will improve midwives' productivity indirectly, as well as clients/family and community health status. Goal attainment decreases stress and anxiety in the nursing or midwifery practice (George, 1995:214).

9.3.7 **Time**

Time is defined as a sequence of events moving onward to the future. In this study the historical development of midwifery
practice reflects advances, which demand a change agent that is the midwife/client. Future changes in the world of knowledge explosion do not accommodate "I don't care" attitudes in the workplace as the public is aware of its rights (George, 1995:213).

9.3.8 **Personal space**

Personal space is defined by the behaviours of those people who occupy it and it is culturally oriented as space that has different meanings to diverse cultural groups and can result in infringement of patients' rights (George, 1995:215). Hence midwives have to be empowered with transcultural nursing knowledge and skills.

9.4 **APPLICATION OF KING’S INTERPRETATION OF NURSING**

According to Mellis (King1985:230-233) interprets nursing as process of human interaction between midwife and the client whereby each perceives the other through communication (health talks/posters/mass media). The involved stakeholders must set goals, explore all available means and agree on means that are accessible/affordable to the client in order to achieve their mutual goals. Midwives also interact with their environment (challenges in workplace) in this study and should identify the challenges and act on them. This is a challenge to the practising midwife of today.

10 **RECOMMENDATIONS OF THE NATIONAL HEALTH PLAN ABOUT MATERNAL AND CHILD HEALTH**

The National Health Plan recommends the following:
➢ Implement measures to improve the social, political, legal and economic powers of women.

➢ Free antenatal, delivery and postnatal care and support for women in the public sector.

➢ Early identification of high-risk pregnancies, improved antenatal care and provision of emergency obstetric services to reduce maternal mortality.

➢ Free health care services to be available in the public sector to all children under the age of 6 years.

➢ Promotion of active participation of male partners in supporting maternal and child health care.

➢ Advocate and ensure the rights of children as articulated in the UN Convention on the Rights of the Child and work towards the promotion and development of a charter for the rights of women.

➢ Rapidly improving immunisation coverage through the Expanded Programme on Immunisation (EPI), using methods that will ensure its sustainability.

➢ Development of a network of comprehensive support and information services to improve the mental and physical health of mothers-to-be and families.

➢ Promotion of the survival, protection and development of children and their mothers through a system of appropriate health care delivery, health, personal education, training and supportive environments for working mothers to allow
continuation of breastfeeding and enforcement of the code of ethics on breast milk substitutes.

➢ Availability of general family planning and educational services.

➢ Encouragement and support of educational programmes that promote health within schools.

➢ Appropriate training, support and services of families and children with special needs, for example teenage mothers.

➢ Promotive and preventive programmes directed at adolescents regarding high-risk behaviour and sexuality with promotion of effective skills, including safe sexual practices.

➢ Development of regulations to ensure the safe and appropriate termination of pregnancy.

➢ Training and re-orientation of health workers and public officials to correct any negative attitudes to women.

➢ Provision of legal protection for women victims of violence and provision of support counselling services for victims of violence.


11 CONCLUSION

This chapter presented a review of literature studied. The role of both basic midwife and advanced midwife was defined, as well as the historical background to midwifery development, midwifery regulations, aspects of legal issues in midwifery practice, ethical aspects, practical aspects, educational aspects, King’s theory of
goal attainment as the theoretical framework relevant to this study and the recommendations of the National Health Plan regarding maternal and child health.

A discussion of the research methodology used in this study including the description of the area of study, will be presented in the next chapter.
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CHAPTER 3

3.1 INTRODUCTION

This chapter deals with the research methodology that includes the research design, target population, sample, research instrument and method of data collection, including the plan for data analysis, as well as the area where this study was conducted. The area of the research study will be discussed first.

3.2 AREA OF RESEARCH STUDY

The area where the research study was conducted is in KwaZulu-Natal.

3.2.1 Regionalization of the area

KwaZulu-Natal has been subdivided into regions as to provide effective services to its public.

The study was conducted in the hospitals and clinics of the Ethekwini region in KwaZulu-Natal.

The actual study took place at King Edward VIII hospital, Prince Mshiyeni Memorial hospital and at the following comprehensive health care clinics: “D” clinic at Umlazi township and Newton “A” and “C” clinics including KwaMashu Polyclinic. The areas where the sample of the study was selected are both urban and semi-urban. The inhabitants of these areas are urban whites, coloureds, Indians and blacks, as well as semi-urban diverse cultural people from the surrounding Durban area.
The boundaries of the Ethekwini region are:

- Tongaat in the North,
- Umkomaas river in the South,
- Camperdown in the West, and
- The sea in the East.

The total population of this region is 2,964,276 (Population Data, 1996).

**Housing in the Ethekwini Region**

There are modernised houses with appropriate infrastructure, sewage, water supplies, roads and electricity except in the areas, which are semi-urban, still dependent on water supply from taps along the roads. There are also quite a number of shack settlements in the semi-urban areas.

**Law and order in the Ethekwini Region**

Law and order is enforced by the police in the centre of town and in the semi-urban areas, as well as by the Department of Justice. Despite this crime, child and women abuse, drug addiction, alcohol consumption, accidents, assaults and unemployment leading to car hijacking, are noticeable in the area.

All these pathological and social problems have an impact on the delivery of health care services, like home visits of puerperal women after discharge from hospitals or clinics.

**King Edward VIII hospital**

The hospital's historical background dates back to 1936, when it first opened its doors for sole use by black people.
The physical structures and other facilities reflect the shameful legacy of the past, when compared with older white institutions which are in better shape than King Edward VIII hospital.

King Edward VIII hospital is built on a massive site of 42 acres; the hospital enjoys a rich heritage from both the Zulu and British royal families.

The hospital was named after King Edward VIII, who abdicated the throne a week after the opening of the institution.

This hospital is situated in what used to be one of King Shaka's residences, Kwa Khangel Aman kengane.

**King Edward VIII Hospital Catchment Area**

King Edward VIII hospital is an academic hospital; over and above that, it is a referral hospital for patients with complicated obstetric problems from KwaZulu-Natal and other regions, such as the Eastern Cape.

It also provides services to the following catchment areas: KwaMashu Polyclinic, Ntuzuma, Lindelani, Goodwins, Rydevale, Kwasimama, Maphephetheni, Qadi, Chesterville, Cato Manor, Overport, Montclair, Seaview, Umbilo and Glenwood.

**Staffing of King Edward VIII hospital**

- In 2002 between the months July and September, there were one hundred-and-thirty-eight (138) trained midwives placed in maternity wards instead of the one-hundred-and-ninety (190) according to the authorised staffing establishment.

- In the antenatal clinic and the gynaecological clinic there were only six (6) trained midwives against a three thousand, three-
hundred-and-seventy-nine (3 379) turnover of antenatal clients and nine-hundred-and-thirty six (936) with gynaecological problems.

- Statistics for the King Edward VIII hospital maternity section between July and September 2002 reflect the following:

<p>| | |</p>
<table>
<thead>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>2 406</td>
</tr>
<tr>
<td>Births</td>
<td>2 025</td>
</tr>
<tr>
<td>Antenatal cases</td>
<td>3 379</td>
</tr>
<tr>
<td>Gynaecology clinic</td>
<td>936</td>
</tr>
</tbody>
</table>

Based on the above data regarding the turnover of patients in this hospital, being a referral hospital for the entire KwaZulu-Natal of pregnant women with complications, including Eastern Cape patients, the staff shortage definitely impacts on the maternal and child health care services. Complications that are dealt with in this institution are clearly reflected in the obstetrical summary for the 2000-year ending in Annexure K of this study.

**Prince Mshiyeni Memorial hospital**

- Historical background

Prince Mshiyeni Memorial hospital was opened in 1981. It was named after the Zulu Royal King, Prince Mshiyeni. It is a regional hospital except that it does not cater for cardiac and renal cases. It is stationed at the entrance to the Umlazi Township in South Sub District of the Ethekwini region. There are quite a number of shack settlements just along the boundaries of this institution.
Catchment area of the Prince Mshiyeni Memorial hospital

This institution administers twenty-one (21) clinics within the Umlazi Township. It also provides services to the following catchment areas: Umbumbulu, Folweni, Bantyena, KwaMakhutha, Odinini, Embo (CHC), Isipingo, Nagasheni, Induma, Inkwali, Umimini, Amanzimtoti, Kingsburgh, Adams Clinic, Lamontville and Clairwood.

Staffing of Prince Mshiyeni Memorial hospital

The staff establishment of professional nurses (trained midwives) for the period between August to September 2002 ranges between 109-112 (August and September 2002).

Statistics (Perinatal and maternity) for Prince Mshiyeni Memorial hospital in September 2002

The total number of births was eight hundred and eighty-three (883) with thirty-seven (37) being early neonatal deaths (0-7 days post delivery), while thirty-five (35) of the births were babies weighing less than two kilograms.

There were sixty (60) babies born outside the health care facility. Two women had assisted deliveries; one was assisted with a vacuum extractor and another one with forceps.

There were nine hundred and forty-four (944) pregnant women who attended the antenatal care clinic and out of these clients only one hundred and sixty-eight (168) made a first antenatal visit before twenty weeks of pregnancy, while others were late bookers. Seventy-five (75) of pregnant women were teenagers younger than 18 years.
In this study the statistics for Prince Mshiyeni Memorial hospital indicate the following 21st century challenges:

- A need for scientific investigation regarding late bookings at the antenatal care clinic.
- Scientific investigation of teenage pregnancies in spite of available family planning facilities.
- Empowerment of trained midwives with advanced technical skills to manage complicated pregnancy/labour, or the ability to use modern facilities like ultrasonics when there is a crisis, for example in antepartum haemorrhage for diagnostic purposes in order to execute relevant midwifery intervention.

**Umlazi “D” clinic**

- Historical background of “D” clinic

This is a comprehensive health clinic, being one of the twenty-one clinics at Umlazi Township, which are under the administration of Prince Mshiyeni Memorial hospital.

Since 1965 this clinic operated as a chest clinic for clients suffering from pulmonary tuberculosis and as a facility for both family planning services and immunization programmes. Since 1991, the services from Umlazi Polyclinic (of eight four rooms) were moved to “D” clinic, and the chest clinic was transferred from “D” clinic to Prince Mshiyeni Memorial hospital.

Trained midwives at “D” clinic render health services for maternal and child consumers of the Umlazi township, a semi-urban township with an increased number of informal settlements.
Statistics for Umlazi “D” clinic during September 2002:

This clinical setting had a turnover of one thousand and thirty-four (1 034) clients within one month against only nine (9) trained midwives.

Umlazi “D” clinic has additional services without additional human resources, and this has an impact on staff performance leading to substandard care.

There are only two trained advanced midwives in this clinical setting, while 21 clinics in the Umlazi Township, there are four trained, advanced midwives and 169 professional nurses.

The clinic has only nine (9) trained midwives instead of sixteen (16). Currently there are two session professional nurses.

This discrepancy regarding the shortage of trained midwives with speciality has a negative impact on a pregnant woman who presents at the clinic with obstetrical emergency.

In Umlazi clinics the turnover of trained midwives leaving the country for greener pastures, is due to financial constraints and lack of incentives from the employers (Shandu, 2002), is ±40%.

Umlazi clinics only deal with emergency deliveries; otherwise deliveries are conducted at Prince Mshiyeni Memorial hospital, where the physical environment (the so-called labour ward) is also utilized for other services.

This clinic is also involved in the HIV/AIDS study of mother-to-child transmission (nevirapine programme). Patients are
tested for HIV after counselling, but although some of them do not want to know the results, 65-75% of those who have been counselled access the nevirapine study.

All clients with complicated pregnancies are referred to Prince Mshiyeni Memorial hospital. This overcrowded clinical setting deals with a great number of health care services, in a clinic that was meant to be a chest clinic. In this study the conditions under which the trained midwives are practising are shown not to be favourable; a challenge that needs to be sorted out by the government.

**Inanda Newtown “A” clinic**

➢ Background of Inanda Newtown clinic

Inanda Newtown clinic is situated in the North/South central sub district of the Ethekwini district.

It provides a comprehensive primary health care package for the following catchments areas: Newtown A, Newtown B and part of B and C extensions, Ntuzuma G, part of F, and part of E sections; Emachobeni, Inanda Glebe and Piesang.

The clinic has a mobile service and a Youth Health centre. The clinic used to render a 24-hour service but this service has now been suspended with effect from April 2001, because of “shortage” of staff and “ambulance delay problems”. This is a challenge to the committed trained midwives as they are not accessible to the health consumers, while ambulance delay problems lead to litigations against the practising midwives due to maternal morbidity and mortality.

➢ Services offered by Inanda Newtown “A” clinic
(a) Minor ailments – daily 7 days a week.
(b) Maternity: Antenatal: Mondays and Tuesdays
     Postnatal: Daily
(c) Child health: Immunization daily.
(d) Reproductive health – daily.
(e) Pre and post test counselling done daily.
(f) PTB clinic is run daily and mental health clinic is run every
     Wednesday and Thursday.

