

**The Factors Influencing the Implementation of the post  
natal home visit program by nurses in an urban health  
district, Botswana.**

**A Research Project**

**To**

**FACULTY OF HEALTH SCIENCES  
SCHOOL OF NURSING  
University of KwaZulu Natal, Durban**

**In**

**Partial Fulfilment of the Requirements for the**

**MASTERS DEGREE IN COMMUNITY HEALTH NURSING  
(MN-CH)**

**By**

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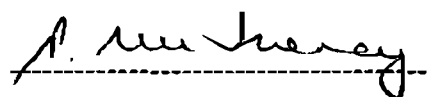
**2006**

**DECLARATION**

This dissertation represents the original work of the author and it has never been submitted before for any degree or examination in any university. Full acknowledgement is given to all the authors' references that are cited and referred to in this thesis.

Signed.......... Date.....02/05/06.....

As the candidate's supervisor, I have approved this dissertation for submission.

  
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02.05.06  
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Signature

Date

Prof. P. McNemey

(Supervisor)

## **DEDICATION**

This thesis is dedicated to my ailing mother, Mrs Kelobonye E. Tsweta, my sons, Desmond, Raymond and Richmond and daughters, Yvette and Pearl.

## **ABSTRACT**

The post natal home visit care program is a maternal and newborn home visit care program, designed to address the needs of the childbearing families following delivery and early discharge, irrespective of the place of delivery.

The study was undertaken to determine the factors influencing the implementation of the post natal home visit care program by nurses and to make suggestions to resolve the problem in an urban health district in Botswana.

A descriptive exploratory study, using both quantitative and qualitative methods guided the process. Two methods were used to collect data, namely, the developed checklist and four focus group discussions.

Twelve clinics were sampled and checklists were completed for the twelve clinics by the researcher. A total of twenty eight Registered Nurses and Registered/Enrolled Nurse Midwives were recruited from the participating twelve clinics through purposive sampling. This included nursing managers and senior nursing staff.

The findings reflect the post natal home visit care program deficits. Protocols and logistics such as transport and staff for the program were not in place. Furthermore, the results also reflect various factors such as lack of motivation, lack of support from management and co-workers, distance and fear of stigmatisation as reasons for not

implementing the post natal home visit care program. The participants felt that there was need to implement the program and attached merit to its importance. Finally, the participants made suggestions to overcome the deficit such as team work, commitment to work, academic development and improvement of management and supervision.

In conclusion, failure to implement the program represents a health delivery deficit.

There is need for improved management and supervision to balance the needs of Registered/Enrolled Nurse Midwives and the needs of the organization in order to attain better results. There is also a need for the provision of logistics needed for the post natal home visit care program such as transport and manpower. Finally, there is need for the coordination of the post natal home visit program by the District Health Team to aid implementation so as to provide the essential service.

## **ACKNOWLEDGEMENTS**

My sincere thanks go to the following;

My Lord and Saviour, for paving the way for me, making it possible for me to complete this project.

Des, Ray, Rich, Yvette and Pearl who endured the pain of staying on their own without their mother's attention while I was busy with this project. Thanks for your patience guys!

Ministry of Local Government Service Management for the sponsoring this project; the Ministry of Health and the management and staff of The City of Francistown City Council for allowing me to undertake this research, their contributions and participation.

To Professor Patricia McInerney, my research supervisor, for her guidance, patience, encouragement and support throughout this project. I would not have made it without you!

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## **ABBREVIATIONS**

WHO.....World Health Organization

HIV.....Human Immune Virus

HIV/AIDS...Human Immune Virus/Acquired Immune Deficiency Virus

AZT.....Zidovudine

# **CHAPTER ONE**

## **1.1 INTRODUCTION**

Francistown is one of the two cities of Botswana situated in the northern part of the country. Botswana, which is found in the southern part of Africa shares borders with South Africa in the South, Zimbabwe in the north, Zambia in the west and Namibia in the south western side and has a population of just over 1,600,000.

The health system in Botswana comprises of the Government Health Sector and the Private Health Sector. The Government Sector is divided into two main sectors supervised by two different ministries, the Ministry of Health for Primary Hospitals, General Hospitals and Referral Hospitals and the Ministry of Local Government Service Management which is responsible for Clinics, Health posts and Outreach mobile stops. The Private Sector, though independent, is regulated by the Ministry of Health. Some Private Health Institutions are partially funded by the Government of Botswana (National Health Policy, 1995).

The City of Francistown is served by both Government and Private Health Care Institutions. The Government Health Care Institutions consist of one referral hospital under the Ministry of Health, three clinics with maternity wards (of which only one provides maternity services due to the shortage of Registered Nurse Midwives) and ten clinics without maternity wards and two health posts which are under the Ministry of Local Government Service Management. The City provides maternal and child health in fifteen (15) government health facilities and a few private surgeries. Of these, only one facility offers maternity services, including deliveries, while all the council clinics offer curative care, ante natal care, child welfare care to children under



the age of five years, family planning and post natal care to mothers. Thus it is the responsibility of the clinics to implement the post natal home visit care program. In 2004, a total of 4391 women were delivered in the two functional maternity wards including the referral hospital and none of these women received a post natal home visit.

Botswana took the initiative of restructuring the health care delivery system by adopting the primary health care approach as a strategy to reach the Primary Health Care goal, "Health for All by the Year 2000" (WHO, 1978). One principle of this approach is that health care delivery should move closer to the people in the communities, particularly the most vulnerable members such as women and children.

One of the effects of this restructuring is the early discharge of mothers with their newborn babies within 12 to 24 hours after normal vaginal delivery and 5 to 6 days after caesarean section delivery. Although these early discharges have reduced maternity costs and overcrowding in maternity wards, they have also decreased opportunities for good care (Lieu, Braveman, Escobar, Fischer, Jensvold and Capra, (2000); Morrell, Spiby, Stewart, Walters, and Morgan, (2000). Consequently, mothers are expected to give birth, adjust to the marked physical and psychological changes, adapt to their newborn and learn the skills needed to care for themselves and their infants in the allocated twelve to twenty four hours (Madden, Soumerai, Lieu, Mandi, Zhang and Ross-Degnan (2002)). Bulatao and Ross (2002) state that the delivery of maternal health services in developing countries has been described as deficient leading to millions of women lacking access to health services.

Population Reports (1998) reports that more than half a million women in the developing world die each year during pregnancy or childbirth. This amounts to one maternal death every minute and millions suffer serious, sometimes permanent injuries. Much of this suffering and many of the deaths are preventable. Families, communities and health professionals working together, can make child bearing safer (Population Reports, 1998). According to WHO (1995), maternal mortality and morbidity are sensitive indices of the quality of any health care system, be it in a developed or underdeveloped community. Consequently, a reduction in the level of maternal morbidity is a direct indication of the improvement in the quality of total health within the country or community. The maternal mortality rate in Botswana is estimated to be 300 per 100,000 live births while the infant mortality rate stands at 45 per 1000 live births according to the Central Statistics Office in Francistown (2001).

The Permanent Secretary of the Ministry of Health in the foreword notes (Safe Motherhood, 1998) stated that when maternal morbidity and mortality occurs, it sends a devastating medico-social and socio-economic message to the society and points a finger at our health care system. The permanent Secretary also emphasized that, "it therefore should be addressed not as a historical event but as a current occurrence that casts a shadow on our medical practitioners, which shadow we must continually strive to remove. Therefore, in doing this, we must maintain high ethical standards, honesty, moral obligation and commitment to the provision of the best health care to the communities we serve."

The post natal home visit programme which is a maternity and new born home visits program is designed to address the needs of child bearing families following their

hospital stay. This program is provided as part of care provided to mothers and their babies and is therefore the continuation of post natal care which was interrupted in the maternity ward due to early discharge (Hodnett and Roberts, (2000) and D'Amour, Goulet, Labadie, Bernier and Pineaultz, ( 2003)).

The Government of Botswana provides the following services to the mother and her child at no cost: Maternal and Child Health, Family Planning Services, Prevention of Mother to Child Transmission (HIV), Isoniazid Prevention Therapy, Voluntary Counselling and Testing (HIV), Anti Retroviral Therapy (HIV/AIDS), Ante Natal Care, Post Natal Care, Child Welfare Care and Post Natal Home Visit Care. In addition, all health facilities have been allocated ambulances (one for health posts and clinics and two for large clinics offering 24 hour services), in order to facilitate the delivery of all health care services and programs. This is definitely a positive step towards the Safe Motherhood Initiative Program which was launched in 1990 by the Government of Botswana in an attempt to reduce the maternal morbidity and mortality by 50% by the year 2000 and to reach its goals for Vision 2016 (Long Term Vision for Botswana, 1997) which aims at a healthy informed society with accessible, available and affordable health services.

There were no recorded post natal home visits in the City of Francistown health district for the years 2003 and 2004, even though the health district annual report (2004) indicated a total of 4621 new antenatal attendances, 4391 supervised deliveries and 282 routine post natal attendances for the year 2004 (City of Francistown Health District Annual Statistics, 2004). According to the Nyangabgwe Referral Hospital Annual Report (2003-2004) there were no records for post natal home visits. This has

been confirmed by the Principal Registered Nurse Midwife, Machola (2005), who works in the Nyangabgwe maternity ward, who stated that the student midwives do follow up of some mothers identified by the students for academic purposes, but these visits are not recorded in the hospital statistics.

## **1.2 PROBLEM STATEMENT**

Despite the concern for the provision of care to mothers and their babies during the post natal period, to reduce post natal complications and thereby reduce the maternal and child morbidity and mortality, there is, surprisingly, no evidence of nurses implementing the post natal home visit care program.

According to the Botswana Obstetric Record (1997) all observations and actions taken on the condition of the mother and baby after 48 hours post partum, should be entered in the post natal section and if the patient has been discharged within 2 days after delivery, this is completed by the home visiting nurse. The final check up at six to eight weeks post partum should be done at a health facility during which a pap smear should be taken, if indicated.

The nurses working in clinics, Registered Nurse Midwives in particular, play an essential role in the provision of good care because they deal with two lives, that of the mother and the baby, therefore it is important to ensure that mothers and their babies go through a safe post natal period. Moreover, the high maternal and infant mortality and morbidity rates in Botswana indicate the need to explore the care provided to mothers and babies at home given the early discharge from maternity wards, that is, within the first twenty four hours following delivery.

There were no records to show that home visits were done for the years 2003 and 2004 (City of Francistown Health District Annual Statistics, 2003 and 2004)

As the Principal Registered Nurse in charge of Itekeng clinic and a trainer of trainers for the Safe Motherhood Initiative Program, the researcher first recognized the problem through observations of the clinic's monthly statistics records and the patients' cards when she was conducting post natal check-ups on mothers and their babies six weeks post delivery. Surprisingly, none of the mothers who attended the post natal clinic had had the initial follow up which should have occurred two to seven days after delivery according to the national standards for midwives on post natal care in Botswana (Botswana Standards of Midwifery Practice, 2001). In fact, the provided columns on the post natal sections of the Botswana Obstetric Record (1997) were not complete and yet some mothers presented with complications such as healed episiotomies that had gaped. Furthermore, the mothers with serious complications usually would be seen either earlier or when they brought their children to the child welfare clinic.

Given the fact that government makes everything available for early post natal home visit care in the form of education of nurses, transport and protocols (National Health Policy, 1995; Nurses and Midwives Act, 1995; Patients' Charter, 1995; Botswana Obstetric Record 1997; The Safe Motherhood Initiative, 1998 and Standards of Midwifery Practice, 2001) for the provision of care, the question that may be asked is "why are nurses of the City of Francistown Council not implementing the post natal home visit care program?"