➢ Statistics of Inanda Newtown “A” clinic

There are ±3 deliveries per month, reproductive health clients of
four hundred and fifty-four (454) with eighty-five (85) pregnant
clients and thirty (30) postnatal clients.

➢ Staffing at the maternity section of Newtown “A”

The maternity and reproductive health facility have three (3)
trained midwives and one auxiliary services officer.

Inanda Newtown “C” clinic

➢ Background

Inanda Newtown “C” clinic is situated in the south central sub
district of Ethekwini district.

It provides a comprehensive Primary Health Care package for
the following catchments areas:

- Nthlungwane, Emachobeni, Inanda Newtown C, B and A,
  Zimangweni, Ohlange and Bester. In spite of the referral
  system clients may choose to go to any health care facility,
e.g. Bester and KwaMashu clients utilize this setting or the KwaMashu Polyclinic.

In this study the freedom of choice and right to access to the health care service as a consumer, contradicts the prescribed referral system leading to increased workloads with less manpower, thus indirectly to substandard care.

➢ Statistics for Inanda Newtown clinic

Between July and September 2002 deliveries were two hundred and twenty-four (224), with forty-five (45) babies born before arrival to the clinical setting; three (3) stillbirths and four (4) macerated (stillborn baby with peeling skin) stillbirths. The turnover of clients in this clinical setting was three thousand eight hundred and seventeen (3 817) clients in July, against eleven (11) trained midwives.

In this study this discrepancy of midwife-client ratio reflects crises regarding staff shortage as this leads to litigations against midwives due to substandard care.

KwaMashu Polyclinic

➢ The overview of KwaMashu Polyclinic

This clinic is in the north of central sub district of Ethekweni region. It is a community health care centre with the following components:

- a 24-hour curative and maternity service, HIV/AIDS units, mother-to-child transmission programme, forensic service, social welfare services, DOT supporters’ programme, five-day laboratory services, five day radiological services, nine
satellite clinics, nine mobile points and teams of school health services.

➤ Catchment area of KwaMashu Polyclinic

The population is ±1,6-million is within a 10-kilometre radius encompassing Bester, Amachoba, Siyanda, Avoca and Westridge, encircling KwaMashu and Ntuzuma.

Statistics: January to June 2002

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal clients (visits)</td>
<td>8 193</td>
</tr>
<tr>
<td>Total normal vaginal deliveries</td>
<td>916</td>
</tr>
<tr>
<td>Postnatal</td>
<td>2 333</td>
</tr>
<tr>
<td>Family health</td>
<td>5 107</td>
</tr>
</tbody>
</table>

Within a three-month period (July-September) forty-nine (49) patients were referred to King Edward VIII hospital with different complications of pregnancy:

- Vaginal bleeding: 2
- Eclampsia: 4
- Pregnancy-induced hypertension: 30
- Bad obstetrical history: 1
- Urinary tract infection: 1
- Twin pregnancy: 1
- Cellulites: 1

Staffing:

- Advanced midwives: 5
- Trained midwives: 19
- Enrolled auxiliary nurses: 2
- Enrolled nursing assistants: 2
- Auxiliary service officer: 1
Statistics reflect a high turnover of clients against low human resources indirectly leading to substandard care.

3.2.2 **Sampling of hospitals and clinics**

The following two hospitals and four clinics of Ethekwini region were conveniently sampled:

- King Edward VIII hospital
- Prince Mshiyeni Memorial hospital
- "D" Umlazi clinic
- KwaMashu Polyclinic
- Inanda Newtown "C" clinic
- Inanda Newtown "A" clinic

These clinical settings were conveniently sampled because they are within reach of the researcher during off-duty time.

The trained midwives were selected as the subjects of the study.

3.3 **THE RESEARCH DESIGN**

3.3.1 **Type of research method**

**Qualitative approach**

A qualitative research method was used to establish the trustworthiness of qualitative data. Qualitative researchers tend to emphasise the dynamic, holistic and individual aspects of human experience and try to take those aspects in their entirety, within circumstances of those who are experiencing them (Burns & Grove, 1997:27; Polit & Hungler, 1987:349). In this study the researcher is concerned about understanding the midwives'
perceptions of the variables under study. The researcher is seeking insights rather than statistical analysis (Bell, 1997:6).

The researcher used both the quantitative and qualitative methods to explore all aspects of the topic under study in order to get at the truth of the subject as expressed by the respondents.

3.3.2 Triangulation

Definition

Triangulation, according to Cohen and Manion (1997:233), refers to the use of two or more methods of data collection in the study of human behaviour. According to De Vos (2000:359) triangulation is used to designate a conscious combination of qualitative and quantitative methodology.

The author believes that the best approach is a mix of qualitative and quantitative methods.

Figure 3.3 shows triangulation schematically

GUBA'S MODEL OF QUALITATIVE RESEARCH
3.3.3 Guba's model of qualitative research

Lincoln and Guba (1985) suggest four criteria for establishing the trustworthiness of quality data: credibility (truth value), transferability, dependability and confirmability.

**Credibility (truth value)**

This refers to the extent to which the researcher is confident about the truthfulness of research findings. This criterion makes use of respondents’ lived experiences. Brink (1999:120) reinforces this statement by confirming that in a phenomenological qualitative research method the researcher should develop awareness of the lived experiences of respondents, without forcing prior expectations or knowledge about the process. The author further states that the researcher should take the phenomenon under study objectively as the respondents describe it (Brink, 1999:119).

**Obtaining qualitative data**

The researcher in the present study ensured truthfulness and trustworthiness by conducting follow-up interviews of respondents who were freely verbalising their experiences, feelings, opinions, perceptions and knowledge about challenges that face them in the workplace.

**Applicability**

The second criterion is concerned with the ability to generalise the findings to larger populations (De Vos, 2000:349, citing in Krefting, (1990). According to Guba (1981) applicability should be seen in the light of its ability to be fitted or transferred to similar contexts outside the area of the study. This is the responsibility of the person who wishes to transfer the study, not the original researcher’s burden (De Vos, 2000:350).
**Consistency**
The third element of trustworthiness in Guba’s model as outlined by De Vos (2000:350), seeks to answer the question that in case the research is undertaken again, it shall consistently present the same results.

**Neutrality**
The last criterion of trustworthiness in this model is concerned with freedom from bias in the research procedure and results.

According to De Vos (2000:350) and Polit and Hungler (1985:255) neutrality refers to objectivity or confirmability of data where the findings are the function of the informants and the condition of the methodology is not biased. There should be an agreement between two or more independent people about the data’s relevance or meaning and there should be no foreign or external interference other than what the respondents have produced uncoerced and uninfluenced. Brink (1999:19) states that whilst bracketing phenomenological qualitative research, the researcher should identify asserts and set aside any preconceived beliefs and opinions one might have about a phenomenon under study. Thereafter all available perspectives of information can be considered with complete neutrality in studying the phenomenon in question.

The researcher bracketed whatever preconceived ideas she had before commencing the study in order to discover what she wanted to discover. The researcher ensured neutrality by distancing herself from respondents and guarded against any untoward influence as the subjects were given the freedom to fill in the questionnaires and to answer as freely and truthfully as possible.
The researcher always stayed in the office and only came back to collect the questionnaires. Other questionnaires were left to be collected after three or four days for the midwives who were off duty.

The researcher deemed it essential to use the model designed by Lincoln and Guba to achieve credibility (truth value), applicability, consistency and neutrality. As a result the respondents who were included in focus group interviewing also had the freedom to ask and answer questions in a relaxed atmosphere, whilst the researcher was writing field notes accordingly.

3.3.4 **Descriptive survey**

The research design used to obtain information from the population under study regarding the challenges that face the trained midwives in the workplace during the 21st century, was a descriptive survey.

Brink (1984) citing Goode and Seates (1954) states that a survey is directed towards ascertaining the prevailing conditions (facts that prevail in the group of subjects chosen for the research study). Polit and Hungler (1995) indicate that the term “survey” can be used to designate any research activity in which the investigation gathers data from a portion of the population for the purpose of examining the characteristics, opinions and intentions of the population.

This method is essentially a technique of quantitative description for the general characteristics of the group. It is an approach to problem solving which seeks to answer questions as to the real facts associated with the existing conditions.
3.3.5 **Phenomenological design**

Phenomenological research according to Morse (1991:56) is a human science that strives to interpret and understand rather than to observe and explain, which is an approach normally found in a natural science. Morse further states that phenomenology has to do with description of experience.

Phenomenological studies according to Brink (1996: 119) examine human experiences through the descriptions that are provided by the people involved. It describes what people experience in regard to some phenomena and how they interpret those experiences, or what meaning the experience has meant for them.

Like other quantitative and qualitative approaches the phenomenological approach consists of a set of steps or stages, which guide researchers in the study of phenomena. These steps are not defined, that is they vary from one phenomenologist to the other. There are certain typical basic actions, which the researcher used during the enquiry process, namely bracketing, intuition, analysing and describing.

**Bracketing**

During the bracketing process the researcher identified and set aside any preconceived beliefs and opinions she might have had about the challenges that face the midwives in the workplace during the 21st century in the Ethekwini region, so that all available perspectives could be considered in studying the phenomenon.

The researcher as someone who has been exposed to the challenges of midwifery practice in the workplace and who has observed substandard care rendered to clients, identified them as
preconceived ideas and bracketed them or put them aside before interviewing.

**Intuiting**
At this stage the researcher tried to develop an awareness of the lived experienced without forcing prior expectations or knowledge in the process.

This stage required the researcher to become totally immersed in the phenomenon under investigation, whereby the researcher had to know about the phenomena as described by the participants.

During this stage the researcher was expected to review the data again and again, until there is common understanding.

**Analysing**
According to Brink (1996:120) this process involves the task of contrasting and comparing the final data to determine what patterns, themes and threads emerge. The researcher applied this process to the process of data analysis, which will be discussed in the following chapter.

3.3.6 **Target population**
Target population is the population that the researcher wishes to study and about which she intends to make generalisations (Polit & Hungler, 1985:447; Woods & Catanzaro, 1988:567). The target population of this study was midwives practising in maternal and child health care services of the Ethekwini region in KwaZulu-Natal, and who are currently registered with the South African Nursing Council. The accessible population of the target population was used with the exception of those who were on leave.
3.3.7 **Sample and sampling**

**Definitions**
A sample is a subset of a population selected to participate in a research study (Polit & Hungler, 1987:536). The researcher used both purposive and convenience samplings.

**Purposive sampling**
According to Brink (1996:141) and Burns and Grove (1997:306-307) purposive sampling entails conscious selection of certain typical respondents by the researcher, those who know about the phenomenon under study and who are able to articulate and explain nuances to the researcher. Hence a number of questionnaires were left for trained midwives who were off duty, including those who were on night duty.

**Convenience sampling**
Brink (1996:140) and Polit and Hungler (1987:209) state that convenience sampling entails use of the most readily available persons as respondents in a study. The researcher selected the sample for study from the clinical settings she could easily reach during her off duty time, as her professional duties demanded most of her time during working hours.

In this study midwives practising at two hospitals and five comprehensive health care clinics in the Ethekwini region were conveniently sampled. Respondents' age distribution was from twenty-one year to sixty years of age.

3.3.8 **Research tool**
A questionnaire is a document that is used to collect self-report information from the respondents through self-administration in a
paper and pencil format. This tool favours collection of data from a large group of respondents, thus allowing respondents to have a greater feeling of anonymity, therefore allowing freedom to provide honest answers without intrusion by the interviewer (Polit & Hungler, 1985:44).

A structured questionnaire was used to collect data. In the structured instrument, the respondents were asked to respond in exactly the same order, and they were given the same questions. The purpose of using the questions with such a high degree of structure is to ensure comparability of responses and to facilitate analysis (Polit & Hungler, 1985:202).

The questionnaires were physically distributed to the target population by the researcher. The respondents were given enough time to fill in the questionnaire without intimidation by the researcher, expressing their opinions, experiences, knowledge and perceptions about challenges that face them in the workplace. Prior to the filling in of the questionnaire, the content was fully explained to the respondents by the researcher.

**Design of the questionnaire**

The questionnaire comprised the following:

(a) Biographical data.

(b) Items on the reason for selection of placement in maternal and child health care service.

(c) Items on reason for choosing midwifery as speciality.

(d) Items on optional choice of preferred clinical setting and reasons based on that choice.
(e) Items on comments regarding professional achievements.

(f) Items on views, opinions and knowledge of the respondents on the subject of the challenges that face the midwives in the workplace during the 21st century, comprising:

- knowledge about challenges that affect the practising midwife in the workplace regarding legal issues,

- knowledge about challenges that affect the trained midwives regarding midwifery administration,

- knowledge about challenges that affect the practising midwife regarding educational aspects of the midwife, client, family and community,

- knowledge about challenges that affect the practising midwives in the workplace regarding ethical issues, and

- knowledge about challenges that affect the practising midwives regarding midwifery practice.

(g) Items on proposed solutions regarding challenges from the midwives’ point of view

**Interviews**

**Focus group interviewing:** According to Marshall and Rossman (1995:84) this technique of interviewing is composed of four to twelve participants who share the same characteristics which are relevant to the question of study.
According to Seaman (1987:244) focused group interviewing is a structured schedule of questions and topics that the interviewer wishes to cover, also to formulate new hypotheses from unanticipated responses, or to collect data on the specified research problems. In this study the researcher conducted focus group interviewing to collect in-depth data about challenges that face the midwives in the workplace and also to consolidate validity and reliability of the study. The same questions contained in the questionnaire were used during interviews with thirty respondents. The researcher chose to conduct face-to-face interviews in addition to the questionnaire method, as it is the most direct method of obtaining facts from respondents. According to Brink (1996:157) this method is useful in ascertaining values, preferences, interests, beliefs and attitudes of respondents.

3.3.9 The pilot study

The pilot study is a trial run of the main study (Brink, 1996:60).

The pilot study was done in order to identify operational problems of the questionnaire, and to test for feasibility of the study, validity and reliability of the instrument.

The sample of the pilot study was selected from six student-advanced midwives of the Ethekwini region, who had just commenced the course but not participating in this study. The purpose was explained to the pre-test group and they were requested to make comments and recommendations on the questionnaires.
3.3.10 Ethical considerations

In this study the researcher had an obligation to protect the human rights and welfare of the respondents who participated in the study whilst ensuring scientific research by relevant stakeholders (Wilson, 1989).

Permission to do the study

Permission to do the research study is essential as this protects and prevents abuse of human rights of the respondents (Brink, 1996:48). The researcher consulted the head office of the Department of Health research section of KwaZulu-Natal Province.

Documents presented to this department were as follows:

➢ Letter requesting permission to carry out research.
➢ Letter from the research supervisor.
➢ Research proposal.
➢ Questionnaire to be used in the research project.

The head office granted permission to carry out the research project within KwaZulu-Natal. Applications were sent to the Department of Health (Durban) Regional Office and heads of the hospitals and clinics in the Ethekwini region requesting permission to conduct the research study in their clinical settings.

There were also accompanying written comments confirming the fact that the researcher is a university student, together with a recommendation from the supervisor and a research proposal. The questionnaire contained information stating the ethical rights of the respondents. Permission for conducting the study was granted by the above stakeholders telephonically and in writing.
Methodology of data collection

Permission was obtained from both the provincial and regional department of health for the researcher to conduct the study at the hospital and clinics under study.

The researcher wrote applications to heads of the hospitals and clinics for permission to conduct the study based on permission granted by the head of the Department of health at the provincial level. Additionally, the head of the Department of Health at the regional office in Durban assisted the researcher by disseminating the information regarding the study to the heads of the selected clinical settings, and also faxed the researcher’s questionnaire to them. This assistance was over and above the applications, which were sent by the researcher to these clinical settings. This facilitated a cordial reception of the researcher on arrival at the relevant clinical settings.

The researcher made appointments telephonically with the heads of the departments, in view of appropriate days preferred for data collection.

On arrival at the clinical settings the matron in charge introduced the researcher to the charge nurses of the units and group of trained midwives, where data was to be collected from the respondents.

The researcher was given the opportunity by the heads of departments and unit nursing managers, to utilize only the time when midwives were available/accessible during tea and lunch breaks, to protect patient care. Some of the questionnaires were collected immediately, i.e. the same day, and others on different days by the researcher. Respondents were requested to answer questions independently.
Purposive sampling was used by the researcher for collecting information on challenges that face midwives from those midwives placed on night duty and those who were off duty as advised by the unit nursing managers (Morse, 1991:129).

Nurses’ tearooms were utilized during collection of data. Informed consent was obtained from each respondent after the researcher gave details regarding the purpose of the study, what was required of the midwives and benefits of the research study (Brink, 1996:42).

Participants were informed about anonymity and confidentiality of information obtained and it was emphasized that participation was voluntary, i.e. midwives who were unwilling to participate were allowed to refrain from doing so. Measures against coercion of midwives were observed as verbal consent was obtained from the respondents (Pera & Van Tonder, 1996:156). The unit nursing managers were responsible for distribution of questionnaires to purposively selected midwives on night duty, as well as those who were off duty. Questionnaires were to be stapled and put in one large envelope, to be collected 3-5 days later from the unit managers.

Focus group interviewing of five to twelve midwives who were on duty during different sessions was used to save time for patient care. Interviews took place in the nurses’ tearoom during lunch times, which was a suggestion from unit nurse managers. Interviews were conducted after collection and perusing of completed questionnaires and subjects granted permission. The trained midwives were asked the same questions contained in the questionnaire but age was omitted, as this is a personal and sensitive factor not to be discussed openly.
The interviewer welcomed the respondents to create a relaxed atmosphere. The purpose of the interview was clearly laid out to the trained midwives. The medium of communication was English and field notes were written to enrich the data.

Respondents were informed and assured of their ethical rights, i.e. to withdraw anytime they wanted to do so, and the dissemination of research findings on completion of the study. Probing was done to get more information on challenges that face the midwives in the workplace, as the researcher had identified that some questionnaires had a low productivity. Field notes were jotted down by the researcher and were confirmed with the respondents at the same time. Each interview session lasted approximately 25 minutes (Brink, 1996:42-46).

According to Cohen and Manion (1997:233), two or more methods of data collection can be used. In this study the researcher used a descriptive survey of the quantitative approach to collect pertinent information regarding the biographic information from subjects, while a qualitative research approach was used to collect information regarding challenges that face trained midwives in the workplace.

The researcher had to ensure that the trustworthiness of the research was maintained, hence Guba's model of qualitative research was applied consisting of the four criteria, i.e. trustworthiness, applicability, consistency and neutrality.

To obtain the true value of the findings, the researcher developed an awareness of the respondents lived experiences by bracketing her preconceived ideas.
Applicability
Applicability of using two sampling methods is concerned with the ability to generalise the findings to larger populations (De Vos, 2002:349 citing in Kreting, (1992). The researcher made an allowance for transferability of the findings to a similar context or generalisation of findings to a larger population.

Consistency
The researcher ensured that the information is handled in such a way that consistency is assured, should another study of this nature be conducted (Burns & Grove, 1997:228).

Neutrality
Neutrality is the best criteria of Guba's model procedure, which is concerned with freedom from bias research. The researcher had to be as objective as possible to obtain data from the subjects and set aside pre-conceived beliefs and opinions that she might have had about the challenges that face the midwives in the workplace during the 21st century.

4 CONCLUSION

Data collection was done from all the trained midwives who formed the sample of the study. Analysis of data and the findings of the inquiry will be done in the next chapter, acknowledging responses from all participants.
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CHAPTER 4

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

The previous chapter dealt with the description of the research methodology used in the study. The analysis and interpretation of data obtained from the subjects, i.e. trained midwives working in the hospitals and clinics of Ethekwini district, who participated in this study, are to be discussed in this chapter.

The questionnaires from the subjects will be analyzed and interpreted. Demographic data will be presented in the form of tables and analysis of responses to questionnaire will be presented using themes and categories.

4.1.1 Definitions

(a) Analysis

Analysis is a method of organising data in such a way that the research questions can be answered (Polit & Hungler, 1985:431).

As indicated in the previous chapter, data analysis involves a process of sorting the information that differs and correlating the ones that explain the same phenomena. The researcher then looks for causal links and this leads to the development of themes.
(b) **Interpretations**

Interpretation is a process of making sense of the results and examining the implications of the findings within a broader context. The researcher explains the findings in the light of what is known about previous work in the area and in the light of the adequacy of methods used in the investigation (Polit & Hungler, 1985:41).

Data collection was carried out at the clinical settings of the Ethekwini region and at times that were convenient for the informants. Some informants were interviewed at the workplace and other filled in the questionnaires during teatime and lunchtime in the nurses’ tearooms. The researcher interviewed only those in hospitals and clinics that were accessible. Unit managers purposively selected some trained midwives on night duty and off duty for completion of the questionnaire.

### 4.2 THE REPORT FINDINGS

#### 4.2.1 Development of themes

After analysing, the data tables were developed for demographic data and seven themes were identified, namely:

- Placement of trained midwives in the maternity section.
- Placement of advanced midwives in the maternity section.
- Choice of midwifery as a speciality by the midwives in their practice.
> Preference and reasons of a midwifery clinical setting for interventions.

> Legal issues identified in the clinical setting by the midwives.

> Administrative issues which are a challenge to the midwifery practice of the 21st century.

> Midwifery education as a challenge in preparation of midwives for more advanced and technical methods required to deal with the more complicated midwifery problems of the 21st century.

> Challenges of midwives in their practice as they relate to the policies of the National Government and Department of Health on controversial issues.

4.2.3 **Data analysis from trained midwives practising in the Ethekwini Region of KwaZulu Natal**

4.2.2 **Quantitative research findings**

It was necessary for the researcher to use a quantitative research approach in order to determine age distribution, gender distribution, years of experience and placement of trained midwives at the clinic versus hospital.

<table>
<thead>
<tr>
<th>Ages</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-30</td>
<td>10</td>
<td>11%</td>
</tr>
<tr>
<td>31-40</td>
<td>34</td>
<td>38%</td>
</tr>
<tr>
<td>41-50</td>
<td>38</td>
<td>42%</td>
</tr>
<tr>
<td>51-60</td>
<td>8</td>
<td>9%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>90</td>
<td>100%</td>
</tr>
</tbody>
</table>
According to Table 4.2.1 the majority of midwives’ ages range from 31-60 years, which is an indication that they are experienced midwives and mature enough to be aware of the problems that they are facing in the workplace.

Table 4.2.2 Gender distribution N=90

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>88</td>
<td>98%</td>
</tr>
<tr>
<td>Males</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>90</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 4.2.2 shows that 98% of midwives who participated in the study were females with only 2% males. These findings are in support of the general view that midwifery is a female dominated profession. It indicates that there is a greater need for recruiting more males into this profession so as to change this view.

Table 4.2.3 Placement of midwives at the hospital versus clinic N=90

<table>
<thead>
<tr>
<th>Clinical setting</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>50</td>
<td>55,6%</td>
</tr>
<tr>
<td>Clinic</td>
<td>40</td>
<td>44,4%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>90</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 4.2.4 shows that the 51.1% of trained midwives who participated in the study has been working as midwives in an obstetric department for more than five years. Therefore these midwives are experienced in this field of nursing and have more insight in the challenges that face them in the workplace during the 21st century.

4.3 QUALITATIVE RESEARCH FINDINGS

It was necessary for the researcher to obtain in-depth knowledge of midwives regarding challenges that frequently face them in their practice.

The qualitative data that was obtained was arranged into themes and the researcher will discuss the themes as follows:

Theme 4.3.1 (a) Placement of trained basic midwives in the maternity section

Some of the basic midwives who participated in the study indicated that their placement in maternity section units was rotational and job related “you just see your name on the change list for the following month without being approached” whilst the rest of the subjects said that “it is where I excel in work, provide
quality total patient care without being bored, especially working in labour ward is challenging because of unanticipated problems that one is faced with at times”.

**Theme 4.3.1 (b) Placement of advanced midwives in the maternity section**

The findings of the study reflected that one particular clinical setting had only one advanced midwife, as the others had left for greener pastures. Advanced midwives head maternity sections in most units of the clinical settings, which were selected for the study except one, which is headed by a community health nurse, who is also a counsellor. Nursing managers without advanced midwifery speciality head some of the obstetric departments. This has an impact on the administration of the department and a concern of some of the subjects who participated in the study, is that: “the needs of maternity section demand a head of the department who is a clinical specialist/consultant in this field as she/he has more insight in maternal and child health care problems”.

**Theme 4.3.2 Choice of midwifery as a speciality by the midwives in their practice**

Some of the subjects who responded to this question indicated that “I wanted empowerment with knowledge and skills, to be able to function independently in the absence of the doctor to save the mother’s life, including that of the baby”. Whilst some nursing managers highlighted that “some of the advanced midwifery qualifiers do not implement their knowledge and skills in practice as expected”.
Theme 4.3.3 Preference and reasons of a midwifery clinical setting for interventions

➢ A portion of the subjects who participated in the study and who were placed either in the clinic or hospital, preferred to practise at the clinic stating that “in the clinic set-up one always has better chances to develop her skills as one is exposed to real situations of different complications, minor and major, in the absence of the doctor, unlike in a hospital situation where there is cushioning of the midwife by the doctor’s coverage”.

➢ Some of the respondents who were either working in hospital or clinic prefer to practise in a hospital situation because they felt “there is enough material and skilled human resources to render quality care timeously, especially in obstetric emergencies”.