### **1.3 SIGNIFICANCE OF THE STUDY**

There appears to be an omission in the provision of continuing care to mothers and their babies following discharge from the maternity wards. Nevertheless, the need for the post natal home visit care program implementation as a way to provide continuing quality care and reduce maternal and child mortality and morbidity cannot be underestimated. As the study is the first of its kind in the City of Francistown health district, findings of this study will be communicated to the health personnel of the City of Francistown health district, the study will also be disseminated among health personnel in other health districts and schools of nursing throughout the country. Furthermore, the findings will be helpful in identifying areas in post natal care that require attention, which may improve the lives of mothers and their babies. Equally important, it will also provide the basis for research in the same field.

### **1.4 PURPOSE OF THE STUDY**

This study aimed to determine the factors influencing implementation of the post natal home visit care program by nurses and to make suggestions to resolve the problem where non-implementation was found.

### **1.5 OBJECTIVES**

- To determine the factors that influence nurses to undertake/not undertake post natal home visits.
- To explore with the nurses possible strategies by which the post natal home visit program can be implemented.

## 1.6 RESEARCH QUESTIONS

1. Does the post natal home visit care program have any benefits for the mothers and their babies?
2. What prevents the nurses from implementing the post natal home visit care program?
3. What do the nurses need to do to ensure that the post natal home visit care is provided to mothers and their babies?

## 1.7 OPERATIONAL DEFINITION OF TERMS

- **Post natal home visit care program** is a maternal and newborn home visit care program, designed to address the needs of the childbearing families following delivery and early discharge, irrespective of the place of delivery. The visit should be made within the first week post delivery and should be conducted by nurses working for the council clinics within their catchment areas.
- **Nurses** are Registered Nurses and Registered/Enrolled Nurse Midwives registered with the Botswana Nursing Council and working for the Ministry of Local Government Service Management.
- **Implementation** refers to registered nurses or registered nurse midwives visiting mothers and their babies in their homes, within the first week of discharge from maternity wards.
- **Urban health District** is the Health District 16, City of Francistown, Botswana.

- **Principal Registered Nurse** is a person appointed to a position of supervision and management at clinic level in Botswana. He/she is answerable to the Chief Registered Nurse who is in a level of appointment one above him/her.
- **Senior Registered Nurse** is a person appointed to a clinic in a senior position but he/she is not in a supervisory or management role unless the Principal Registered Nurse is absent. He/she is subordinate and answerable to the Principal Registered Nurse.

## **1.8. CONCLUSION**

In an effort to reduce maternal and child morbidity and mortality, the post natal home visit program is one of the means used to compensate for the early discharge of mothers and their babies from maternity wards. This is part of the Global Safe Motherhood Initiative. Implementation of the initiative may prove worthwhile for the underdeveloped and the developing world where maternal mortality is still high. Botswana is part of the developing world with high maternal and infant mortality rates. The need for the implementation of the post natal home visit program cannot be over emphasized.



# **CHAPTER TWO**

## **LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK**

### **2.1 LITERATURE REVIEW**

This chapter consists of a review of the relevant literature. The discussion will be divided as follows:

1. Post natal health care
2. The home visit health care program: global and national (Botswana) perspectives
3. Quality of maternal and child health care

#### **2.1.1 POST NATAL HEALTH CARE**

##### **2.1.1.1 What is post natal health care?**

The post partum period or fourth trimester is a time of restoration of the body after pregnancy, labour and delivery. It is also a time for learning self-care and infant care skills, integrating new roles and continuing family attachment and adjustment to the newborn. This period usually proceeds without complications. When complications do occur, however, they may create significant physical and psychological health problems for the mother and difficulties for family members. Therefore, a careful nursing assessment can facilitate prompt recognition and treatment of these complications, thereby limiting harmful consequences.

The period immediately after the birth of the baby is both a meaningful and an overwhelming time for the new mother and her baby (Fredriksson, Hogberg and Lundman, 2003). During the past decade, many states in the United States of America have introduced home visitation programs as a means to reduce infant and maternal

morbidity and mortality and improve outcomes for at risk families. For instance, in South Carolina, standard assessment forms are used for documenting health history and physical findings on the mothers and infants during early post natal home visits. In addition, family planning information and education of the mothers about breastfeeding, safety procedures, and what conditions warrant immediate attention versus those that can be expected is also provided. The nurses spend a considerable amount of time discussing other community resources available and making referrals for follow-up service like scheduling doctor's visits and referring to Family Support Services (Wager, Lee, Bradford, Jones and Kilpatrick, 2004).

In Canada, a trend toward the reduction in the length of hospital stays has been widely observed. This shift is particularly evident in peri natal care. A stay of less than 48 hours after delivery has been shown to have no negative effects on the health of either the mother or the baby as long as they receive adequate follow-up care (D'Amour *et al*, 2003).

In the United States of America, Minnesota's early discharge legislation was enacted in 1969 and although the legislation mandated coverage for home visits after short stays, only 12.4% of short stay newborns had early home visits (Madlon-Kay, DeFor and Egerter, 2003).

In Botswana, mothers and their babies with normal vaginal deliveries are kept in the lying in ward after delivery for four to six hours depending on the conditions of the mother and/or the baby and the time of delivery. They are then discharged home to be visited by a nurse within the first two to seven days (early postpartum home visit).

According to the protocol, the first visit is mandatory while the consecutive visits depend on the outcome of the first visit (Botswana Obstetric Record, 1997). Furthermore, the mother is given a take home card on discharge which includes three pages on pregnancy and delivery summary, the discharge summary and the postnatal section. The postnatal section is to be filled in during the early postpartum home visit and the six to eight weeks postpartum visit examinations (Botswana Obstetric Record, 1997). The final check up is at six weeks postpartum and should be done at a health facility during which a pap smear should be taken if indicated (Botswana Obstetric Record, 1997).

#### **2.1.1.2 Implications of deficiencies in post natal care**

The postpartum period is experienced as a period of great unpredictability in the lives of the new parents and their babies (Fredriksson *et al.*, 2003). A WHO (1995) report highlights the fact that post natal haemorrhage remains the second leading cause of maternal death in developing countries. Other harmful effects of short postpartum hospital stays include dehydration and malnutrition of breastfed infants according to Gagnon, Dougherty, Jimenez and Ledduc (2002).

##### **2.1.1.2.1. Mental health**

Women experience psychological problems during the post natal period. These psychological problems range from emotional disturbances to psychosis. Sobey (2002) reported that 80% of women experience mild depression characterized by a period of labile mood, despondency, fatigue, tearfulness, anxiety and poor concentration. In addition, 10% experience post natal depression with persistent mood change, sleep disturbances, decreased appetite, loss of libido, increased fatigue,

constipation, weight loss, sadness, feelings of hopelessness, low self-esteem, self criticism, distortion of body image and inability to cope with the infant. Post natal psychosis is the least frequent occurrence and the most severe. The rate is about four cases per thousand women and accounts for 2% to 8% of admissions to mental hospitals. Most episodes are said to occur within two weeks of delivery. It is also estimated that at least 1 in 10 women will experience post partum depression (Sobey, 2002)

#### **2.1.1.2.2 Nurses' Support**

Wager, Lee, Bradford, Jones and Kilpatrick (2004) state that having nurses provide the home visits increases the effect on selected social outcomes. The new mother feels she is receiving care when the midwife takes part in different ways in the mother's new situation, when she learns through the midwife's teaching and even indirectly, when she is allowed undisturbed time together with her baby and family (Fredriksson *et al.*, 2003).

In a United Kingdom study, Proctor (1998) found that midwives underestimated women's concerns about issues, such as the importance of post natal information, the need for control and confidence in adjusting to the role of mother, and involving the woman's partner in the delivery of care. As a result, for staff providing post natal care, it is important to understand the concerns and needs of new parents (Fredriksson *et al.*, 2003). Cronin (2002), in her study, found that mothers received support from the public health nurses in the form of a visit in the early stages of their return home.

#### **2.1.1.2.3. Family Support**

In recent years, family support is less readily available due to the changing cultural norms and urbanization. This therefore, poses a threat to the care of the mother and her baby following early discharge from maternity wards. Most mothers of newborn babies need to be left in peace to take care of themselves and to rest and be with the family, and at the same time have the carers close at hand should the need for information and support arise (Fredriksson *et al.*, 2003).

#### **2.1.1.2.4. Effectiveness of the Program**

The study conducted by Norr, Crittenden, Lehrer, Reyes, Boyd, Nacion and Watanabe (2003) suggests that home visits by a nurse-advocate team (a team of trained community residents led by a nurse) can improve maternal and infant outcomes.

Home visits used to identify mothers' concerns with breastfeeding were found to be effective during the post natal period by de Oliveira, Camacho and Tedstone (2001) in their study of the effectiveness of the prenatal and postnatal strategies and procedures used to extend breastfeeding duration.

A home nursing visit after the newborn's nursery discharge is cost effective in reducing the need for subsequent hospital based services (Paul, Phillips, Widome and Hollenbeak 2004).

Armstrong, Fraser, Dadds and Morris (2000) conclude that this form of early home based intervention promotes an environment conducive for infant mental and general health and hence long-term psychological and physical well-being, and is highly valued by the families who receive it as costs are greatly reduced.

## **2.1.2 POST NATAL HOME VISIT CARE PROGRAM**

### **2.1.2.1 Global perspectives of the post natal home visit care program**

The post natal home care program, which is a maternal and new born visit program, is designed to address the needs of child bearing families following their hospital stay. As initially designed in other parts of the world like the United States of America, the post natal home visit program implemented by registered nurses was provided for women discharged on the first post natal day following caesarean birth. Because of the positive outcomes demonstrated by the program, a post natal home visit is provided to all post natal families regardless of their length of stay. Additional home visits may be scheduled if a need is identified by the provider (Olds, Hill, Robinson, Song and Little, 2000)

It is becoming more common for women to leave hospitals with their newborn as early as eight hours postpartum, or after a short hospitalisation of one to three days (Fichard, van Wyk and Weich, 1994). The shorter hospitalisation contributes to the possibility of a crisis in the post partum period, hence Fishbein and Burggraf (1998) state that longer hospital stays would allow nurses and other professionals to provide support and education to ease the mother's transition to parenthood. Undeniably, returning home with a new born baby can be a very difficult time, as infant care issues may create anxiety for new parents. Therefore, the provision of support from midwives is most important during the first week at home. Lieu, Braveman, Escobar, Fischer, Jensvold and Capra (2000) add that the national guidelines in the United States of America recommend a follow-up visit on the third or fourth post partum day.

In general practice, only the immediate early post natal care and neonatal care provided in the maternity wards is available to new mothers and their babies as they are discharged 12-24 hours after delivery. This is supported by Moumouni (2000), with the observation that after discharge, women do not interact with health care providers until the scheduled post natal or follow up visit that occurs six weeks after delivery and the community follow up is seldom done. Because of the short length of stay, nurse-run birthing centres are pressed to complete essential assessments, ensure holistic care (psychologic, physiologic and spiritual) and provide opportunities for education about maternal self care and new born care. Therefore, the needs of the family and the goals of the health care provider can be addressed through the development of post natal home care according to Olds, London and Ladewig (2000).

A study in the United Kingdom by Kendrick, Elkan, Hewitt, Dewey, Blair, Robinson, William and Brummell (2000), found that home visiting programmes were associated with an improvement in the quality of the environment. In Sweden, early discharge with home visits after normal delivery was introduced at Uppsala University Hospital in 1990 and the home visiting midwives used a checklist to give and gain information about the health of the mother and child and about how breastfeeding is going (Johansson and Darj, 2004). The results of this study showed that the checklist worked sufficiently well as a work tool, and could be adjusted further according to the parents' needs. The study also showed that the mothers needed more information about the care of the infant, primarily concerning hygiene.

Quinlivan, Box and Evans (2003) did a study in Australia to ascertain whether a postnatal home visiting service for teenage mothers younger than age 18 years could

reduce the frequency of adverse neonatal outcomes and improve knowledge of contraception, breastfeeding and infant vaccination schedules. The study found that postnatal home-visiting services by nurse midwives reduced adverse neonatal events and improved contraception outcomes, but did not affect breastfeeding or infant vaccination knowledge or compliance.

In Zimbabwe, a study by Sibanda, Saungweme, Nleya, Mutyambizi and Rutgers (2001) advocated that, because the first two weeks post partum is the period with highest morbidity and mortality, women should be advised to make a post natal clinic visit within 14 days, or whenever they have problems, rather than at six weeks.

Several studies have been conducted in the United States of America on the provision of post natal home visit care. According to Norr *et al* (2003), effective programs must be culturally sensitive, intensive and adequately staffed and financed. In Kansas City, Dana and Wambach (2003) state that in 1995, to meet the needs of mothers and newborns discharged early, a home care follow-up program using an advanced practice nurse was initiated at a Midwest academic medical centre. Another study by Madlon *et al.* (2003) found that although Minnesota's early discharge legislation was implemented, very few short-stay infants received the post discharge care for which coverage was mandated. Yet another related study by Escobar *et al* (2001) found that the current guidelines provided scant guidance on how routine follow-up of newly discharged mother-infant pairs should be performed.

In Canada, over the past decades, a number of randomised trials have examined the effect of home visitation programs on a range of maternal and child health outcomes



and home visitation programs have long been advocated as a strategy for improving the health of disadvantaged children according to Hodnett and Roberts (2000). They also state that post natal home-based support programs appear to have no risks and may have benefits for socially disadvantaged mothers and their children, possibly including reduced rates of child injury. In addition, follow-up by nurses after short post partum hospital stays, in either the home or a hospital-based clinic, of healthy infants discharged at 36 hours were associated with satisfactory infant breastfeeding outcomes (Gagnon *et al.*, 2002). Still in Canada, D'Amour *et al.* (2003) found a low accessibility to services, less than half of the mothers received a home visit by a nurse.

#### **2.1.2.2 The post natal home visit program in Botswana**

The Safe Motherhood Initiative (1993) as adopted in Botswana's post natal home visit program stipulates that post natal care be provided at the following levels and time:

- Immediate institutional postpartum care
- Care at home by family members
- Home visit by registered nurses in the first week
- Routine post natal care at six to eight weeks after delivery in the facility.

All the above activities are included in the curriculum for Registered Nurse Midwives where they receive both theoretical and practical instruction. Likewise, the Registered Nurse Curriculum includes a module on obstetric nursing. The module has a practical requirement in which student nurses are required to make a home visit with a health worker.

Makokha, Khulumani, Modisaotsile, and Baakile (1994) in their study in Botswana, state that the majority of traditional birth attendants provide post natal care to their clients, taking care of the mother for at least three weeks after delivery and provide appreciable supportive postnatal care to the mothers. Traditional birth attendants are also capable of identifying danger signs. They further outline the aspects of post natal care as follows:

- The general care and assistance given to the mother after delivery
- The visit by health workers which is expected within the first week after delivery
- The routine postnatal examination that the woman should have at the end of the puerperium, which is six weeks after birth.

In Botswana, post natal attendance ranks lowest in the health facilities as compared to antenatal care and supervised deliveries. This appears to influence the weight of the importance placed on post natal care (Makokha *et al*, 1994).

### **2.1.3 MATERNAL AND CHILD HEALTH CARE**

The delivery of maternal health services in developing countries has been described as deficient (Bulatao and Ross, 2002), leading to millions of women lacking access to health services. Nurses are legally liable and morally responsible for the quality of the care they provide to patients according to Gunther and Alligold (2002).

Maternal morbidity and mortality are sensitive indices of the quality of any health system, be it in the developed or the under developed community. Reduction in the levels of maternal morbidity and mortality is a direct indication of the improvement in

the quality of total health care within the country or community (The Safe Motherhood Initiative, 1998).

### **2.1.3.1 Factors affecting provision of care**

WHO (1997) explains that the provision of a health service is based on the availability of facilities, equipment, drugs and basic supplies as well as competent health care workers. Shortage of all these has a negative impact on health care. Shortage of staff was identified by Irurita (1999), as a major factor inhibiting the provision of care, limiting the time available for the nursing care delivered to each patient. Patients perceived shortage of staff as a major factor inhibiting the provision of care, along with a high patient turnover and early discharge (Irurita, 1999). This was felt to limit the nursing care delivered to patients. When registered nurses work in environments that do not enable them to consistently meet their nursing practice standards, patient safety is jeopardized (Winslow, 2004).

Donabedian (1984), as cited by Micevski, Mulcahy, Linda Belford and Kells (2004), defined quality of care as that which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and that attend the process of care in all parts.

## **2.2 CONCEPTUAL FRAMEWORK**

According to Donabedian (1988), a standard model for measuring quality of care provision is based on three measures of quality; structure, process and outcome.

Nursing relies heavily on the industrially derived structure-process-outcome model with current emphasis on outcomes (Gunther and Alligold, 2002).

### **2.2.1 The structure**

Structure is defined by Donabedian (1988) as the characteristics of the physical and organizational settings in which care takes place, of the providers of care, of the equipment and resources they have at their disposal. In addition to the above, Donabedian (1966) also adds administrative organization including management, economic and environmental conditions. Donabedian (1988) summarized the components of the structure measures as inputs which include systems characteristics which are; equipment, provider characteristics (staff) and financial resources. Structure evaluations compare the inputs provided against existing norms or standards, previous measurements, or comparable areas and services (Katzenellenbogen, Joubert and Abdool Karim (1997). The various inputs are often summarized by their total money value.

This measure evaluates the characteristics of the health system including the personnel and facilities that provide health care and how they are organised. The qualifications of the registered nurses, characteristics of the administrative organisation, facilities, information, policies, procedures, and equipment are all components of his measure (Booyens, 2001).

In this study, organizational setting refers to the City of Francistown clinics where nurses are expected to conduct post natal home visits to all mothers in their catchment area within the first week post delivery, irrespective of the place of delivery. The components include availability of transport, policies, procedures, and the ratio of nurses to mothers.

Donabedian (1988) states that structure is based on the assumption that when certain specified conditions are satisfied, good care is more likely to be provided. Hence,

structure is necessary for the provision of quality post natal care through provision of all the essential components needed for early post natal home visits by nurses.

### **2.2.2 The process**

Donabedian's (1988) process measures are the complex interactions which occur in the delivery of health care, and which take place when infrastructure and other inputs are applied to communities or individual patients with health problems.

According to Donabedian (1988), process is a set of activities that exist between the practitioners, such as general nurses and the post natal mothers as they interact with one another. Donabedian (1966) also states that process refers to the skills used to provide health care. Services may be preventive, diagnostic, therapeutic and rehabilitative. Process standards are concerned with the delivery of patient care, in this case, the post natal home care visit within the first week post delivery.

The process measures relate to actions which must be taken by staff in order to achieve the standard (Booyens, 2001). These measures explore the manner in which the care provider interacts with the mothers. Process measures also allow the identification of acceptable, accessible, efficient, appropriate and equitable care provided to mothers and their babies. For quality of care measures based on process measures to be valid, there must be evidence that changes in the process result in improvement in the mothers' outcome (Siu and Albert, 1992; Brook and Robert, 2000). Process evaluation assesses the way in which care is provided, and whether it meets any institutional guidelines which may exist (Katzenellenbogen et al, 1997).

This study seeks to determine the actions which the staff members take to improve the mothers' and her child's health and the implementation of the national guidelines.

### **2.2.3. The outcome**

The outcome measures of Donabedian's (1988) model are health states of people, groups, or communities that result from interaction with the health system. According to Donabedian (1988), outcome means a change in a patient's current and future health status that can be attributed to received health care. In 1966, Donabedian stated that outcome can be assessed in terms of patient's health, wellbeing and degree of satisfaction, which indicates that the health care provided was indeed based on the assessed needs of the post natal mother and her baby.

Outcome evaluations check that the intervention was effective, that the desired health goal was achieved, and that the patient, client or community obtained prevention, amelioration, cure, or rehabilitation of a particular problem (Katzenellenbogen et al, 1997).

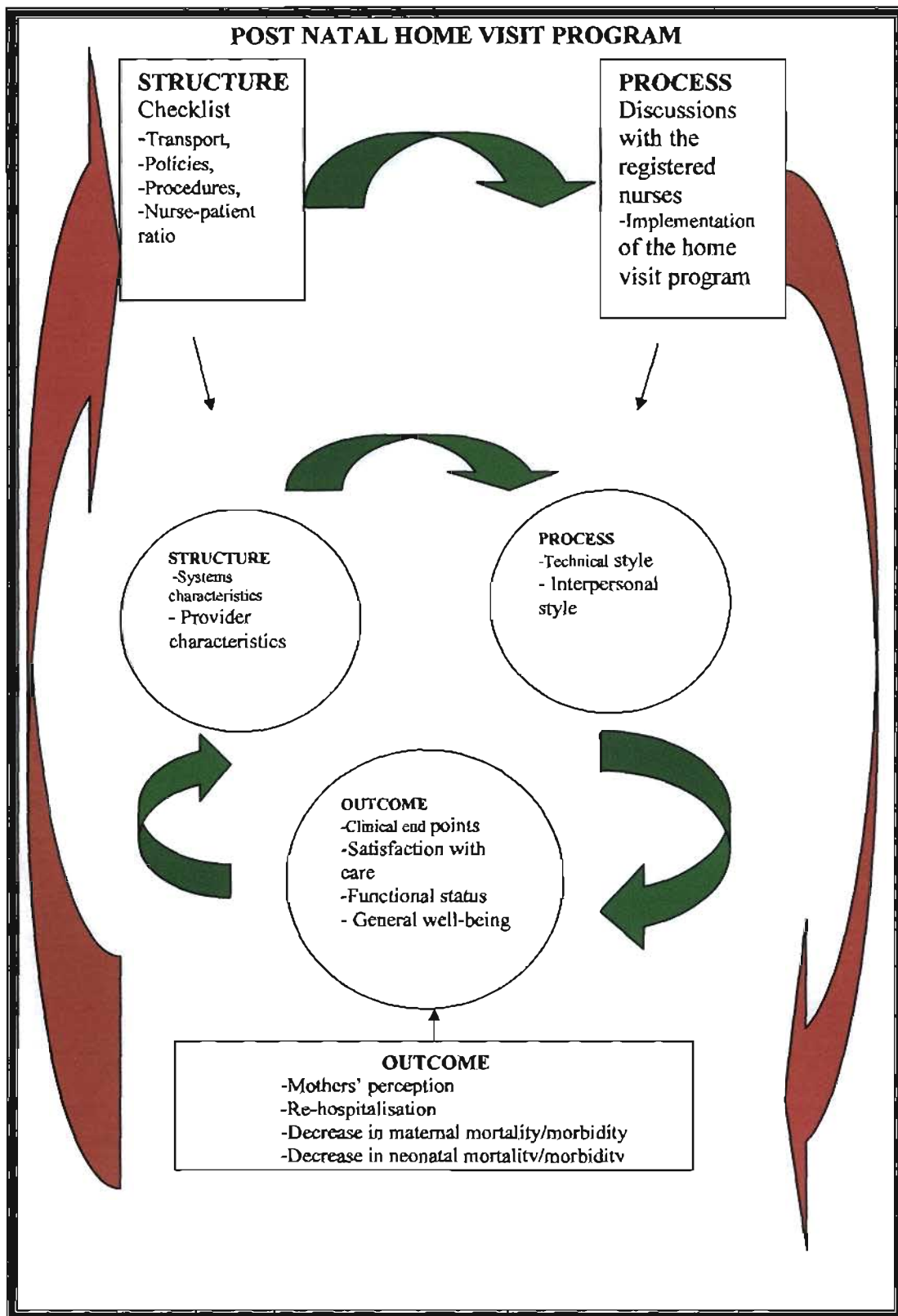
The outcome dimension includes a set of results from the delivery of health services. Most important of them is satisfaction with care. In this study, the outcome measures would be the number of mothers and their babies visited in their homes following early discharge and provided with continued care and the mothers' perception of quality care shown by records made by nurses working in the clinics. The outcome measures relating to mothers' perceptions and hospital utilization after delivery are not within the scope of this study.