➢ The remainder of the subjects who participated in the study preferred to render midwifery services in a home clinical setting stating that “the client is relaxed psychologically and physically because she is in a familiar physical environment with her beloved ones around her, while cultural beliefs are easily considered by the midwife, unlike in a clinic or hospital set-up”.

Theme 4.3.4 Legal issues identified in the clinical setting by the midwives

➢ A portion of trained midwives said “lack of a legalised scope of practice for advanced midwives results in poor recognition by the basic midwives and doctors, which is a limited practice leading to professional role conflict”.
Some informants stated that "South African Nursing Council Regulation 2488, October 1990, for basic midwives, restricts them from doing certain procedures which, if not administered, would endanger the life of a patient, for example, to refrain from performing a vaginal examination if there is bleeding instead of training them on usage of ultrasonics for diagnostic purposes".

Some of the subjects who participated in the study stated that the health care consumers use the termination of pregnancy facility as a form of contraception instead of using the family planning facility, as Act No. 92, November 1996, does not state the number of abortions allowed per person.

Some of the subjects stated "midwives working in the Termination of Pregnancy (TOP) facility are associated with social stigma because the public feel this service is taking lives therefore it is against human morals".

Some of the midwives who participated in the study stated that free health services that were introduced by the government after 1994, especially in maternal and child health care services have led to an influx of clients amidst staff and shortages of maternal resources, thus exposing the midwives to litigation, as the public is aware of its human rights. These legal implications have an impact on the midwives who receive no support from their employer when faced with such litigation. Overworking also leads to poor recording with indirect legal implications.

Some of the trained midwives said that there are no clear protocols for abused women and children when they present themselves in the clinical setting.
Midwives who participated in the study said that maintenance of confidentiality of HIV-positive clients is problematic especially those who are part of the nevirapine study. This causes problems for the trained midwives because it is difficult to trace these clients when they default.

Theme 4.3.5 Administrative issues which are a challenge to midwifery practice of the 21st century

Some of the subjects who participated in the study stated “a woman delivered her baby outside the clinic as she did not know that night duty in our institution is on hold”. This reflects that there are communities who are not informed about changes of availability and accessibility regarding the health care facility that serves them.

Some of the respondents who participated in the study said “I am willing to do everything for the patient but because of the shortage of resources, it is very difficult to perform my midwifery interactions: there is a shortage of cardio-topograph machines, dynamaps, ivac pumps, and scales for weighing patients, even the beds for patients in maternity ward at times”.

Some of the midwives confirmed that transport was their major problem. A radio system and telephone are available, but the delay and insufficient number of ambulances are major problems when transferring the patients with problems to the hospital, as it takes ± four hours to arrive, at times. Some stated, “When complications arise (medico legal hazards) midwives suffer legal implications”. It has been revealed that because of this some of the midwives are used in favour of working at the clinics because of the problem.
Some of the midwives who are placed at the clinics said “The changes that have been implemented in referral systems seem to be used as an argument by the clients, as they may go to any health care facility because it is their human right, thus overcrowding the facility of choice leading to substandard care and possible litigation against the practising midwives”.

Theme 4.3.6 Midwifery education as a challenge in preparation of midwives for more advanced and technical methods required to deal with more complicated midwifery problems of the 21st century

Some of the respondents who participated in the study stated “ignorance of traditional birth attendants and Sangomas about the outline of complications of pregnancy, even ordinary signs and symptoms of labour, contributes to late booking/unbooking with the health care facility leading to an increased maternal mortality rate.”

Some of the subjects who participated in the study said “It is difficult to work with the old student midwife of 59 or 60 years old, as they are reluctant to take orders from the younger trained midwives, let alone the pool of student midwives/medical students/newly qualified midwives in labour wards. When you are so short staffed they still need supervision, and this leads to substandard care and burnout syndrome”.

Some of the subjects who participated in the study said “One is not so confident in midwifery interventions currently as one attends to diverse racial clients who are concerned about their human rights (cultural values and beliefs) whilst one is not sure of their cultural beliefs”.
> "As an advanced midwife when I am faced with complications like antepartum haemorrhage away from hospital I always feel bitter due to ignorance regarding usage of ultrasound which would give an exact diagnosis promptly, leading to proper management, and save a number of women’s lives and that of their babies". A number of advanced midwives who participated in the study reflected this as their concern.

> Some qualifiers of the Four Year Comprehensive Course who participated in the study said, “the first six months after qualification when allocated in labour ward, exposes one to emotional trauma and confusion due to skills that are lacking. The experienced midwife does not have time for you; she is irritable, complaining of being overworked without incentives. The midwifery module of six months is too short and by the end of the fourth year of training, all you have is theory with deficient skills”. The comment of the newly qualified midwives reflects that they are a burden to experienced midwives, especially with current shortages due to the brain drain of experienced nurses/midwives.

> Some of the subjects who participated in the study highlighted in questionnaires that “although there is advanced technology in our clinical settings like computers, one cannot access them and remains computer illiterate, yet management of the patient demands usage of the computers”.

Theme 4.3.7 Issues and dilemmas related to midwifery practice as they apply to challenges that midwives face in the 21st century

Some of the subjects who participated in the study were concerned about controversial issues regarding termination of pregnancy and
the practising midwives: “Should the pregnant woman’s right to termination of pregnancies be abandoned because it violates the social/personal values of midwives? Once one works in termination of pregnancy clinic, even colleagues associate her with low morals”.

Some of the subjects who participated in the study said “We are victimised by the community who want to be attended to even if it is not an emergency, especially after hours. The practising midwives allocated in these clinical settings are often threatened and the public they serve infringes their human rights.

Theme 4.3.8 Issues that negatively impact on the Government National Health Plan of 1994 regarding midwifery practice

➢ Some of the subjects who participated in the study said “exposure to crime (i.e. life threatening situations) and vandalism in the clinic infringe benefits of the community to access the clinical setting’s 24 hours service, thus affecting implementation of Primary Health Care according to the National Health Plan of 1994”.

➢ Other subjects who participated in the study stated “dealing with HIV-positive/AIDS women has an impact on them: especially when allocated to work in labour wards one is scared of needle pricks, or even worse, to nurse dying patients in lying-in wards”.

➢ Others are concerned about confidentiality issues when HIV-positive women are discharged. Who will nurse them at their homes: ignorant family members? “Lack of access to modern
technology (computers, internet) leads to delays in getting patients' information and results”.

- Poor communication: “A woman delivered her baby outside the clinic. She did not know that night duty in our clinical setting is on hold”. This reflects the concern of some of the respondents about patient care.

- Some of the trained midwives said, “Poor communication between midwives and clients and amongst midwives and multidisciplinary team members remains a problem hence poor patient care”.

- “Poor communication is also reflected in recording in pantograph and this has an impact in management of the patient”.

- Some of the subjects who are ADM (Advanced Midwifery) trained said “I feel retarded because there is no opportunity to practise advanced midwifery skills effectively as a change agent/a researcher due to staff shortage and lack of equipment.

4.4 CONCLUSION

Data analysis has been discussed in this chapter according to the identified themes based on the questionnaire and research questions.

Discussions of research findings, guidelines to solutions, limitation of the study, summary, recommendations and conclusion will be done in the next chapter.
CHAPTER 5

5.1 INTRODUCTION

5.2 DISCUSSION OF THE RESEARCH FINDINGS

5.2.1 Triangulation

5.3 OBJECTIVES OF THE STUDY

5.3.1 Discussion of objectives

(a) Professional role conflict amongst the health personnel

(b) Problem of lack of specifications regarding the number of pregnancies to be terminated by the client

(c) Impact of free health services

(d) Poor communication system

(e) Educational role of a midwife

(f) Patients delivering outside the health care services

(g) Problem of confidentiality

(h) Lack of support for HIV pregnant mothers

(i) Competence of midwives

(j) Lack of job satisfaction

(k) Impact of traditional birth attendants on maternal and child health services

5.4 GUIDELINES TO SOLUTIONS DETERMINED BY THE CHALLENGE THAT FACE THE TRAINED MIDWIVES IN THEIR WORKPLACE IN THE 21ST CENTURY

5.4.1 Antenatal care
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<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
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<td>5.4.2</td>
<td>HIV/AIDS issue</td>
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<td>Traditional birth attendants</td>
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<td>5.4.8</td>
<td>Development of Medical Obstetrics Clinics</td>
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<td>5.5</td>
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<td>5.6</td>
<td>SUMMARY</td>
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<td>CONCLUSION</td>
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<td>REGULATIONS</td>
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CHAPTER 5

DISCUSSION OF FINDINGS, GUIDELINES, LIMITATIONS OF THE STUDY, SUMMARY RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

The researcher wishes to make specific conclusions and recommendations based on data analysis. The researcher obtained information regarding the challenges that face the trained midwives in their workplace in the 21st century.

Literature was studied and general information was obtained through the use of questionnaires and interviews which revealed that there is quite a number of challenges that face the trained midwives in their midwifery practice, which have to be addressed urgently for effective patient care and midwives' job satisfaction, also to limit claims laid by the public, as clients, against employee/employer when they sue for substandard care.

The nursing managers together with nurse educators, including other relevant stakeholders (multidisciplinary team members, community members and doctors), should collaborate with each other for a common goal of effective patient care, destructive criticisms are not solutions.

It became clear that the current midwifery curriculum is obsolete, and should therefore be reviewed to accommodate contemporary
issues of the 21st century. It is also clear that community and practising midwives' involvement is still lacking when the midwifery administrators design policies, and that this impacts negatively on these stakeholders. Involvement of grassroots stakeholders in designing policies improves their cooperation; their feeling of being recognised boosts self-esteem, according to the midwives' point of view.

This chapter will present a discussion of the findings and the objectives of the study, guidelines to solutions determined by the challenges that face the trained midwives in the workplace of the 21st century, limitations of the study, a summary, recommendations and conclusion.

5.2 DISCUSSION OF THE RESEARCH FINDINGS

Both quantitative and qualitative research methods were used to collect data. The researcher used the quantitative research method to collect demographic data and the qualitative research method to collect data on frequent challenges that face the midwives in the workplace of the 21st century. Trained, practising midwives were chosen as respondents for the study. The sample size was ninety subjects who were conveniently and purposively selected from both public hospitals and Comprehensive Health Care clinics in the Ethekwini Region. Responses from the respondents were elicited by means of a questionnaire followed by focus group interviews using the same questionnaire. Biographic data was analysed statistically and a descriptive qualitative survey design was used for the study.
5.2.1 **Triangulation**

According to Cohen and Manion (1997:233) triangulation refers to the use of two or more methods of data collection with a study of human behaviour so as to consolidate the reliability and validity of research findings.

5.3 **OBJECTIVES OF THE STUDY**

- To explore the knowledge of midwives regarding the problems which they have to face in their midwifery practice of the 21st century.

- To identify the challenges that are currently faced by the midwives in their practice from their own perspective or own point of view.

- To develop guidelines regarding solutions that can be implemented so as to address problems directed to maternal and child health as well as the needs of the midwives, during the 21st century.
5.3.1 Discussion of objectives

Objective Number One: To explore the knowledge of midwives regarding the problems which they have to face in the midwifery practice of the 21st century.

This objective was met because: The respondents' knowledge was tested through questionnaires, while focus group interviews were conducted to establish midwives' perceptions regarding the problems that occur in their midwifery practice. This is noted by the responses such as the following that were raised by the midwives:

(a) Professional role conflict amongst the health personnel

Professional role conflict amongst health personnel (advanced midwife) due to the lack of the South African Nursing Council's prescribed scope of practice, was identified. Currently there is no scope of practice relevant to the advanced midwife's competencies thus leading to frustration and job dissatisfaction, as they cannot produce professional evidence to back them up when arguments arise from other colleagues whilst they execute their competencies in their clinical settings.
(b) Problem of lack of specifications regarding the number of pregnancies to be terminated by the client

Since the Termination of Pregnancy Act, Act No. 92 of November 1996 was introduced, some clients who access this facility, appear to be using it as a form of contraception because the content of this Act does not indicate the exact accepted number of abortions per client, as a result clients are free to abort as often as they wish. This has an impact on the government’s finances because the service rendered by this facility is free. This also results in an increased influx of pregnant teenagers to this facility.

(c) Impact of free health services

The free health services policy that was introduced by the government since 1994, such as free maternal health and child health services, was a good decision but the last authorised to be given to single parents contradicts the family planning service, as these women are being paid for delivering babies. Whilst the rate of poverty is high due to unemployment, midwives who are already short-staffed are faced with an influx of pregnant teenagers at the antenatal clinics and labour wards, who are conceiving in order to be paid through the government grant.

> Over and above the already mentioned factors there are additional projects conducted in the midwifery clinical settings like nevirapine project, without additional staff being provided. This leads to substandard care as the number of midwives for
the maternal and child health service is limited. This is reflected by the patient-midwife ratio of 1:40, which impacts on midwives’ productivity.