#### **2.2.4 Relations of structure and process components in the dynamics of health outcome**

According to Donabedian's model which includes the structure, process and outcome factors as discussed above, each of these dimensions can be assessed separately or in combination, and it has been argued that if both the structure and process elements are well attended to, a positive health outcome for mothers receiving care will result.

In this study, the main focus will be on the structure and process dimensions. The structure factors which may impact on the implementation will be determined, as well as the process factors which relate to the actual service delivery to mothers and their babies who were discharged within four to six hours after delivery (Katzenellenbogen et al, 1997). The outcome factors will not be assessed due to time constraints.

Structure and process measures if not attended to, may affect the outcome of nursing care as shown in the diagram below.



**Figure 1.** A Diagrammatic Adaptation of Donabedian's Quality Assurance Model for the Post Natal Home Visit Program



The inside circles show Donabedian's model of structure, process and outcome and the circles are connected by the green arrows to run in a cyclical manner denoting that fulfilment or availability of one factor consequently leads to fulfilment of the other and fulfilment of the next will also lead to fulfilment of the other. Therefore, if the factors in the structure circle are adequately provided, the process factors will be able to be easily delivered resulting in positive outcome factors. Ultimately, positive outcome factors will lead to reinforcement or change in the structure factors in an aid to promote even better process factors leading to better outcome factors. The cycle will continue as long as there is no breakage in the cycle. Nevertheless, breakage of the cycle may be due to insufficiency or inefficiency in either of the structure or process factors.

The outer rectangles denote the variables for each factor as identified in this study. Each rectangle is connected to the corresponding circle of the Donabedian's cycle with an arrow. The rectangles are also connected to each other with cyclic arrows to form a cycle. The green arrow connecting the structure and the process factors assumes that there is no break between them, that is, the structure and process factors are assumed to be in place.

In contrast, the red arrow connecting the process to the outcome rectangle shows the interruption of the cycle that has been explained in the study, that is, lack of the implementation of the home visit program leading to assumed poor outcome factors. Similarly, the other red arrow connecting the outcome factors to the process factors also shows an interruption of the cycle with the assumption that there are poor

outcome factors and therefore no feedback to the structure factors resulting in no response and no change in the factors.

The structure factors are assumed to be available in the study and this needs to be verified by the study. What is known is that the post natal home visit care program is not implemented in the process factors and this is the main focus of the study.

Factors including availability of transport, readily available and accessible policies and procedures, including an accepted nurse-patient ratio, will ensure provision of continuing care to mothers and their babies after an early discharge through the post natal home visit care program. Consequently, mothers and their babies should have reduced and controlled complications associated with early discharge.

### **2.3 CONCLUSION**

The post natal home visit program is an essential component of the care of mothers and their infants which should be regarded as continuity of care following pre natal care, labour, delivery and immediate post natal care in the maternity ward setting. The dangers that the mother and her infant are exposed to due to the early discharge from the hospital cannot be over emphasized. Early discharge, which is a benefit to the health system, should also benefit the recipients of the health services. No studies were found which addressed reasons why the program is not being implemented in Botswana despite its value in reducing maternal and infant morbidity and mortality (The Safe Motherhood Initiative, 1998).

# **CHAPTER THREE**

## **METHODOLOGY**

### **3.1. INTRODUCTION**

This chapter describes the study design, population and sample, data collection procedure, research instruments and data analysis. Ethical considerations applied to this study are described and as well as the limitations of the study.

### **3.2 RESEARCH DESIGN**

A descriptive exploratory study, using both quantitative and qualitative methods, was the most appropriate design for this study as it satisfied the researcher's curiosity and the desire for better understanding of the personal and collective opinions and experiences of nurses in relation to the implementation of the post natal home visit care program (Bryman, 2004). Robson (2002), states that this type of study is an available means of "finding out what is happening; to seek new insights; to ask questions and to assess phenomena in a new light." The study was also to determine priorities for further research and develop new hypotheses about an existing phenomenon (Mouton, 2003).

Data were collected utilizing a checklist for structure factors and focus group discussions for the process factors. Essentially, a focus group discussion is a qualitative research technique used to obtain data about the feelings and opinions of a defined group of participants (Mouton, 2003). According to Mouton (2003), focus group interviews are used to find information that one would not otherwise be able to access. He further states that the method is useful because it tends to allow a space in

which people may get together and create a meaning among themselves rather than individually.

### **3.3 SETTING**

The study was conducted in the health district 16, City of Francistown. The City of Francistown is in the northern part of Botswana with an area of 19,657 hectares. The population of Francistown is 83,023, (with 48.4% being males and 51.6% being females) accounting for 23% of the total urban population in the country (Central Statistics Office, Francistown, 2001). The Francistown health district has one District Health Team, one referral hospital, one Institute of Health Sciences, thirteen clinics, two health posts, one military clinic and nine private practitioners (City of Francistown District Health Team Annual Statistics, 2004).

This health region was chosen because it was where the researcher had identified the problem.

### **3.4. STUDY POPULATION**

The study population was all the practicing nurses who had worked in the City of Francistown clinics for a period not less than six months by September 2005.

### **3.5. SAMPLE SELECTION AND SAMPLING TECHNIQUE**

Of the thirteen clinics, twelve were selected for inclusion in the study and one was omitted due to the fact that it had information starting from January 2005 as it was newly opened.

Qualitative inquiry looks in depth at a relatively small sample selected purposively because of their ability to inform the research topic (Bryman, 2004; Mouton, 2003).

Bryman (2004) and Mouton (2003) further state that the degree of homogeneity required will be considered when selecting participants and delegating them to different focus groups.

In order to gain insight from nurses shared experience, common characteristics of group members consisted of their occupation (Nurses), place of employment (City of Francistown Council Clinics), their clinical grade (Nurse Midwife and Registered Nurse) and duration in the City of Francistown Council Clinics (Not less than six months by September, 2005). It was recognized that power relations or hierarchy within a group would adversely affect the data (Kitzinger, 1995) and therefore participants were divided into two focus groups for Registered Nurses and another two for Registered /Enrolled Nurse Midwives.

Recommendations for the exact requirements for group size vary in the literature (Mouton, 2003). Bryman (2004) suggests that the size should be in the range of 5-10 as this allows everyone an opportunity to participate while still obtaining a range of responses. The four groups consisted of 5-9 members per group.

### **3.5.1. Sampling frame**

#### *3.5.1.1. Structure Factors*

The structure factors were assessed using a checklist (See Annexure A (4)). Twelve council health clinics in the City of Francistown were included in the sample.

#### *3.5.1.2. Process Factors*

Participants, who were Registered Nurses and Registered/Enrolled Nurse Midwives who had worked in the City of Francistown for at least six months by September,

2005, were drawn from the participating twelve clinics and were recruited from each clinic through purposive sampling. Registered nurses and Registered/Enrolled Nurse Midwives who were on duty on the day of the group discussion were recruited. This included nursing managers and senior nursing staff.

### **3.6. DATA COLLECTION**

The researcher sought permission to undertake the study from the City Clerk and the Nursing Superintendent of the City of Francistown council (See Annexure F).

#### **3.6.1. Data Collection Procedure**

##### **3.6.1.1. The Structure Factors**

Data on the structure factors were collected by the use of a checklist to identify the availability of staff and materials needed for the implementation of the post natal home visit care program in the participating clinics of the City of Francistown (See Annexure D). The checklists were completed by the researcher with the help of the Principal Registered Nurses and Senior Registered Nurses in charge of the clinics.

##### **3.6.1.2. The Process Factors**

###### **3.6.1.2.1. *Generating the interview schedule***

In formulating the interview schedule, the researcher took Bryman's (2004) advice on the development of the schedule which includes the following:

###### **a) *Affectively worded questions***

Questions which are emotionally loaded were avoided as much as possible including during probing.

*b) Double-barrelled questions*

Clear questions requiring a single response were asked so that the participants would grasp the component of the question to be answered.

*c) Complex questions*

Long and complicated questions were avoided to prevent confusing the participants.

*d) Sequencing of questions*

Intrusive data were requested at the end of the interview when participants were at ease and adjusted to the discussion environment.

*3.6.1.2.2. Pre-testing the interview schedule*

According to Bryman (2004) and Mouton (2003), pre-testing involves critical examination by other people familiar with the study's subject matter-technical experts, other researchers, or persons among the type to be studied so as to identify poorly worded questions, questions with offensive or emotionally laden wording or questions revealing the researcher's own biases, personal values or blind spots.

The interview schedule was reviewed by a more experienced researcher at the University of KwaZulu-Natal and two experts of maternal and child health care in the City of Francistown, Botswana. This helped the researcher to assess whether the interview schedule revealed the information wanted. Assessment of the tool revealed the problem of obtaining the nurse-patient ratio as data needed to calculate it was not available. This item was then omitted. In addition, the number of post natal care clients at six weeks was included as it would provide a comparison between its

utilization and that of the post natal home visit care program, number of deliveries and the ante natal care attendance.

#### **3.6.1.2.3. Data collection**

The researcher obtained permission to undertake the study from the Ministry of Health and the City Clerk. The latter brought the study to the attention of the Principal Registered Nurses of each of the clinics who informed the staff of the forthcoming study. The researcher visited each clinic and approached the Registered Nurses and the Registered/Enrolled Nurse Midwives and asked their consent to participate.

The Registered Nurses on duty on the day of data collection from the twelve clinics sampled were divided into two focus groups. Likewise the Registered/Enrolled Nurse Midwives from the twelve clinics were also divided into two focus groups so that from the twelve clinics sampled there was a total of four focus groups.

All four focus group discussions led by the researcher were conducted at one of the clinics in the City of Francistown, Botswana over a period of four days. The discussions varied from forty minutes to one hour in length.

Selection of the venue was according to availability of space conducive for the discussions. Convenience for the participants was also taken into consideration as some nurses depended on public transport to travel to and from work. Therefore, the clinic which was also nearest to the public transport routes was used. Participants were transported to the venue by their respective clinic transport. The actual room for discussion was requested from the Principal Registered Nurse in charge of the clinic (Annexure F). The setting was made conducive for the discussion by ensuring proper seating arrangements, privacy, adequate lighting and ventilation.



There were four focus group sessions conducted, two for Registered Nurses and two for Registered Nurse Midwives. The researcher engaged in an unofficial conversation with the participants prior to the commencement of the discussions to build rapport and to stimulate participation in discussions. Furthermore, the purpose and objectives of the study were explained to participants before the commencement of the discussions and participants were given a chance to ask questions about anything that they were unsure of. Participants consented by signing a consent form (Annexure B) that had an information sheet (Annexure A) which were provided by the researcher prior to participating. Anonymity and confidentiality were assured. The participants were informed of the presence of the tape recorder before the group discussion. The tape recorder is recommended by Bryman (2004) and its purpose and usefulness was explained by the researcher.

An interview schedule developed by the researcher was used in all the focus group discussions (Annexure C). The questions were open ended and simple techniques were used to facilitate discussion between the interviewer and participants. The interview schedule was used to ensure that all aspects related to the research questions were covered. The researcher continued to probe when there were related concepts that came to the fore. The principle of data saturation was used which means that additional focus group discussions were to be done if new information came to the fore. This would have meant returning to the clinics and recruiting staff who had not already participated in the group discussions. Additional group discussions were not employed as saturation was reached with the four focus groups conducted. All focus group discussions were conducted during clinic days.

### **3.7. DATA ANALYSIS**

#### **3.7.1. The Structure Factors**

Data analysis for the structure factors was done quantitatively. Descriptive statistics were used to summarize the data generated.

#### **3.7.2. The Process Factors**

According to Brink (2002), there are no distinct steps in analysing qualitative data, but analysis is concurrent with data collection. Data analysis was done manually using Downe-Wambolt's (1992) model of qualitative content analysis.

All the tape recorded data were first transcribed in full. This was done after every focus group discussion. The researcher then read through the transcribed data to get acquainted with the data.

Transcribing the data was difficult as a number of people within the focus group spoke at the same time, and some individuals spoke privately to other participants, aside from the main discussion in a few instances. The most important problem, as stated by Webb and Keven (2000), arises from the desire to use and make clear the interaction within the group. These issues were encountered during the analysis process.

Colour coding, encoding and categorizing were used to identify the main themes and sub themes. Validating findings was done with two members of each group after transcription to check as to whether the findings denoted what was said during the discussions. Data from each focus group discussion were constantly compared with

one from the other focus group to determine the final theme. The reliability of the coding was checked by having the researcher's supervisor encode the same data and by checking for agreement (Brink, 2002).

### **3.8. ACADEMIC RIGOUR**

#### **3.8.1. Trustworthiness**

##### *a) Credibility*

To establish credibility in this study, the researcher undertook to acknowledge her own biases before conducting the discussions. This was done in order to ensure objectivity in that the researcher would not observe and interpret findings according to her own values, beliefs and preconceptions.

The researcher acknowledged being a Registered Nurse Midwife who has been involved in the Safe Motherhood Program as a trainer of trainers for the Safe Motherhood Initiative Program in another health district in Botswana (Serowe/Palapye Sub District Council). The researcher was concerned about the non availability of records indicating the non functioning post natal home visit care program despite the government's initiative of providing free maternal and child health services to reduce the maternal mortality rate in the country and the availability of protocols for the program. The researcher was also interested in finding out the opinions of the registered nurses and nurse midwives on the post natal home visit care program.

In addition, Bryman (2004) refers to member validation as the recycling of information back to the study participants and obtaining feedback from them about the accuracy of the content. After the discussion, data were transcribed and a short

summary was made from the transcriptions and referred back to two participants of each focus group to validate it.

The transcripts, data analysis and conclusions were authenticated by a more experienced researcher.

*b) Transferability*

Transferability is about how findings can be generalised or transferred from a representative sample of a population to the whole group (Holloway and Wheeler, 1998).

By providing a thick (dense) description in respect of the demographics of the focus group members who participated in the study, and also in respect of their work place, experiences and contexts, the researcher has facilitated the reader's being able to assess the transferability to their own contexts (Krefting, 1991).

*c) Dependability*

Dependability is demonstrated by following the acceptable standards of the processes of qualitative research (Holloway and Wheeler, 1998). External checks were done by the researcher's supervisor and the ethics committees of the University of KwaZulu Natal and the Health Research Unit of Botswana.

To avoid the threat of participant error, a more neutral time was chosen, about an hour after resuming work, when the registered nurses were expected to have settled into their daily assignments (Saunders, Lewis and Thornhill, 2003) and the discussions were held during less busy weekdays.

Summarized data were presented to two members of each focus group for validation and clarification and the researcher was able to obtain feedback concerning the accuracy of the content of data collected.

*d) Confirmability*

Confirmability was ensured by keeping all raw data collected, analysed data, formation of the findings, the process of the study, the early intentions of the study and the development of the measures used for constant review and to confirm that the findings come from the data gathered (Holloway and Wheeler, 1998). The researcher used the participants' own words to summarize, illustrate or clarify points. Analysed data and conclusions made including the research process were subjected to audit and external checking.

### **3.9. ETHICAL ASPECTS OF THE STUDY**

Permission to conduct this research was requested from the ethics committee of the University of KwaZulu Natal through the supervisor of this research project, as well as from the Botswana Health Research Unit in Gaborone and the City Clerk of the City of Francistown Council. Permission for the venue was requested from the Principal Registered Nurse in charge of the clinic where all the discussions were held (Annexure F).

Permission was also requested from individual participants to participate in a focus group discussion (Annexure A and B). Participation was voluntary. Participants were assured of confidentiality and anonymity in that their names were not used or documented. The participants were informed that they had the right to refuse to

answer any questions with which they did not feel comfortable. The participants were also informed that they might withdraw from the group discussion and the study at any stage. They were informed about the presence and use of a tape recorder and the need of its use was explained to them. The participants were further informed that according to the researcher's knowledge they were unlikely to encounter any harmful effects as a result of participating in this study (Annexure A).

The purpose of the study was fully explained to the participants. The discussions were only used for the purpose of this study. The participants' contributions did not affect their work in any way. Information given was kept confidential. Participants were requested to keep all information from the discussion confidential and not to cite or quote any member of the group. All information discussed belonged to the whole group and thus no one was singled out in anyway. A written informed consent was obtained from each participant prior to the discussions (Annexure B).

Although all research should guarantee anonymity for its participants, qualitative researchers work with small samples and it is not always easy to protect identities (Holloway and Wheeler, 1996). The desire in qualitative research to describe the context and detail of an event can also complicate the issue of anonymity. Smith (1995) reminds the researcher that using the focus group cannot guarantee that each participant will maintain the confidentiality of other participants. With this difficulty in mind, prior to the start of each group interview, the group was asked to have regard for other participants, by ensuring that members do not repeat any of the contents of the discussion to others outside the group. The names of the participants did not appear on any written document.

### **3.10. LIMITATIONS OF THE STUDY**

**3.10.1.** Participants who were on duty on a specific day convenient for the researcher were selected from the clinics due to time constraint.

**3.10.2.** The sample was drawn from an urban area, one city and the results may not necessarily apply to other communities such as those in the rural areas.

### **3.11. CONCLUSION**

Twelve out of thirteen clinics were included in the study and a checklist was used to solicit information on the structure factors. A convenience sample of twenty eight Registered Nurses and Registered Nurse Midwives who had worked for a period of six months in the City of Francistown clinics participated in the four focus group discussions to determine the process factors.

Analysis for the structure factors was done quantitatively using descriptive statistics while data for the process factors was done manually using qualitative content analysis.

Trustworthiness was taken into account in that the credibility, transferability, dependability and confirmability of the study were ensured. Ethical considerations were also taken into consideration.

# **CHAPTER FOUR**

## **PRESENTATION AND DISCUSSION OF FINDINGS**

### **4.1. INTRODUCTION**

This chapter deals with data analysis of the structure factors from the checklists completed in the twelve clinics and data collected through four focus group discussions with nurse midwives and registered nurses for the process factors. Initially data were planned to be collected from the thirteen clinics that are Tatitown, Botsalano, Kagiso, Botswelero, Masego, Boikhutso, Lapologang, Tshwaragano, Botshelo, Jubilee, Gerald Estates, Itekeng and Ntshe clinics. Ntshe clinic, which was newly opened, only had statistics from January 2005, so it was excluded. Data from the other twelve clinics were collected for the period April 2004 to March 2005.

### **4.2. THE STRUCTURE FACTORS**

Data on the structure factors were collected using a checklist to identify the availability of staff and materials needed for the implementation of the postnatal home visit program that were in place within all the twelve participating clinics in the City of Francistown (See Annexures C and D).

The tool was modified with the input from the more informed safe motherhood officers, who advised the researcher that it would be possible only to get reliable and accurate nurse patient ratios by calculating patients seen by each nurse at a given time. This information was not available. With that advice, the researcher decided to leave out the nurse patient ratio from the checklist.



The information on post natal care visits at six weeks, which was not initially included in the research proposal was included, as it provided some information on the extent to which the post natal service is utilized.

Collection of data was done by the researcher with the help of the Principal Registered Nurses in charge of the twelve clinics. Data were collected over a three day period. The information on total deliveries and ante natal clients registered was collected for the period April 2004 to March 2005.

Data analysis for the structure factors were done quantitatively. Descriptive statistics were used to summarize the data generated. Information in numbers is presented in table form for easy interpretation.

#### 4.2.1. Transport

**Table 4.1. Total Number of Ambulances and Drivers per Clinic (N= 12)**

Clinic	Ambulances	Drivers
Tatitown	1	1
Botsalano	1	1
Kagiso	1	1
Botswelelo	1	1
Masego	1	1
Boikhutso	1	1
Lapologang	1	1
Tshwaragano	1	1
Botshelo	1	1
Jubilee	2	5
Gerald Estates	1	1
Itekeng	2	5
Total	14	20

Table 4.1 shows that Jubilee and Itsekeng clinics have two ambulances and five drivers each. The two clinics operate twenty four hours a day and seven days a week. The drivers work shifts. The remaining ten clinics operate for eight hours during the day on weekdays and in the mornings only over weekends. These clinics have one ambulance and one driver each. The table also reflects that all clinics are equipped with at least one ambulance.

All the ambulances were reported to be in a good running condition by the nurses in charge of the clinics. The health posts share ambulances with the mother clinics which are less than five kilometres apart. All clinics are equipped with telephones for easy communication when in need of an ambulance. In emergencies, transport can be requested from the District Health Team offices.

#### **4.2.2. Availability of Policies and procedures**

None of the clinics had policies or procedures for the post natal home visit care program in place.

#### 4.2.3. Category of Nurses

**Table 4.2. Number of Nurses by Professional Category per Clinic (N= 12)**

Clinic	Enrolled Nurse Midwife	Registered Nurse	Registered Nurse Midwife	Total nurses
Tatitown	0	3	3	6
Botsalano	0	2	1	3
Kagiso	0	2	1	3
Botswelelo	0	0	4	4
Masego	0	3	3	6
Boikhutso	0	1	2	3
Lapologang	1	3	1	5
Tshwaragano	0	5	5	7
Botshelo	0	2	1	3
Jubilee	0	10	10	20
Gerald Estates	0	3	2	5
Itekeng	1	13	14	28
<b>Total</b>	<b>2</b>	<b>47</b>	<b>47</b>	<b>93</b>

From Table 4.2 it can be seen that only Lapologang and Itekeng clinics had Enrolled Nurse Midwives on their staff complement, with each having one Enrolled Nurse Midwife.

It is also shown in this table that Itekeng clinic had the greatest number of Registered Nurses, with thirteen, followed by Jubilee clinic with ten, then Tshwaragano clinic

with five. Four clinics namely, Gerald Estates, Lapologang, Masego and Tatitown each had three Registered Nurses. Botsalano, Kagiso and Botshelo had two Registered Nurses each followed by Boikhutso with one Registered Nurse and lastly Botswelero with no Registered Nurses.

The table also depicts that all clinics are staffed with at least one Registered Nurse Midwife with Itekeng clinic and maternity ward having the highest number at fourteen followed by Jubilee clinic with ten.