Practising midwives usually deal with problematic pregnant women, especially those who are placed at the peripheral clients without a doctor, presenting with problems like obstetrical emergencies, HIV infected victims of sexual abuse, physical abuse, emergency family planning, etc. with a limited legalised scope of practice. In some instances the midwife functions as a doctor, junior nurse/midwife, senior midwife, and counsellor.

Over and above the workload faced by the midwives the midwives also face poor working conditions due to limited or outdated resources, leading to substandard care of pregnant women. Also, drugs used at the hospital are not available at the clinics.

(d) Poor communication system

Lack of communication or break in communication due to attitudes is illustrated by the following comment by one of the respondents: “at times when you contact the doctor in the base hospital per referral system, you are thrown through from pillar to post, until worse complications take place in the patient, like intra-uterine death when you are told there is no bed available.” The outcome of this type of behaviour leads to legal implications for the practising midwives.
Poor communication is also due to burnout syndrome from tiredness without incentives, which impacts on oral or written interactions between doctors and midwives, midwife and client and midwife and colleague. This affects the attitudes, which portray the professional image of the midwifery discipline, because when the practising midwives are emotionally disturbed, they are not approachable by their clients and tempers flare. Thereafter a client who is aware of her human rights regarding health services may lay charges against the midwife concerned.

(e) **Educational role of a midwife**

Record-keeping also remains a problem of practising midwives, especially in labour wards with increasing numbers of inexperienced midwives who are not competent in the usage of a partograph. The following is a comment from one of the newly qualified midwives from the four-year comprehensive course programme: “Some of the experienced midwives are not prepared to teach you, when you are newly qualified instead they enlist their grievances, most of the time you appear stupid in the labour ward, really six months midwifery module done in third year is too short for mastering obstetric skills to deal with the lives of the mother and the baby”.

This problem impacts on both productivity of the newly qualified midwives and experienced midwives acting as mentors of the qualifiers, leading to substandard care.
(f) Patients delivering outside the health care services

A comment from one of the respondents regarding patients delivering outside the health services illustrates the impact of the problem: "At times the pregnant women deliver outside the health care facility because it does not function for twenty-four hours around the clock due to the impact of violence like threats against practising midwives by community criminals. This also leads to increased staff turnover."

There are some community members who are not aware of the availability and accessibility of services that are offered by their relevant health care facilities.

The Code of Ethics is known but not implemented by the midwives due to increased workloads when experienced nurses/midwives leave for greener pastures.

(g) Problem of confidentiality

HIV-positive pregnant women who consent to participate in the Nevirapine study are instructed by the midwives to breastfeed exclusively the first six months post delivery, but once discharged, the partner or mother-in-law questions her for not feeding the baby artificially when the baby cries. She is questioned because the partner or relatives are ignorant about her HIV-positive status.
The woman ends up mixing both types of feeding, causing the baby to suffer from diarrhoea.

(h) **Lack of support for HIV pregnant mothers**

- HIV-positive women at times default in the Nevirapine project because they feel that as there is no cure for HIV/AIDS, there is no need to comply with Nevirapine project. They prefer to die with their babies rather than leaving orphans when they die. Whilst some pregnant women believe Nevirapine is a cure for AIDS, there are still some controversial issues about the Nevirapine project of which they are not aware.

(i) **Competence of midwives**

- A maternity section which is led by a midwife without advanced midwifery speciality poses a lot of administrative problems as this section needs a nurse clinician/consultant who will have insight in maternal and child health problems including doctors' and midwives' concerns regarding midwifery practice.

(j) **Lack of job satisfaction**

- A comment from one of the respondents regarding lack of job satisfaction illustrates frustration: “There is no job satisfaction, as after hours, during weekends and public holidays one
attends to maternity cases as well as casualties; whilst you are still observing the woman in labour, a gunshot patient arrives, whose condition demands individual attention, and you are expected to deliver optimum care to both otherwise you are victimised by the relatives, yet you are accountable to patient employer and law for your actions and omissions (SANC R387 as amended). At times the behaviour portrayed by the midwives impacts on the professional image of nursing, based on these dilemmas.

➢ The practising midwives are not involved in the development of policies/protocols that affect their practice, in contrast to the theory since 1994 of South Africa as a democratic country with freedom of speech and the Batho Pele principle of transparency.

(k) Impact of traditional birth attendants on maternal and child health services

According to Nolte (1998:59) the traditional birth attendant is a middle-aged or elderly lady with no formal training, who only acquired her skills through experience. She prescribes mainly herbs like Isihlambezo, which hastens delivery. At times isihlambezo damages vital organs like the kidneys (renal failure). Other herbs cause bleeding from the uterus after delivery. These complications contribute to the increase in maternal morbidity and mortality rates.
**Objective number two**

To identify the challenges that faces the midwives in their practice from their own point of view. This objective was met because the trained midwives stated explicitly the challenges that concern them in their midwifery practice:

Challenge No. 1  *Application of the Batho Pele principles of transparency on reproductive health*

➢ Midwives have to strategise the implementation of the Batho Pele principle of transparency by developing a means of informing the public about times of availability and accessibility of their maternal and child health care services.

Challenge No. 2  *Increased emphasis on patients’ human rights*

➢ The government’s release of the Bill of Rights after 1994 has increased the health care consumers’ awareness about their rights; hence there is often litigation brought against the nurses/midwives emerging from substandard care, or poor communication or attitudes towards the clients/patients served by them.

Challenge No. 3:  *Self-empowerment of midwives*

➢ Midwives need to be up-to-date with the management of obstetric emergencies as they practice independently at the
clinic, to prevent unnecessary maternal and foetal deaths. Therefore they must devise a plan for revamping their scope of practice in accordance with SANC Regulations 2488, chapter 2, R2598, as amended, and Regulation 777, as amended, as these regulations limit their scope of practice.

Challenge No. 4: Promotion of forensic nursing in midwifery clinical settings

➢ The trained midwives are dealing with abused pregnant women as sexually, physically or emotionally abused mothers who often deliver congenital malformed newborn babies or babies delivered by HIV-positive mothers. The midwives often lack in competencies of caring such problems, especially in diagnosis of abused women, or the counselling and referral of such cases, or how to prepare for court cases.

➢ Ideally nurses/midwives should coordinate programmes in collaboration with doctors, police and social workers to ensure that health, justice and needs of each abused woman are catered for (Gee, 2003:1)
Challenge No. 5: Public awareness regarding termination of pregnancy facility

- Midwives need to know more about the nevirapine project as some members of public believe that nevirapine is a cure for AIDS.

- Midwives must understand and have more insight regarding the approach to exclusive breast-feeding or artificial feeding, as the public often thinks that everyone who is breastfeeding exclusively is HIV-positive.

Challenge No. 7 Self-empowerment with research skills

- The midwives are still lacking in research skills, yet they are concerned about the improvement of maternal and child health care services based on research findings as much as possible.

Challenge No. 8 Professional commitment

- Trained midwives have a duty to care for clients of all racial groups with no discrimination; otherwise they are accountable for their actions and omissions according to South African Nursing Council Regulation 387, as amended. In spite of poor working conditions or staff shortage and litigations laid against
them, midwives must not lose focus of the nursing/midwifery philosophy.

Challenge No. 9  **Violation of patients' privacy**

➢ At times maintenance of privacy is lacking as the labour ward is often situated next to the corridor where all types of patients (casualties, patients with medical problems, etc.) are attended to during weekends, after hours and during the night.

Challenge No. 10  **Ethical dilemmas in the workplace**

➢ The patient-midwife ratio in some maternal and child health care services are ±1:40 resulting in delays in execution of midwifery interventions, hence some pregnant women deliver their babies outside the clinic.

➢ Regarding the development of research skills, primary health care, screening and counselling skills of abused women, midwives have to strategise how they are going to deal with these aspects as they impact on the abuse of women by males.
Challenge No. 11 Competence in diagnostic techniques

➢ The midwife should be competent in making differential diagnoses of conditions, prioritise problems for prompt, appropriate intervention and refer the patient early, accordingly to Nursing Act 63 of 1977 (South African Nursing Council Regulation 2488 of October 1990:Chapter 2, section 10).

Challenge No. 12 Self protection

➢ The trained midwife must be able to protect herself from HIV and AIDS physically and psychologically. The midwife must embark in role modelling and good moral standards in her lifestyle and use protective measures against HIV and AIDS.

Challenge No. 13 Midwife as a resource person

Self-empowerment of the midwife is essential in order to be a resource person of information regarding midwifery practices like HIV and AIDS. This can be achieved through attending conferences, short courses, updates on HIV and AIDS, for example the mother to child transmission issue addressed through the Nevirapine projects. They should be well versed in new referral systems and available resources for support groups regarding maternal and child health issues, including crisis centres when clients are faced with problems of abuse.
Challenge No. 14  **Midwife as a health educator**

- To initiate education programmes (awareness campaign) like talks on the prevention or causes of maternal deaths and teenage pregnancies, which lead to a population explosion or an increase in young women infected with HIV.

- To initiate education programmes about the “Big Five” killers of women (AIDS, pregnancy induced hypertension, obstetric haemorrhage, puerperal infection and indirect causes, mainly cardiac disease), which involve training of traditional healers/birth attendants as they see pregnant women at first hand.

- Midwives need to re-train communities that the termination of pregnancy facility has not been developed by the government as another form of family planning facility but as per Government Act 92 of November 1996 which states the conditions. Women in the community have no moral responsibility or self-control if their bodies are carelessly exposed to regular terminations of pregnancy meanwhile the family planning facility is a free service.

- Midwives have a responsibility to reinforce to the public moral sexual behaviour, healthy lifestyle and the complications of successive abortions like cervical incompetence or uterine rupture.
Re-training the public about correct utilisation of grants given to unmarried women for children, emphasise personal integrity, morale and abstinence by waiting until married, because the availability of this financial facility is often misused by the public.

Health talks regarding the use of emergency contraception within 72 hours of unprotected sex is essential, especially with the increased number of rape victims, thus preventing unwanted pregnancies. Midwives should ensure that the public is aware of crisis centres and family planning services for emergency contraception post rape (Nursing Update, March 19, 2002:28-29).

Childbirth education – According to Kelbritsch (Nursing Update September 2001:38) implementation of childbirth education is a demand as the public served by midwives has changed from extended families to nuclear families. The childbirth educator is a teacher who provides information about the physiology, psychology and sociology of pregnancy, childbirth and post delivery experiences. Empowering couples with this knowledge will indirectly promote a marriage bond between them. It will also encourage active participation of partners in pregnancies, childbirth etc. and will dilute stereotyped cultural beliefs, prevent extramarital affairs and sexually transmitted diseases like HIV/AIDS. Trained midwives must promote a healthy society by all means.
> There is a need to sensitise all health workers, but especially the practising midwives, about domestic violence in pregnancy, its determinants, presentation, complications, consequences and how it can be recognised.

> There is a need to teach health workers/midwives about domestic violence and to include this social pathology in the reproductive health curriculum (i.e. midwifery curriculum). The course content should include counselling and communication skills.

> Routine screening for domestic violence should be done to all women that seek reproductive health care services in public institutions as such women do not easily open up about their problems.

> There are limited research studies on the impact of domestic violence on reproductive health of the victims in KwaZulu-Natal; therefore further research studies are essential.
5.4 GUIDELINES TO SOLUTIONS DETERMINED BY THE CHALLENGES THAT FACE THE TRAINED MIDWIVES IN THEIR WORKPLACE IN THE 21ST CENTURY

In this section guidelines are presented following important discussions of the phenomena. The following should intensify guidelines:

5.4.1 Antenatal care

➢ Education of females and their partners about pregnancy and antenatal care. It should be emphasised that compliance to scheduled antenatal visits as indicated by the midwife or an obstetrician for monitoring pregnancy in order to detect and treat early any abnormalities is essential, thus preventing maternal morbidity and mortality rates.

➢ Preparation of midwives and advanced midwives for screening of pregnant women regarding sexually transmitted diseases, HIV/AIDS, anaemia, hypertension in pregnancy, etc. through mentoring of newly qualified midwives, induction courses, workshops and conferences is essential.

➢ Identification of clients who need counselling timeously, screening and commencement of treatment by the midwives within their competencies and scope of practice.
Midwives should diagnose and treat sexually transmitted infections according to the protocol of the institution.

Midwives should be competent and prevent complications by developing a criteria for judgement of abnormal labour through:

- Reinforcement of understanding of partograph, correct recording and interpretation of findings on partograph and immediate intervention to prevent complications like ruptured uterus due to obstructed labour.

Development of stations for dual communication between the client at home and the relevant midwife, should be developed at the health care centre, when antenatal visits scheduled for low obstetric risk clients is initiated (MIDIRS, June 2000:169-170).

Address the problem of the delay of transport at the clinics by:

- Early admission of pregnant women at risk.

- Organisation of at least one well equipped ambulance stationed at each clinical setting to counteract delay of transport leading to complications or maternal deaths due to conditions like excessive vaginal bleeding.

Development of refund strategies for any staff member who has offered his/her motor vehicle to transport the patient when
there is a crisis, which can lead either to foetal or maternal death.

➤ Guidelines should be provided for midwives faced with problems of doctors’ attitudes whilst consulting for referral of patients with complications.

5.4.2 HIV/AIDS issue

➤ Intensive screening and counselling (pre and post) are essential to prevent non-compliance to health care services.

➤ Workshops on nurses/midwives’ attitudes towards HIV/AIDS victims, as the South African Constitution, section 12 (2) states that “everyone has the right to bodily and psychology integrity” (Geyer, 2001:27).

➤ Conferences/seminars: Midwives should involve the HIV-positive clients who have been targets of discrimination at the maternal and child health care facilities when having conferences/seminars to address attitudes towards HIV clients (own opinion).

➤ Reinforce beacons of the South African nurses’ credo which describe nursing as a belief in the uniqueness of man and the realisation that creator has put in our hands as midwives’
responsibility for our own welfare as well as that of our fellow human beings. This belief provides an underlying strength, which carries and provides meaning to midwives’ work even when they feel overworked. **Acceptance:** nursing is an acceptance of uniqueness of the client and necessity of using all resources to provide for the health needs of the unique person/client, therefore it has to be instilled in the minds of the current practising midwives that midwifery service is a professional service for mankind with no discrimination, i.e. even if she is HIV-positive (Potgieter, 2002:34-35).

- The midwives should refer victims of HIV/AIDS to relevant support groups.

- Reinforcement of health lifestyles and prevention of re-infection through use of condoms is essential during health talks by the midwife (both female and male condoms are available in any family planning facility).

5.4.3 **Guidelines about the necessity of using the condoms**

- The research studies have reflected that using a condom during coitus is more than 10 000 times safer than not using a condom, provided it is used correctly and consistently (Nursing Update, November, 2000:26).
Well developed skills and intrinsic motivation of the client in consistent and correct use of condoms have been proven through research studies to prevent pregnancy and to reduce the risk of transmission of sexually transmitted diseases when combined with by ±99% spermicides.

The midwives should emphasise the following guidelines regarding reinforcement of understanding the consistent and correct use of condoms during health talks:

- Consistent use: use a condom with every act of coitus from start to finish, including penile vaginal intercourse, and oral intercourse.

- Correct use of condoms:
  * Check the expiry date of the condom prior to use.
  * Store the condoms in a cool place, out of direct sunlight as latex brittles from changes in temperature, rough handling, or age.

Carefully open the condom package; teeth or fingernails can tear the condom.

Put on the condom after the penis is erect prior to touching any part of the partner's body.
If the penis is uncircumcised the man must pull the foreskin back before putting on the condom.

Put on the condom by pinching the reservoir tip and unrolling the condom all the way down the shaft of the penis from the head to the base.

If the condom does not contain a reservoir tip, pinch it to leave a half-inch space at the head of the penis for the semen to collect post ejaculation.

Withdraw the penis immediately if the condom breaks during coitus and replace it with new condom before resuming intercourse.

Use spermicidal foam and jelly and arrange with the midwife for an emergency contraception.

Use only water-based lubrication; avoid the use of oil-based lubricants like cooking/vegetable oil, baby oil, hand lotion or petroleum jelly as these predispose a condom to breakage.

Withdraw the penis immediately after ejaculation, whilst the penis is still erect, grasp the rim of the condom between the fingers and slowly withdraw the penis so that no semen is spilled.
According to Matsau (2001:20-21) the research studies have revealed that men are more responsible for the spread of HIV/AIDS because for every man there are 3 women infected by him. Therefore midwives should form women's groups or join existing societies or church groups, thus creating the opportunity to talk to both men and women about HIV/AIDS. Also to address the youth including boys to combat teenage pregnancy, sexual transmitted infections including HIV/AIDS, and to promote males' commitment in combating diseases that affect the maternal and child health status.

- Reinforcement of use of female condoms by females as they are vulnerable to males due to African acculturation in their socialisation, is essential.

Research findings of several studies have reflected that people who use condoms live longer than those who do not use them.

- Prevention of transmission of HIV from the mother to the child through administration of Nevirapine.

  - Mothers must be told about the effect of Nevirapine to prevent myths about it, i.e. that it cures the disease.

  - Mothers must also be told that Nevirapine does not cure HIV/AIDS but that it prevents transmission of the virus.
from the mother to the baby, and that it is not one hundred percent protective.

- The midwives who participate in Nevirapine (prevention of transmission of HIV from mother to child) should enjoy what they are doing, have good communication skills, be knowledgeable about and skilled in their project in order to achieve good results (i.e., guidance to both pre and post counselling of subjects of their project).

> According to Abdullah (2002:35) basic calculations have shown that for every one Rand spent on the PMTCT (Prevention of mother to child transmission of HIV) programme, government has saved ± R2,50 on hospital costs for treating an HIV-positive baby.

5.4.4 **Implementation of the Batho Pele principle of accessibility**

> The public must be informed about the working hours of the clinical setting and the services it provides through the mass media, meetings between key figures of the community and health care centre administrators, and also through pamphlets, etc. to prevent litigations being brought by the public against midwives due to failure to access the facility, e.g. delivery of a client outside the health care facility when night duty is on hold.
5.4.5 **Professional development**

- It is the responsibility of current practising midwives to keep themselves knowledgeable and skilled by attending workshops, seminars, conferences, stressing accountability, professional confidentiality, and communication skills, because of the possibility of clients laying charges against practising midwives regarding negligence whilst executing midwifery, as the clients are aware of their human rights.

- Guidelines on managing conditions of the “Big Five killers” (AIDS obstetric haemorrhage, pregnancy induced hypertension, puerperal sepsis and indirect causes like cardiac disease) must be accessible to all newly employed midwives and be implemented throughout the clinical settings of the Ethekwini Region to eliminate an increase in the maternal mortality rate.

- Practising midwives should ensure that the data to be filled in when there is maternal death is done properly to promote the process of notification of maternal deaths, in order to identify causes and prevent them in future.

5.4.6 **Implementation of forensic nursing in clinical settings of the Ethekwini Region**

- Forensic nursing is a new nursing specialisation, which deals with education and training of nurses/midwives in diagnosis,
management (including referral to support groups, the police, social workers, doctors, etc.) of sexual assault victims, i.e. women. This goes beyond the traditional scope of practise of nurses/midwives in South Africa.

> Nurses/midwives should be trained as Sexual Assault Nurse Examiners (SANE) in order to perform forensic examinations and care with a “forensic mind”, to combat increased maternal morbidity and mortality rates due to violence.

> There should be written recommendations in the National and Maternal and Child Health Care Programme to guide and support midwives in questioning all pregnant women about violence/abuse (Gee, 2003:2)

> To achieve adequate, optimal assessment and intervention during antenatal, intrapartal and postpartal periods, the employer should provide a supportive professional network both for the practising midwives and for the abused women, as the World Health Organisation has stated that violence against women is a priority issue in health fields and human rights (WHO, 1977 cited in Edin & Högberg, 2002:268).

> Steps must be taken against any husband (or male partner) that is committing violence against women.
Pregnant women must be encouraged to formulate groups in their communities, have key figures in those groups who will coordinate talks on the variety of violence and impact of violence on their health, and orientate them about crisis centres and other available resources. These community members will be in direct contact with maternal and child health care service.

Mothers suspected to be abusing their babies must be investigated. It is the responsibility of the practising midwives to consult relevant stakeholders.

5.4.7 Traditional birth attendants

Guidelines should be laid down in the National Maternal and Child Health Care programme regarding the training of traditional birth attendants and how trained midwives should interact/work with them.

The public should be made aware of the training facility of traditional birth attendants and the advantages of this facility should be revealed through press, mass media, etc.

The public should be trained to realise that delivery by a birth attendant may not be as safe like one conducted by the trained midwives. Traditional birth attendants should be utilised as a last resort when no professional help can be obtained.
Practising midwives, i.e. midwifery administrators, must identify the known traditional birth attendants in their communities and conduct health talks to prevent increased maternal mortality rates due to Isihlambezo, etc.

5.4.8 Development of Medical Obstetrics Clinics

The establishment of medical obstetric clinics may enhance optimum management of women with pre-existing medical problems like anaemia, cardiac disease, diabetes mellitus, etc.

5.5 LIMITATIONS OF THE STUDY

During the process of the study problems not envisaged beforehand will always challenge the researcher irrespective of carefulness in the preparation and methodology. Most studies show limitations that relate to conceptual definitions and methodological problems (Nzimakwe, 1997:172).

The following factors were areas of limitation in this study:

The researcher experienced difficulties in collecting data due to time constraints.
The researcher was not granted study leave from work and it was therefore difficult to do the study as the researcher is employed full-time.

Financial constraint was another limiting factor since there was no funding available for the study; this prevented the researcher from extending the research study to other regions of KwaZulu-Natal.

Some institutions took a long time to grant permission to conduct the study in their clinical settings.

5.6 SUMMARY

The researcher investigated the challenges faced by the registered midwives in their workplace.

The sample size was 90 subjects and the sampling of clinical settings for the study comprised two hospitals and four clinics of the Ethekwini region, which were conveniently selected. The subjects that were off duty and those on night duty were purposively sampled through the assistance of the unit nursing managers. Other subjects were conveniently sampled in these clinical settings during lunch times, tea times and the researcher’s off duty time.
The responses from respondents were elicited by means of both questionnaire and interviews.

Demographic data was analysed statistically and was presented in the form of tables whilst analysis of responses to the questionnaire was presented, using themes.

The findings of this study reflected explicitly the following:

- Job dissatisfaction of practising midwives due to stressful working conditions.

- Staff shortages with a ratio of 1:40 with fewer incentives.

- The need for staff empowerment with transcultural nursing, forensic nursing, research skills, computer skills, counselling skills, Nevirapine study, PEP (Perinatal Education Programme), Advanced Midwifery and Neonatal Nursing Course and continuing education.

- Reinforcement of health promotion so as to prevent an increased maternal mortality rate due to the "Big Five" conditions.
Revamping of South African Nursing Regulations that govern the practising midwives and development of a scope of practice for advanced midwives.

Revamping of the current midwifery curriculum to suit the needs of the relevant community being served.

Demand for improved involvement and training of traditional birth attendants in aid of health promotion and early identification of referral of problematic pregnant women to hospital.

Necessity of regular student accompaniment during training of the midwives to relieve the burden of supervision from understaffed trained midwives.

The necessity of mentoring the newly qualified midwives to prevent substandard care.

The necessity for increased capacity building of employees from ENAs (Enrolled Nursing Assistants) upwards to cover staff shortages.

The reinforcement of application of the Batho Pele principles of transparency, and the availability/accessibility regarding
services rendered by the appropriate clinical settings to prevent legal charges laid against practising midwives.

> Midwives fear and have concerns about conducting deliveries of HIV-positive patients who can infect them, without Workmen’s Compensation benefits being available to them. They also have to face questions on the Nevirapine project from the public.

5.7 RECOMMENDATIONS

Based on the findings, the researcher wishes to propose the following recommendations.

**Placement of trained midwives in the maternity section**

The findings on the study reflect that placement of a number of midwives in the maternity section according to rotational allocation, is job related. Therefore the allocation of more experienced midwives in labour wards for mentoring the inexperienced midwives reduces possible litigation being lodged by the public against midwives due to substandard care. This will indirectly save money when the institution is sued for such practices, but there should also be incentives for the experienced midwives.
Gender

Most subjects who responded to questionnaires are females with very few males. Contrary to doctors (male obstetricians) there is a very small proportion of male nurses in South Africa who choose to practise midwifery. This may indicate the need for the provision of choices of modules in the basic nursing training programme, rather than the current comprehensive nursing training programme in which all modules are compulsory.

Placement of advanced midwives in the maternity section

Placement of an advanced midwife to head the maternity section could minimise complaints from doctors/clients/patients. This officer has more insight into the management of maternal and child health care services, rather than having a nursing manager “who will just move from patient to patient listening whilst being given a report by the midwives in labour wards without challenging the management of the patients because she has no insight”. Experienced midwives lose confidence and respect in such a head of department.

Preference of midwifery allocation/placement and reasons

Rotational allocation of trained midwives in the clinics and base hospitals has been suggested by a number of subjects who participated in this study as to improve competence of knowledge and skills in both parties. The midwives allocated in the clinics function as independent practitioners because they are faced with diverse obstetrical problems in the absence of the doctor, whereas
the hospitals ones are under the umbrella of the doctor. Some of these midwives end up with inefficient skills because of dependency. On the other hand, those allocated in the clinics need exchanges with hospitals in order to receive induction courses regarding advanced technology and to update themselves with new drugs used in hospital including hospital management of pregnant women.