It is also reflected in Table 4.2 that Itekeng had the greatest number of nursing staff, with twenty eight nurses followed by Jubilee clinic with a total number of twenty nurses. These two clinics operate twenty four hours a day. Itekeng clinic has an operating maternity ward. The remaining ten clinics have between three and seven nurses each.

#### **4.2.4. Total Deliveries**

Itekeng clinic, the only clinic with a labour ward, had a total of 473 deliveries for the period April 2004 to March 2005. The other eleven clinics do not have labour wards and therefore had no records of deliveries.

#### 4.2.5. Total Ante Natal Clients Registered

**Table 4.3. Number of Ante Natal Care and Post Natal Care Visits Conducted by the Twelve Clinics**

Clinic	Ante Natal Care	Ante Natal Care	Post Natal Care
	New Visits	Repeat Visits	Visits
Tatitown	259	2102	166
Botsalano	119	759	65
Kagiso	146	825	90
Botswelero	334	2298	215
Masego	390	2670	224
Boikhutso	311	1746	155
Lapologang	352	2421	218
Tshwaragano	277	1535	141
Botshelo	126	694	82
Jubilee	168	1233	77
Gerald Estates	150	1130	114
Itekeng	310	1923	119
<b>Total</b>	<b>2942</b>	<b>19336</b>	<b>1666</b>

It is reflected in Table 4.3 that more than half (1697) of the new ante natal clients were registered at Masego, Lapologang, Botswelero and Itekeng clinics. Itekeng clinic also had the highest number of nursing staff. Jubilee clinic which had the second highest number of nursing staff, only registered 168 new clients.

The table also shows that mothers did attend the six weeks post natal care clinics though the number of post natal visits is less than the number of ante natal new visits. Jubilee clinic had the lowest number of post natal visits, with the highest number being at Masego clinic. Masego clinic also had the highest number of new ante natal visits. It has a nursing staff complement of six.

### **4.3. THE PROCESS FACTORS**

#### **4.3.1. The Procedure of Data Collection**

As stated earlier, four focus group discussions, two with Registered/Enrolled Nurse Midwives and two with Registered Nurses were held to describe the process factors. The focus groups were conducted over a period of four days. The four focus groups were held at the same clinic (See p33). The venue was organised by the Principal Registered Nurse in charge of the clinic and privacy was ensured. In order to prevent interruptions, the telephone handset was removed from the receiver.

There was only one interruption during the first Registered/Enrolled Nurse Midwife's group discussions when one Principal Registered Nurse was called by the receptionist for an urgent phone call from the Nursing Superintendent's office.

The interview guide was used to guide the discussions and probing questions were used to solicit more information or redirect the discussions where it was seen fit.

The focus group discussions were led by the researcher.

#### **4.3.1.1. The Participants**

Participants were drawn from different clinics through purposive sampling. Informed consent was sought and participants signed consent to participate. An ice breaker was used to ease the tension from the participants who were able to deliberate freely.

All participants participated actively and productively though there was an instance where the researcher had to rephrase the question before there was a response in one of the Registered Nurses' group discussion.

The first group of Registered/Enrolled Nurse Midwives had seven participants while the second focus group had five participants. The first focus group of Registered Nurses had nine participants while the second focus group had seven participants, giving a total of twenty eight participants.

All Registered/Enrolled Nurse Midwife participants were female whose length of service ranged from four to thirty years. They all had diplomas in general nursing and midwifery except one Enrolled Nurse Midwife who had a certificate in nursing and a diploma in midwifery. The Enrolled Nurse Midwife participated in the group with the Registered Nurse Midwives. There was only one male in the second group for Registered Nurses and their length of service ranged from one year to three years. All the Registered Nurses had a diploma in general nursing. None of the participants had a specialist qualification.



#### **4.3.1.2. Data Analysis**

Data were subjected to content analysis using Downe-Wambolt's (1992) method. A core feature of qualitative content analysis is developing categories on the basis of similarities and differences at different logical levels (Woods and Catanzaro, 1988). Data analysis, which was not guided by any particular assumptions, was performed as follows:

- All data were first transcribed from the audio tape. This was done after every group discussion.
- The researcher repeatedly read through the documentation to get acquainted with the data from the informants and to gain a familiarity with the content.
- Significant statements relating to participants' experiences were colour coded and sub categories given identifications from each group discussion.
- Thereafter the text was divided into content areas to provide a rough structure.
- Data were divided into meaningful units, which were statements organized according to categories which related to the objectives of the study.
- The meaningful units were condensed and coded.
- The codes were compared based on similarities and differences and sorted into a set of six of categories and nine sub-categories, which were then reviewed by the researcher's supervisor in order to ensure both accuracy and objectivity (Silverman, 2002).

#### **4.3.2. Identified Categories and Sub-Categories**

The categories and sub-categories that were identified relating to the objectives of the study are shown below.

**OBJECTIVE 1: To determine the factors that influence nurses to undertake/not undertake post natal home visits**

All the participants admitted to not implementing the post natal home visit care program. Participants presented three main categories and five sub categories under reasons for not implementing post natal home visit program as listed below;

***Category 1: Staff Issues***

Sub categories: a) shortage of staff with lack of motivation  
c) Lack of support from management and co-workers

***Category 2: Patient Issues***

Sub categories: a) Distance  
b) Fear of stigmatisation

***Category 3: Policies***

Sub category: a) Program and its logistics not in place

**OBJECTIVE 2: To explore with the Registered Nurses possible strategies by which the post natal home visit program can be implemented.**

All the participants agreed that the post natal home visit care program was a worthy program and advocated for its implementation. Three categories and four sub categories were identified for strategies for implementing the post natal home visit care program.

**Category 1: Implementation issues:**

Sub categories: a) Team work and commitment to work

b) Give program priority it deserves

**Category 2: Education**

Sub category: a) Training to improve skills and increase manpower

**Category 3: Policy Development**

Sub category: a) District Health Team to take responsibility of the program

**4.3.3. REASONS FOR NOT IMPLEMENTING THE POST NATAL HOME VISITS CARE PROGRAM**

When asked whether they provided post natal home visit care, all focus groups said they did not. The participants gave various reasons for not conducting the post natal home visit care program.

All the participants felt that there was need to implement the program and attached merit to its importance. There was consensus on the reasons for the need to implement the program as described in the following comment by one of the Registered/Enrolled Nurse Midwives:

*“Mothers and their babies are discharged early within the first twenty-four hours following delivery and anything can happen... such as... post natal sepsis, haemorrhage, psychosis for mothers and the babies may have neonatal problems such as ophthalmic neonatorum, sepsis, diarrhoea, pneumonia and malnutrition...”*

When asked whether they had witnessed the mothers or their babies with the above mentioned health problems, one of the participants stated:

*“Yes, all the problems that were just stated occur and are seen in our consulting rooms.”*

Given that the participants all agreed that there was a need for the program, reasons for their not undertaking the visits were probed. The following reasons were identified:

### ***Category 1. Staff Issues***

#### ***Sub category A: Shortage of staff with lack of motivation***

All of the participants felt that there was a shortage of Registered Nurse Midwives who are overburdened by other services that they provide to clients. For this sub category however, the Registered/Enrolled Nurse Midwives gave a slightly different explanation from the Registered Nurses. One of the Registered/Enrolled Nurse Midwives stated:

*“There is shortage of staff, so it is not possible for the few staff members to do ‘additional tasks’ such as home visits”*

The Registered Nurses expressed it as follows:

*“There are not enough midwives, we operate with only one midwife in a clinic, surely we cannot expect her to provide all these services expected of her. We need more midwives.”*

When the Registered Nurses were reminded that they also had a notion of safe motherhood which they covered during basic obstetric training, they answered: *“Yes, we did. That was only an exposure so that ‘where there is no midwife’ slogan is covered and can be implemented, that is, in times of crisis. But the program is not a crisis at all as it is a routine activity for the midwives. They should do their work, they are paid for it.”*

Registered/Enrolled Nurse Midwives expressed job dissatisfaction. They felt that they were overworked and experienced very slow professional progression either through promotion or career development. One Registered/Enrolled Nurse Midwife declared: *“Some of us have been here since time immemorial, and are still ‘marching’ at the same spot. We are not promoted because we are told there are no posts...Neither are we sent for further training...All we have to do is work...This is why nurses are leaving for greener pastures”*

***Sub category B: Lack of support from management and co-workers***

Participants all agreed that there was lack of support from management and that it was of concern. They expressed mixed feelings concerning the credibility of their managers and questioned their supervisory skills. One Registered/Enrolled Nurse Midwife declared:

*“There is need to develop managers on management and leadership skills so that they may ensure that the government health policies are followed... otherwise if the leaders are quiet, who will question them?”*

The Registered/Enrolled Nurse Midwives were worried that their supervisors seemed to have forgotten their responsibility in providing maternal health services as they did not support vital services such as the post natal home visits, nor encourage their implementation. To emphasize this, one Registered/Enrolled Nurse Midwife declared: *“When we want to use the ambulance to follow up mothers, the ‘boss’ instead of providing transport to the midwives, would use the same ambulance to go for a meeting or for management issues when she could have walked or called for an administration vehicle to pick her.”*

The Registered/Enrolled Nurse Midwives felt that there existed a problem of lack of support from co-workers. There was a consensus that this state of affairs demotivated one as there was a tendency to ‘fear’ the negative midwives who might have a nasty comment to make against anyone who diligently provided the service or tried to rectify a shortcoming identified in service delivery. The remarks might discourage the minority who are dedicated to their work as illustrated by the following statement: *“If you do it (implementing the program), then other nurses say you are trying to be smart or worse still, you want to run your own errands (Doing their personal activities such as shopping).”*

## ***Category 2: Patient Issues***

### ***Sub category A: Distance***

Registered/Enrolled Nurse Midwives felt that another factor contributing to non implementation of the post natal home visit program was the fact that some mothers go back to their rural homes for the lying in period. These rural homes are far from

the clinic. It would therefore be difficult to visit them as they would now be out of the catchment area. This was reflected in the statement below by one participant:

*“... and those that are found in the house will tell you that she (the mother) had only come for delivery and she has gone back home (Village) or cattle post or something...”*

#### ***Sub category B: Fear of stigmatisation***

Registered/Enrolled Nurse Midwives raised a concern whereby mothers did not give their correct house addresses so as to avoid being visited by nurses. When a newly delivered mother is visited by nurses, it gives an impression that she is HIV positive or “code one” as they are referred to in the Prevention of Mother to Child

Transmission Program. The mothers are said to hide by giving wrong addresses in order to avoid stigmatisation. One Registered/Enrolled Nurse Midwife declared:

*“Yes... especially the ‘code ones’ (HIV positive mother) they do not want people to see that nurses are visiting them... so they try to hide by giving wrong house numbers...”*

#### ***Category 3: Policies***

##### ***Sub category A: Program and its logistics not in place***

Data generated from the four focus groups has shown that the program was not in place in the health district of the City of Francistown as indicated by the statement below:

*“It is only that the program is not done here...we are literally short staffed. Since I came I have not heard anything about conducting domiciliary (the post natal home care visit).”*

Transport was also one of the reasons given for not implementing the program. Even though data for the structure measures showed that all the clinics had at least one ambulance, this was said not to be enough as the ambulance had to be available in the clinic at all times for the patients in cases of emergencies as portrayed in the statement below:

*“Yes transport that will be out for as much as it is needed by the staff on home visits and not to be disrupted by being called back when there is an emergency in the clinic”.*

Data from the Registered Nurses repeatedly explained one of the factors that influenced non implementation of the post natal home visit care as the fact that they were not trained to provide the service. Although the protocol includes the Registered Nurses in the implementation of the program, it has been shown by data generated from the participants that Registered Nurse training is not sufficient to provide the skills. This is portrayed in the statement from one of the participants below:

*“Ah... I don't even know that program, it must be in the midwifery curriculum...In fact...no. we did not cover that one”*

#### **4.3.4. RECOMMENDATIONS MADE FOR IMPLEMENTING THE POST NATAL HOME VISIT CARE PROGRAM**

In response to the above inquiry, the Registered Nurses felt that more Registered/Enrolled Nurse Midwives should be trained to increase manpower and that Registered/Enrolled Nurse Midwives *“must do their work.”* This clearly indicated that they excluded themselves from the program. On the other hand, the



Registered/Enrolled Nurse Midwives had a lot of input as to what they felt should be done to correct the situation.