Reintroduction of home visits

➢ Re-implementation of home visits is essential as another form of clinical setting to study individuals' cultural beliefs in a relaxed atmosphere.

➢ Short courses on home-based care are essential to empower practising midwives skills to implement during home visits, as they will increasingly be faced with HIV/AIDS victims in the community.

Involvement of midwives in development of policies

Senior administrators should ask for input from practising midwives when developing policies as these impact on the practising midwives.

Safety of the midwives in the workplace

Government must ensure the security and safety of the midwives whilst on duty, by providing twenty-four hour security services at
the clinic to prevent threats against staff and vandalism of the facility by thugs in the community.

**Provision and protection of maternal and child safety in the clinical setting**

- There are clinics where slum areas are at the doorstep, resulting in a high turnover of patients with diverse conditions and lack of privacy.

- The professional nurses consulting general patients must be separated from those who are dealing with pregnant women, as pregnancy involves two lives and needs privacy.

- At least one ambulance should be stationed in the clinic to prevent delays in medical intervention, and thereby increasing the maternal mortality rate.

**Development of good working conditions**

- Working conditions as well as salaries must be improved to promote productivity and to prevent brain drain to other countries.

- Government must provide compensation for working during weekends especially to midwives placed in labour wards.
Social rewards

Development of childcare facilities in the clinical setting will relieve stress and the burden on practising nurses/midwives, leading to absenteeism. In the clinical settings that were sampled for the study none had a childcare facility (Zwaikat, Mashat & McCloskey, 1986:268).

Psychological rewards

➢ Instant recognition of the practising midwives by their supervisors through positive feedback whenever they have done well, is essential.

➢ Decentralisation of certain powers to unit managers/subordinates is essential, thus boosting their self-actualisation and productivity.

➢ Development of distinguished devices for post basic courses like the one for Primary Health Care of the University of Natal, can serve as incentives for midwives.

Career advancement

➢ Promotions based on annual evaluations, with regard to creativity and dedication to their work.
Development of nursing research departments within the institutions to improve midwifery interventions based on research findings.

The employer must provide qualified counsellors to alleviate stress from nurses/midwives who are always at risk of being infected with HIV/AIDS, especially in labour wards, and in lying-in wards where they are often faced with dying HIV/AIDS patients.

Resolutions to staff shortages

To counteract the brain drain government can liaise with sister hospitals abroad so that nurses/midwives can work overseas whilst on leave to offload their financial burden (Mhlambi’s Opinion, 2000).

A pull posts plan could be implemented, i.e., if nurses/midwives leave the service for any reason, and to avoid employing new staff, the employer can instead offer voluntary overtime allowances to employees during their off duty time, as in the United Kingdom and the private sector in South Africa.

According to Zuraikat et al. (1986:147) the opportunity for part-time work should be given to employees and also flexibility with weekends off.
Retired personnel: to counteract staff shortages and to manage the financial distress of most retired midwives the employer can implement induction employment on a temporary basis.

Structured and controlled exchange programmes within the hospitals in South Africa and those in the United Kingdom. Nurses/midwives can be given three months leave to work abroad and retain their posts. The process can be driven by a Human Resource Manager with the assistance of hospital board members to negotiate the issue with the employer/government.

Educational aspects

Peri-natal Education Programmes should be implemented in the KwaZulu-Natal maternal and child health care services in order to empower the practising midwives with skills and knowledge, as this is slow in being implemented.

Strategies like auditing should be implemented to evaluate if the practising midwives read and understand obstetric manuals, South African Nursing Council Regulations and protocols/policies relevant to midwifery practice.

The practising trained midwives must take the initiative in upgrading themselves and familiarise themselves with modern methods of technology through in-service education, computer studies and continuing education for effective patient care. Participation in continuing education has a positive association with job satisfaction (Watson et al., 1999:225).
Reviewing of the current midwifery curriculum is essential as a community based one will fulfil community needs like transcultural nursing, intensive counselling skills, primary health care, computer studies and nursing research, in order to execute midwifery interventions based on research findings, thereby indirectly improving patient care.

The following strategies may help in empowering qualifiers with confidence and competence in midwifery skills:

- Transfer of the midwifery module from third year level to fourth year level to qualify whilst information is still fresh in qualifiers' minds.

- Implementation of six months' internship or mentorship to counteract problems experienced by newly qualified midwives and experienced midwives (mentors).

- Conducting regular workshops, seminars and in-service education for midwives on partograph, etc. to address substandard care, substandard management of service and attitudes of midwives towards clients, including poor health seeking behaviour resulting in increased maternal mortality and morbidity rates.

- Regular clinical accompaniment both by clinical supervisors and nurse educators in order to relieve the burden of
supervision of students from the shoulders of already overworked trained midwives, especially in labour wards.

➢ Institutions that incorporate education and training of midwives should have well equipped skills laboratories in place to ensure that students become competent in skills through simulations, using models to protect patients’ lives. This will also relieve stress on understaffed trained midwives when allocated ignorant student midwives, especially in labour wards.

➢ Placement of student midwives in comprehensive health care clinics during their period of training, with updated procedure manuals, protocols or files with standard care plans of all conditions in that particular obstetric unit. This will improve the competence of qualifiers, as they will be exposed to practise in clinical settings without an obstetrician.

➢ Intensive training of traditional birth attendants, traditional healers and spiritual healers.

The researcher strongly recommends regular meetings between the above stakeholders, as they are the key figures in the community, with maternal and child health teams, like midwives and doctors, to discuss the causes of maternal deaths and strategies to combat these.
Intensive training of increasing numbers of traditional birth attendants on health promotion regarding maternal and child care problems like the impact of *Isihlambezo* being issued by them that infringes the lives of both mother and foetus thus increasing the maternal mortality rate, as most of them do not refer their clients to hospital timeously.

All trained midwives must inform the public about available reproductive health care facilities like crisis centres and family planning, especially with current strategies like emergency contraception in cases of unprotected sex, termination of pregnancy, when to use the facility and where to find it. Indications should be stated clearly through the mass media, press pamphlets, health talks in the organisations to prevent overpopulation, increase the incidence of street kids and poverty, thus protecting taxpayers’ money.

**Traditional healers**

Traditional healers play an important role amongst most African people. Therefore this sector could play a major role in the prevention of “Big Five” killers (AIDS, obstetric haemorrhage, pregnancy induced hypertension, puerperal sepsis and indirect causes especially cardiac disease) if they can be trained, acknowledged and involved in the health education of their clients.

**Common working platform**

Health professionals must create a common working platform so that they are able to share problems and ideas with the
communities they serve, especially in the prevention of HIV and AIDS including dropouts in mother-to-child transmission programmes, teenage pregnancy, complications of pregnancy like eclampsia, post partum haemorrhage, etc.

Health professionals should also make people aware that AIDS is incurable, that drugs that could kill the virus have not yet been found, and that they should therefore practise protected sex, that is to abstain or be faithful to their partners (who are HIV-negative) and use condoms. Traditional healers also do not have treatment for AIDS. Introduction of a home-based care service is ideal for the nursing care of HIV and AIDS patients.

**AIDS model**

The researcher recommends the adoption of the AIDS Partnership Prevention (AIDAP) model. This model depicts the governmental position as presented by the then Deputy President, Thabo Mbeki on the 11th September 1998 that “HIV/AIDS is everybody’s problem”. It is not confined to the health sector only. Estimates indicate that by the year 2005 there will be 4 544 000 HIV infected people. About 34 million people are infected with the HIV virus and 90% of HIV sufferers are found in the developing countries, like South Africa.

The World Bank research suggests that when adult infection reaches eight percent of the population, it reduces per capita growth rates by 0,4% a year. It is already at this percentage level in 21 African countries (Changing Gears article: Leader, January, 2001). Therefore, the people of KwaZulu-Natal are no exception.
Adoption of the AIPAP model will ensure that sectors join hands to fight HIV/AIDS. This model identifies sectors like religion, housing, community, traditional healers, health-related organisations, educational sector, economic and labour unions, family and individuals as important partners in the prevention of HIV/AIDS.

The media

The Media, i.e. television, radio, newspapers and publications can play an important role as a source of information about the “Big Five” killers of women in pregnancy, labour and puerperium if they can be utilized by the midwives during health talks.

➢ The maternity section must work closely with the department of social welfare and have social workers to address suspected or known cases of domestic violence against pregnant women and babies.

➢ The Maternity section must work closely with the South African Police Services to investigate cases of rape or any form of abuse.

➢ Midwives should be trained in forensic nursing, which will equip them with skills to investigate and complete a case of rape or abuse of mothers and babies.
5.8 CONCLUSION

The challenges that face the trained midwives in their practice during the 21st century indicate that the increased maternal mortality and morbidity rates are not only the midwives’ problem but also everybody’s problem.

Every individual should be aware of the “Big Five” killers of women, especially the youth. They should be encouraged to practise safe sex, talk amongst themselves about HIV and AIDS and problems of teenage pregnancy. To avoid indulging in premarital sex if possible, and if not, to use condoms thus preventing sexually transmitted diseases and pregnancy.

It is the belief of community members that a lot can be done and be achieved through collective work of concerned stakeholders. Reinforcement of cultural norms and values when teaching the youth sex education is still important and essential.

To those who have contracted the HIV virus, it is the duty of midwives, friends, family members and church groups, etc. to care for HIV/AIDS patients. It is they that will create a warm environment at home so that their dear ones will die peacefully, knowing that their families did their best for them and will take care of their babies.

To those women who suffer chronic diseases like hypertension, cardiac disease, etc. it is the duty of the midwives to reinforce the
importance of compliance to prescribed treatments, healthy lifestyles, follow-ups and family planning, in order to prolong life.

Midwives should engage in in-service education on all matters that affect human resource development in midwifery services; continuing education, advanced midwifery and neonatal nursing courses, embark on short courses like AIDS counselling and forensic nursing, including the role of the Sexual Assault Nurse Examiner (SANE) (Gee, 2003:1), as well as maternal to child transmission of HIV/AIDS.

All practising midwives should strive for a safe midwifery practice and obtain international competencies which are professional, ethical and legal, and practice care provision/management and professional development to maintain professional image of South African midwives despite all the negative aspects that may face them in their midwifery practice (Kaye-Peterson, 2002:26).


REPORTS


JOURNALS


SHANDU, O.T. Interview. Chief Nursing Service Manager.


REGULATIONS


SANC *Regulation* R254 of 14 February 1975 as amended.

SANC *Regulation* R2598 of 30 November 1984 as amended.

SANC *Regulation* R2488 of 26 October 1990 as amended.


ANNEXURE 'A'

CERTIFICATE OF CLEARANCE

BY

THE ETHICS COMMITTEE
CERTIFICATE OF CLEARANCE BY THE ETHICS COMMITTEE

NAME OF STUDENT: ELLEN NOMANDLA MPANTHA

DEGREE: MCur

RESEARCH TITLE: INVESTIGATING THE CHALLENGES FACING THE MIDWIVES IN THE 21ST CENTURY

The ethics committee hereby declare that the research proposal for the study mentioned has been scrutinized for accuracy and ethical standards in the following manner.

A. The proposal meets the professional code of ethics of the researcher:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
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B. The proposal also meets the following ethical requirements:

<p>| | | |</p>
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<tr>
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<tbody>
<tr>
<td>1. Provision has been made to obtain informed consent of participants.</td>
<td>√</td>
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</tr>
<tr>
<td>2. Potential psychological and physical risks have been considered and minimized.</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>3. Provision has been made to avoid undue intrusion with regard to participants and community.</td>
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</tr>
<tr>
<td>4. Rights of participants will be safe-guarded in relation to:</td>
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<tr>
<td>4.1 Measures for the protection of anonymity and the maintenance of confidentiality.</td>
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</tr>
<tr>
<td>4.2 Access to research information and findings</td>
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<tr>
<td>4.3 Termination of involvement without compromise</td>
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</tr>
<tr>
<td>4.4 Misleading promises regarding benefits of the research</td>
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<tr>
<td>4.5 Availability of results after the study</td>
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<td></td>
</tr>
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</table>

SIGNATURE OF STUDENT: ELLEN MPANTHA DATE: 07/06/01

SIGNATURE OF SUPERVISOR: MPANTHA DATE: 03/08/01

SIGNATURE OF CHAIRPERSON OF THE COMMITTEE DATE: 10/08/01

UNIVERSITY OF ZULULAND DUC.
NURSING SCIENCE DEPARTMENT
PROF. D. NZIMAKWE
ASS. H.O.D. VICE DEAN OF ARTS
ANNEXURE 'B'

APPLICATION FOR THE REGISTRATION
OF A RESEARCH PROJECT
APPLICATION FOR THE REGISTRATION OF A RESEARCH PROJECT

A PERSONAL PARTICULARS

1. Name of Applicant: EELN NOMANDLA MPANTSHA
2. Qualifications: R/N B/M R/ADM BCUR
3. Department: NURSING SCIENCE
4. Faculty: NURSING

B PARTICULARS OF PROJECT

1. Title of project (attach a brief description as indicated overleaf under section D):
   INVESTIGATING THE CHALLENGES FACED BY THE MIDWIVES IN THE 21ST CENTURY
2. Type of project:
   (a) Master's, doctoral or departmental: M.CUR
   (b) University where you will register (for master's and doctoral projects only):
      UNIVERSITY OF ZULULAND
3. Names of fellow researchers (if applicable):
   (a) PROF. D. NZIMAKWE of the Department of NURSING SCIENCE
   (b) __________________ of the Department of __________________
   (c) __________________ of the Department of __________________
   (d) __________________ of the Department of __________________
4. Approximate expected duration of the project:

SIGNATURE OF APPLICANT: MPANTSHA DATE: 28/06/2001

C RECOMMENDATIONS BY

1. Head of Department: ______________
   SIGNATURE: ______________ DATE: 28/06/2001

2. Dean:

UNIVERSITY OF ZULULAND
DUC
NURSING SCIENCE DEPARTMENT
PROF. D. NZIMAKWE
ASS. H.O.D. VICE DEAN OF ARTS
D.1.TITLE
INVESTIGATING THE CHALLENGES FACED BY MIDWIVES IN THE WORK PLACES.

2. RESEARCH PROBLEM TO BE INVESTIGATED OR HYPOTHESIS TO BE TESTED.

The changes that take in the clinical settings during the 21st Century have an impact on the midwife.

3. PURPOSE OF THIS STUDY (PREPARATORY / PILOT / FEASIBILITY OF STUDY ALREADY UNDERTAKEN).

4. RESEARCH PROCEDURES SCHEDULING AND METHODOLOGY.

(a) Questionnaire preparation - 4 weeks
(b) Questionnaire administration - 4 weeks
(c) Data analysis - 6 weeks
(d) Report writing - 4 weeks

5. VALUE OF THE RESEARCH.

Research findings will reveal the challenges faced by the midwives which may be problematic in the midwifery practice and will be addressed by the findings of this research study as recommendations will be made. The status of midwife will be improved as a member of multidisciplinary team, be recognized for better care and placement in midwifery practice. Researcher anticipates dissemination of research findings for example: publication, incorporation into curriculum, incorporation in seminars etc.

6. ANTICIPATED DISSEMINATION OF RESEARCH FINDINGS e.g. PUBLICATION, INCORPORATION INTO SYLLABUS, SEMINAR.

- research findings will be published in midwifery journals
- the information will be incorporated in the seminars and midwifery syllabus.
ANNEXURE ‘C’

APPLICATION TO MR TROMPE
FOR CONDUCTING RESEARCH STUDY
IN HOSPITALS AND CLINICS
WITHIN THE PROVINCE OF
KWAZULU-NATAL
03/04/2002

Attention: Mr. Trompe
Province of KwaZulu-Natal
Health Department
P/B X 9051
3200

Dear Mr. Trompe

REQUEST TO UNDERTAKE RESEARCH IN HOSPITALS AND CLINICS WITHIN THE PROVINCE OF KWAZULU-NATAL.

I hereby request permission to undertake research project titled "Investigating the challenges that face the individuals in the workplace during 21st Century: Aim of the study is to explore the perceptions of the practicing midwives about the challenges that are facing them in their practice with the intention of bringing them in their practice with the intention of bringing these challenges to their awareness and implement a system whereby these challenges can be addressed in order to improve maternal and child health care services.

Currently I am registered as a Masters student at the University of Zululand Durban – Umlazi Campus Private Bag X 10 Isipingo 4110 South Africa. I am practicing at King Edward VIII Hospital Campus as a registered midwifery nurse educator.
Find enclosed the following: (1) Confirmation letter from my supervisor Prof. D. Nzimakwe. (11) My application for conducting the study. (111) Research proposal and questionnaire to be utilized in the study.

Hoping that my request will receive your favourable consideration.

Yours Faithfully

E.N. Mpantsha (Mrs) student no: 013148
CPN/R/T/ADM
CONFIRMATION OF STUDENT STATUS FOR MRS.E.N.MPANTSHA.

This letter serves to confirm that Mrs.E.N.Mpantsha is a post graduate student registered for a Masters Degree with this University. She is doing a Research project titled “Investigating the challenges that face the midwives in the workplace during 21st Century: Implications for learning and continuation of the struggle for a better health status of mother and child.”

Thank you

Yours sincerely

Prof.D.Nzimakwe
Assistant H.O.D
Vice-Dean of Arts
ANNEXURE 'D'

PERMISSION FOR UNDERTAKING THE RESEARCH STUDY FROM THE PROVINCIAL DEPARTMENT OF HEALTH KWAZULU-NATAL
REQUEST TO UNDERTAKE RESEARCH IN HOSPITALS AND CLINICS WITHIN THE PROVINCE OF KWAZULU-NATAL

I refer to your facsimile transmission dated 17 July 2002 and wish to advise that authority is granted for you to conduct research in hospitals and clinics in the province of KwaZulu-Natal provided that :-

(a) Prior approval is obtained from the Heads of the relevant institutions;

(b) Confidentiality is maintained;

(c) The Department of Health is acknowledged; and

(d) The Department of Health receives a copy of the report on completion.

Yours faithfully

[Signature]

SECRETARY: DEPARTMENT OF HEALTH
KWAZULU-NATAL
ANNEXURE 'E'

MAP OF ETHEKWINI REGION
WHERE THE RESEARCH STUDY
WAS UNDERTAKEN
Visit the hospitals in Durban / eThekwini by simply clicking on a hospitals name.

ANNEXURE ‘F’

QUESTIONNAIRE FOR DATA COLLECTION
UNIVERSITY OF ZULULAND
QUESTIONNAIRE

ON:

A STUDY TO INVESTIGATE THE CHALLENGES THAT FACE THE MIDWIVES IN THE WORKPLACE DURING THE 21ST CENTURY IN THE ETHEKWINI REGION OF KWAZULU-NATAL

PRESENTED BY:

E. N. MPANTSHA.

M CUR STUDENT

SUPERVISOR:

PROF. D NZIMAKWE
NURSING SCIENCE DEPARTMENT
UNIVERSITY OF ZULULAND
UMLAZI CAMPUS
QUESTIONNAIRE FOR TRAINED MIDWIVES

TO OBTAIN INFORMATION CHALLENGES THAT FACE THE MIDWIVES IN THE WORKPLACE DURING THE 21ST CENTURY

Dear Participant

You are hereby requested to answer the following questions, where applicable tick(✔) Yes or No, fill in relevant information in spaces provided.

N.B Participation is voluntary and confidentiality will be maintained therefore do not write your name or the name of the institution or clinic.

1. Age: 21-30 [ ] 31-40 [ ] 41-50 [ ] 51-60 [ ]

2. Gender: Male [ ] Female [ ]

3. Place of work: Hospital [ ] Clinic [ ]

4. Number of years in Midwifery Department:- .............
   Number of years in Family Planning Clinic:- .............
   OR Number of years/months in T.O.P. Clinic:- .............

5. Placement: Ante-natal Clinic [ ]
   Labour Ward [ ]
   Ante-natal Ward [ ]
   Post-natal Ward [ ]
5.1 Where were you allocated before the above unit?

5.2 Did you request to be allocated in the current department?
   Yes: ☐       No: ☐

5.3 If yes explain....

5.4 If not explain....

5.5 Why did you choose midwifery as a speciality?

6. If you were given an option, would you prefer to render interventions in a:
   Hospital ☐
   Clinic ☐
   Home Setting ☐

6.1 Explain why for any response to the above.
7. As a midwife what challenges have you identified in your clinical setting during the 21st century with regard to:

7.1 Legal Issues that impact on midwifery practice......
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7.2 Midwifery Administrative Issues.....
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7.3 Educational Aspect regarding: Midwife , Client/Family/Community.
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7.4 Ethical Dilemmas regarding Midwifery Practice.....
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7.5 Aspect of Midwifery Practice......
8. **What do you think could be done to overcome each of the above challenges?**

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Thank you for your co-operation
ANNEXURE 'G'

PERMISSION FOR UNDERTAKING
THE RESEARCH STUDY FROM
THE DEPARTMENT OF HEALTH
REGIONAL OFFICE
Dear Mrs Mpantsha

My apologies for the delay in replying to your request.

Please find a copy of the letter sent out to the services you requested, informing them that you will be conducting research at their institution.

You are required to set up an appointment and to assist you, the following Managers need to be contacted:

- King Edward VIII Hospital - Dr Z. Karva : Tel: 031-3603014
- Prince Mshiyeni Hospital - Dr N. Gxagxisa : Tel: 031-9078111
- Kwa Mashu - Mrs A. Mtalane : Tel: 031-5036604
- Newtown A - Mrs V. Madikizela : Tel: 031-5101956
- Inanda C - Mrs Shandu : Tel: 031-5190455

This office would be extremely interested in your findings.

Ms S. Dunkley

ACTING DISTRICT MANAGER
etHEKWINI DISTRICT
TO : HOSPITAL MANAGERS: KING EDWARD HOSPITAL
PRINCE MSIIYENI HOSPITAL

CHC MANAGERS : KWA MASHU
NEWTOWN A
INANDA C

RESEARCH ON CHALLENGES THAT FACE THE MIDWIVES IN THE WORKPLACE DURING THE 21ST CENTURY : MRS MPANTSHA

This is to inform you that Professor R. Green-Thompson has given Mrs E.N. Mpantsha authority to conduct research in your institution subject to your approval. See attached application and authorisation.

Mrs Mpantsha will contact you with a view to setting up an appointment with your maternity staff.

It would be appreciated if you would assist her in this regard.

Ms S. Dunkley
Date: 2 September 2002

Enquiries: Ms. S. Dunkley
Index: 39/2002/9

ACTING DISTRICT MANAGER
eTHEKWINI DISTRICT

c.c. Mrs. D. Nyasulu
Maternal, Child and Women's Health
ANNEXURE 'H'

PERMISSION FOR CONDUCTING
THE RESEARCH STUDY FROM
KIND EDWARD VIII HOSPITAL
Application for research at King Edward VIII Hospital

Protocol: The challenges that face the midwives in the workplace during the 21st century.

Your application received on the 14 August 2002 is approved.

Please ensure that the following is done:
- Make an appointment with our Nursing Manager, Mrs G Zola through her secretary Mrs Glazer (Ext 3031) to discuss your protocol and proposal.
- Sign an indemnity form at Room 8, Admin Block before commencement.
- Ensure that King Edward VIII Hospital receives full acknowledgement in the study on all publications/reports.
- Provide KEH Management with a copy of your paper.

The Management of King Edward VIII Hospital reserves the right to terminate the permission for the study should circumstances so dictate.

Yours Sincerely

Dr ZN Kharva
Hospital Manager (Acting).
ANNEXURE 'I'

PERMISSION FOR CONDUCTING THE STUDY
FROM INANDA NEWTOWN
"A" CLINIC
For attention: Mrs. Mpantsha  
King Edward viii Campus  
Private Bag x 02  
Congella  

Re: Application to conduct research into challenges faced by Midwives in the 20th Century.  

Your request dated 11th August 2002 refers.  

I have pleasure in informing you that the institution has no objection in assisting you in whatever way possible to conduct the research.  

Thank you,  
Yours faithfully  

Nurse Manager.
ANNEXURE ‘J’

PERMISSION FOR CONDUCTING THE
RESEARCH STUDY FROM INANDA
NEWTOWN “C” CLINIC
Dear Madam,

RE: PERMISSION TO CONDUCT RESEARCH AT ICHC

The telephonic conversation and correspondence you brought from Prof. Green Thompson’s and District Manager’s office on 2002.09.16 refers.

You are herewith granted permission to conduct research on challenges facing the midwives in the workplace during the 21st century at Inanda C Community Health Centre during the month of September 2002. The permission is granted following the approval in the aforementioned correspondence.

I wish you all the luck in your study.

Yours sincerely,

V.N. Shandu - NURSE MANAGER
ANNEXURE ‘K’

SUMMARY OF STATISTICS FOR THE
DEPARTMENT OF OBSTETRICS
AND GYNAECOLOGY
KING EDWARD VIII HOSPITAL
(YEAR 2000)
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<th>MATERNAL DELIVERIES</th>
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<td></td>
</tr>
<tr>
<td>HIV</td>
<td>111</td>
<td>1.56</td>
<td>0.96</td>
<td></td>
</tr>
</tbody>
</table>
ANNEXURE 'L'

SUMMARY OF HIV SEROPREVALENCE AT
KING EDWARD VIII HOSPITAL
(1990-2000)
Figure 1: HIV Seroprevalence at King Edward VIII Hospital, Durban (1990-2000)