The information which emerged from the data generated from the focus group discussions was divided into three themes namely: staffing issues relating to implementation, education and policy development.

### **CATEGORY 1: Implementation issues**

#### ***Sub category A. Teamwork and Commitment to work***

The Registered/Enrolled Nurse Midwives wished to contribute to the rectification of the omission by making a concerted effort. By supporting each other to become aware of their shortcoming in service delivery, Registered/Enrolled Nurse Midwives could facilitate the implementation of the post natal home visit care program. One Registered/Enrolled Nurse Midwife made the following illustrative remark:

*“We need to discuss this problem... and determine how we can commence the program... It is the responsibility of the midwives ...to complete care rendered to mothers following delivery.”*

Data suggested that Registered/Enrolled Nurse Midwives, who were aware of their professional incompetence, appeared to deepen their understanding of what they owe the midwifery practice. They made various suggestions as to what they felt should be done to rectify the problem as stated below:

*“We should be committed to our work as midwives and do our duty towards the mothers and their babies, we need not be reminded”*

The above statement suggests that Registered/Enrolled Nurse Midwives wished to contribute to the health of mothers and their babies. The Registered/Enrolled Nurse

Midwives also stated that they, themselves needed to be aware of the responsibilities that they, as Registered/Enrolled Nurse Midwives had to face and also endure challenges connected with the post natal home visit care program. The other factor that the Registered/Enrolled Nurse Midwives suggested was that there was need for them to include mothers by empowering them to be able to claim the care they have to receive during the early post partum period. This was suggested by one Registered/Enrolled Nurse Midwife in the statement below:

*“... We should empower our mothers to claim the visit by educating them on their right for the visits...”*

This was to be reinforced by having the protocols available to the mothers through education and attaching the protocols to the mothers’ take away card for reference as shown in the statement below given by one of the midwives:

*“I think the best way to keep the mothers informed about their rights would be to educate them and attach the protocols of the program written in both English and Setswana to their cards (mother’s take away card) for easy reference.”*

#### ***Sub category B. Registered/Enrolled Nurse Midwives’ role in the program***

Data shows that the Registered/Enrolled Nurse Midwives also blamed themselves for the non-implementation of the program. They admitted that they had contributed one way or another to the “natural death” of the program. This was explained in the following statements contributed by one of the midwives:

*“I think the midwives are responsible for the program’s natural death. How can we ignore our responsibility and blame other programs? Midwives have just decided not to go home visiting for no apparent reason. Surely, all these reasons are secondary, had we kept the program going, the government could have done something about it.”*

The Registered/Enrolled Nurse Midwives also felt that the post natal home visit care program should be given the priority it deserves and not be overridden by other programs. Data shows that the Registered/Enrolled Nurse Midwives had an interest in seeing the program in place. They expressed the need to advocate for the program of their specialty.

*“The program should be given the priority it deserves...you see...and not be overridden by other programs...Midwives should advocate for the program of their speciality.”*

The participants have expressed the opinion that the program should be implemented by Registered/Enrolled Nurse Midwives as they were the ones who are academically prepared for the provision of the service and thus possessed the skills. The Registered Nurses are not academically prepared to render post natal home visit care services as it was not included in their curriculum. They are therefore not qualified to implement the program. The Registered/Enrolled Nurse Midwives also expressed their concern of having Registered Nurses implement “their program” as they referred to the post natal home visit care program. The Registered/Enrolled Nurse Midwives were worried that the care provided to mothers and their babies would be compromised if conducted by unqualified personnel hence the cry for additional midwives. This is conferred in the statement below from one of the Registered/Enrolled Nurse Midwives:

*“The program should be done exclusively by midwives and not registered nurses as they are not trained in the speciality of midwifery. We don't want ‘on the job training’ in our speciality, they will compromise care...”*

Another Registered/Enrolled Nurse Midwife emphasized this by stating:

*“We don’t want them (Registered Nurses) in our territory otherwise we will be worsening the situation.... Lets just leave them out; they have no place in this program until they go for midwifery training.”*

Registered Nurses also contributed in support of the above as portrayed in the statement below which was said by one participant:

*“The program should be done exclusively by midwives not registered nurses as this is a specialty area, let us forget all about cheap labour, it is not practical this days, think of the law suits. The government will not protect you when there is a problem.”*

## **CATEGORY 2. Education**

### ***Sub category A. Training to improve skills***

Data suggest that Registered/Enrolled Nurse Midwives identified inadequacies in service delivery that concern both Registered/Enrolled Nurse Midwives and management. They felt that these inadequacies could be addressed through academic development hence they advocated for continuing education through workshops and seminars so as to remind Registered/Enrolled Nurse Midwives of their duties which tended to be neglected. One Registered/Enrolled Nurse Midwife stated:

*“My opinion is that seminars and workshops should be held more frequently to sensitise and motivate the midwives on the program.”*

Further training to develop and advance Registered/Enrolled Nurse Midwives in midwifery in order to increase motivation in their work and thus perform their duties

without any reservations was also advocated as one participant suggested in the statement below:

*“Midwives should be sent for further training to develop and advance them in midwifery in order to be motivated and thus perform their duties without reservations.”*

The statement below shows the concern that the Registered/Enrolled Nurse Midwives have about the quality of their supervisors and management:

*“There is need to develop management and leadership skills so that they (managers) may ensure that the government’s health policies are followed.”*

Data also revealed that there was need to address the problem of inadequate staffing especially of midwives for the success of the implementation of the post natal home visit care program. Though the nurses had shown interest in reviving the program despite the problem of shortage of staff, they advocated for the deficiency to be addressed by training more midwives as shown in the comment below from one of the participants:

*“More staff... this is the main factor... we are running midwifery services with an inadequate staff. There is need to train more midwives...”*

### **CATEGORY 3: Policy Development**

#### ***Sub category A. District Health Team to take responsibility of the program***

The participants advocated for the program to be revived and to be coordinated by the District Health Team, which is the overseer of other health programs in the district.

One participant had this to say:

*“I think the District Health Team should form the post natal home visit care program... This team will have a coordinator... who will be responsible for the day to day running of the program.”*

Data revealed the absence of policies and protocols that the staff could readily access and refer to in the implementation of the post natal home visit care program.

Provision of these policies and protocols were advocated for by one of the participants:

*“What about policies and procedures? These should be readily available in each clinic for all to see and reference.”*

The Registered/Enrolled Nurse Midwives expressed the need to have them in place while the Registered Nurses advocated their revision to exclude them as they were not qualified to render the services as shown in the plea given by one of the Registered Nurses:

*“We do not know how that came about (being included in the implementation of the program) because we are not midwives and cannot be expected to deliver services we have not been adequately trained for. It is really amazing. The protocol needs to be revisited.”*

The District Health Team was recommended to provide for the logistics of the program such as policies, staff, equipment and transport. In this manner, the participants felt that the program would be successful as it would have a coordinator who would be able to monitor progress on a daily basis.

## **4.4. DISCUSSIONS OF THE FINDINGS**

### **4.4.1. The structure factors**

There is at least one ambulance in all the clinics operating eight hours a day and two for those operating twenty four hours a day. The participants stated that the ambulances are mainly for patients and cannot be used for the post natal home visit program. There is a need to provide transport which will be for the post natal home visit program to enable its smooth running.

Participants raised a number of concerns in relation to staffing levels. Although they recognized funding problems, they felt disempowered by a situation in which they are supposed to implement the program but they feel lacking in knowledge and skills. Gilford et al. (2002) also suggests that staffing levels require attention, and argue that strategies to save labour costs may end up costing an organization more in the end, as they may increase staff turnover and burnout, and are associated with poor outcomes for the health of mothers and their babies.

Out of a total registered number of 2942 ante natal mothers, only 473 deliveries were conducted at Itekeng clinic and a total of 1666 post natal clients visited the twelve clinics at six weeks post delivery. This shows that more mothers attend ante natal clinics than post natal clinics and a considerable number of mothers are delivered elsewhere.

Protocols and procedures for the post natal home visit care program were not available in any of the clinics. These logistics are necessary for guiding the implementers and to ensure uniformity throughout the district and country.

No records were available for the post natal home visit care program. This suggested that the post natal home visit care program was not being implemented. The only available document with guidelines for follow-up of mothers was the obstetric record card which is used for monitoring the mother and her baby from pregnancy until six weeks following delivery (Botswana Obstetric Record, 1997). Despite these guidelines, the participants felt that the post natal home visit care program is not the responsibility of the Registered Nurses as they are not fully academically prepared.

#### **4.4.2. The process factors**

As indicated in this study, focus group discussions were used to determine the factors that prevent Registered/Enrolled Nurse Midwives and Registered Nurses from implementing the post natal home visit care program and to find out what could be done to rectify the situation.

An exploration through the focus group discussions was initiated by the researcher to identify possible strategies in which post natal home visit care program could be enhanced. The focus groups were composed of Registered Nurses and Registered/Enrolled Nurse Midwives who varied in their length of service (four years to thirty years for midwives and one year to three years for registered nurses), positions held (Enrolled Nurse Midwife, Registered Nurse, Senior Registered Nurse, Principal Registered Nurse) and academic qualifications (Certificate in Nursing, Diploma in Nursing and Diploma in Midwifery).



The focus groups revealed the fact that the Registered/Enrolled Nurse Midwives were aware that the program was not implemented and at the same time acknowledged its usefulness. They also excluded Registered Nurses from the responsibility of implementing the program because they are not academically prepared and so lack the skills. This study further shows that Registered/Enrolled Nurse Midwives with the responsibility of the post natal home visit care program, had themselves explicit needs related to shortage of staff with lack of motivation, lack of support from management and co workers. The other factors that emerged as reasons for not implementing the program were patient related such as distance of the mothers' rural homes and fear of stigmatisation. In regard to policies, the program was revealed to not be in place. These factors are addressed under implications for the midwifery practice, role function and Registered/Enrolled Nurse Midwives' job satisfaction and motivation.

#### **4.4.2.1 Implications for the midwifery practice**

This study indicates that Registered/Enrolled Nurse Midwives responsible for the post natal home visit program experience challenges related to supervision, shortage of staff, lack of motivation (due to being over worked, lack of opportunity for promotions and no career advancement) and inter group conflicts. Swansburg (1990) in Booyens (2001) states that when morale of employees is high, they tend to work enthusiastically, courageously, confidently, productively and in a disciplined manner. When the morale is low, employees are timid, rebellious and unruly, and display an indifferent attitude towards their job with the result that their productivity is low.

The Registered/Enrolled Nurse Midwives in this study have expressed their concerns regarding their further academic progression and the very slow professional

advancement they were subjected to. This may be an indication that these Registered/Enrolled Nurse midwives are dissatisfied and de-motivated and thereby have lowered morale hence non implementation of the post natal home visit care program. To create high morale, the nurse manager should find out what the values are which the personnel would regard as caring for the worker and should try to match these values in her management (Booyens, 2001).

Management should try to involve their staff members at all levels of program planning and implementation. In making protocols and nursing standards for the post natal home visit care program, Registered Nurses and Registered/Enrolled Nurse Midwives should be involved as this will help them to actively contribute and own these tools as implementers and thus implementation would be enhanced (Booyens, 2001).

#### **4.4.2.2 Role function**

Registered Nurses in this study stated that they were aware that they were not performing up to standard because they were leaving out the most critical part of mother and child health service. Following early discharge from maternity ward, the mother would be far from the medical personnel and both her and her babies' health lie in a balance. The participants highlighted problems that can occur to mothers and their babies to include post partum bleeding, emotional disturbances, wrong feeding practices and infections. This is supported by Fredriksson et al (2003) in their findings that the home visits were opportunities for the parents to be reassured that everything was going on well, to get answers to their questions and to receive practical assistance.

Furthermore, data in this study suggest that Registered/Enrolled Nurse Midwives were certain about the responsibilities and the demands they were expected to fulfil in the role of provision of services to the mothers and their babies in the post natal home visit care program. In today's society, social ties have weakened and many new parents lack the active support of family and friends. It therefore seems very important that Registered/Enrolled Nurse Midwives recognize the need the mothers have for the staff to take a certain amount of responsibility during the first days after child birth (Fredriksson et al 2003).

Where it is difficult to employ more staff in a particular area of specialty, managers may be tempted to employ unskilled or unsuitable people to deal with staffing crisis. This study confirms this fact because Registered Nurses without midwifery specialty are expected to implement the post natal home visit care program which demands midwifery expertise. The Registered Nurses were not aware of being included in the protocols of the post natal home visit care program and outwardly stated that they were not responsible for the post natal home visit care program. The Registered Nurses questioned their expected role in the post natal home visit care program as they felt the program was not within their jurisdiction. The concern was supported by the Registered/Enrolled Nurse Midwives in this study who felt that only qualified Nurse Midwives should implement the program as unqualified staff might compromise the care to mothers and their babies.

The study findings suggest a need for further training, supervision, clarification of role function and a clearer definition of role expectations from management.

The Registered/Enrolled Nurse Midwives' responsibilities in the post natal home visit program can not be over emphasized.

#### **4.4.2.3. Registered/Enrolled Nurse Midwives' job satisfaction and motivation**

Job satisfaction is of interest to employees and is considered to be a desirable outcome of employment. It has been linked positively and negatively to motivation (Arnold and Feldman, 1982; Anderson, Aird and Haslam, 1991; de Jonge, van Breukelen, Landeweerd and Nijhuis, 1999), poor performance and staff turnover (Dahlke, 1996 and Gilford, Zammuto and Goodman, 2002). De Jonge *et al* (1999) found that job characteristics such as job demands and autonomy at the individual level had a significant positive association with job satisfaction. Although motivating the long term employee is difficult, it is significant as motivation affects attitude and behaviour and consequently job satisfaction (Vance and Davidhizar, 1997).

In this study, the participants revealed job dissatisfaction as a problem in their clinics. This was cited in the sub categories of staff issues where they expressed their dissatisfaction with the work load, poor academic advancement and lack of opportunities for promotion. The participants even questioned the credibility of their managers and their supervision.

Support for autonomy, executives' leadership styles, communication, adequate time for patient care and reported nursing stress have been found to contribute to the job satisfaction and motivation to perform well at work and a work group's effectiveness (Dunham-Taylor, 2000).

Adams and Bond (2000) found that in hospitals, nurses' interpersonal relationships (cohesive working relationships and relationships with medical staff), their perception of workload and their evaluation of the appropriateness of the system where nursing care is practiced, were influential factors of nurses' job satisfaction. In this study, the nurses identified shortage of staff, lack of motivation and lack of support from both the management and co-workers as factors leading to lack of implementation of the post natal home visit care program. They further indicated that by giving the program the priority it deserved, working as a team and being committed to their work would improve the service.

The value of peer support in reducing the occupational stress experienced by nurses has been documented in literature. The Registered/Enrolled Nurse Midwives in this study have evidenced the presence of inter group conflicts which lead to stress and burnout. There is need to provide support for these Registered/Enrolled Nurse Midwives if complete care is to be diligently provided to the mothers and their babies. Davis and Thorburn (1999) advocate development of nursing peer support programs which help with preventing and dealing with occupational stress. In forming peer support groups, participants may effectively deal with the differences that exist among them which have a negative effect on their provision of health services to mothers and their babies.

Finally, if Registered/Enrolled Nurse Midwives perceive that they are team members and feel that their views are respected, this may have a motivating effect, which will ultimately improve workforce morale (Vance and Davidhizar, 1997).

Registered/Enrolled Nurse Midwives then would feel that what they do make a

difference. Strategies that build trust and commitment could be implemented, such as regular meetings where the Registered/Enrolled Nurse Midwives can have their needs and suggestions listened to, a report can be made on progress of ideas that have been implemented and Registered/Enrolled Nurse Midwives' concerns can also be heard by management. This would lead to complete care delivery as well as meeting the needs of the nurses.

#### **4.5. CONCLUSION**

Data revealed that there is a service deficit in providing mothers and their babies with continued care through the early post natal home visit program. Participants stipulated the reasons for not implementing the post natal home visit program and how they felt the problems could be addressed in order to reconsider implementation. They felt that the best way to ensure the smooth running of the program was for the District Health Team to coordinate the program and to provide logistics such as transport, staff and equipments. In addition, the Registered/Enrolled Nurse Midwives expressed the need for team work amongst themselves. Participants also advocated further training as a vehicle to improve leadership skills, increase manpower by training more midwives, and advanced training for nurse midwives to improve their skills and increase motivation.

# **CHAPTER 5**

## **SUMMARY, RECOMMENDATIONS AND CONCLUSION**

### **5.1. INTRODUCTION**

This chapter discusses the summary, recommendations as well as conclusions of the study which aimed to determine the factors influencing implementation of the post natal home visit care program by nurses and to make suggestions to resolve the problem.

### **5.2. SUMMARY OF THE STUDY**

The purpose of this study was to determine the factors influencing implementation of the post natal home visit care program by nurses and to make suggestions to resolve the problem. The following objectives were identified:

- To determine the factors that influence nurses to undertake/not undertake post natal home visits.
- To explore with the nurses possible strategies by which the post natal home visit program can be implemented.

A descriptive exploratory study utilising qualitative and quantitative designs was implemented. A checklist was designed to collect data relating to the structure factors and four focus group discussions were held for the process factors with Registered Nurses and Registered Nurse Midwives working in the twelve of the thirteen clinics in the City of Francistown.

The findings of the study are reflected in the preceding chapter. Findings reflect the post natal home visit care program deficit. Furthermore, the findings reflect various factors such as shortage of staff, lack of motivation, lack of support from

management, lack of support from co-workers, distance and fear of stigmatisation as reasons for not implementing the post natal home visit care program.

Registered/Enrolled Nurse Midwives and Registered Nurses recommended resolutions to curb the deficit. Suggestions such as coordination of the program by the District Health Team, midwives working as a team and being committed to their work, timely professional advancement and their academic development were made.

### **5.3. RECOMMENDATIONS**

#### **5.3.1. The Practice**

**5.3.1.1.** The District Health Team to take the responsibility of the coordination of the post natal home visit care program and provide logistics needed for its smooth running such as policies, transport, staff and equipment.

**5.3.1.2.** Managers and supervisors should be reminded of the importance of the post natal home visit care program as a tool of the safe motherhood initiative to reduce maternal and neonatal morbidity and mortality. They should be encouraged to include this category of program in their regular supervisory assessments.

**5.3.1.3.** Development of new post natal home visit care program protocols and standards that address childbearing women and their babies during the post partum period. The implementers should be included in this so that they own the protocols and standards and thus implement them as necessary.

**5.3.1.4.** Development of post natal discharge care plans, written in both English and Setswana, which are the official languages of Botswana that can be attached to the



discharge cards given to the mothers on discharge, for the mother to act as a guideline and reminder for the provision of the post natal home visit care program services.

### **5.3.2. Education**

**5.3.2.1.** There is an urgent need to train more nurse midwives to reduce the current shortage.

**5.3.2.2.** Midwifery education should have an intensified component of community midwifery practice which emphasizes the post natal home visit care program.

**5.3.2.3.** Opportunities for continuing education for nurse midwives and their managers to enhance skills and thereby provide job satisfaction and motivation.

### **5.3.3. Recommendations for further research**

**5.3.3.1.** Larger sample in similar settings in other parts of the country to determine the prevalence of factors that impinge on the implementation of post natal home visit care program.

**5.3.3.2.** If the findings and recommendations are accepted by the health authorities of the City of Francistown, then action research should be implemented to assess the re-implementation of the post natal home visit care program.

#### **5.4. CONCLUSION**

The purpose of this study was to determine the factors that influence the implementation of the home visit care program in the City of Francistown. Analysis of the structure factors revealed that the twelve clinics sampled all had at least one ambulance and one driver each. All the clinics had a mix of Registered Nurses and Registered Nurse Midwives in their staff complement.

The post natal home visit care program was not being implemented by any of the staff at any of the clinics. The main reasons given by the participants for failure to implement the program were, shortage of staff with lack of motivation, lack of support from management and from co-workers, distance between the clinic and the mothers' homes, fear of stigmatisation on the part of mothers including the program and its logistics not being in place. However, all of the participants felt that the program should be implemented and made suggestions relating to team work, commitment to work, education and policy development.

## REFERENCES

1. Adams A. and Bond S. (2000). Hospital Nurses' Job Satisfaction, Individual and Organizational Characteristics. *Journal of Advanced Nursing*. 32(3), 536-43.
2. Anderson M.A., Aird T.R. and Haslam W.B. (1991). How Satisfied are the Nursing Staff? *Journal of Geriatric Nursing*. 12(2), 85-7.
3. Armstrong K.L., Fraser J.A., Dadds M.R. and Morris J (2000). Promoting a Secure Attachment, maternal Mood and Child Health in a Vulnerable Population: a Randomized Controlled Trial. *Journal of Paediatric Child Health*. 36(6), 555-62.
4. Arnold H. J. and Feldman D.C. (1982). A Multivariate Analysis of the Determinants of Job Turnover. *Journal of Applied Psychology*. 67(3), 350-360.
5. Booyens S. W. (2001). Introduction to health Services Management. 2<sup>nd</sup> Edition. Juta.
6. Botswana Obstetric Record (1997). Botswana Government Printer: Gaborone.
7. Botswana Safe Motherhood Program - The Curriculum (1993). Botswana Government Printer: Gaborone.
8. Botswana Standards of Midwifery Practice (2001). Botswana Government Printer: Gaborone.
9. Brink H.I. (2002). Fundamentals of Research Methodology for Health Care Professionals. Kenwyn, South Africa: Juta.
10. Brook R.H. and Robert P. (2000). Defining the Measuring Quality of Care, a Perceptive from US Researchers. *International Journal of quality of Health Care*. 12 (4) 281-295.
11. Bryman A. (2004). Qualitative Research Methods. Oxford University Press.

12. Bulatao R. A. and Ross J. A. (2002). Rating Maternal and Neonatal Health Services in Developing Countries. *Bulletin of the World Health Organisation*. 80, 721-727.
13. Central Statistics Office (2001). Botswana Population Census. City of Francistown, Botswana.
14. City of Francistown District Health Team Annual Statistics (2003). City of Francistown, Botswana.
15. City of Francistown District Health Team Annual Statistics (2004). City of Francistown, Botswana.
16. Cronin C. (2002). First Time Mothers- Identifying Their Needs, Perceptions and Experiences. *Journal of Clinical Nursing*, 12, 260-267.
17. Dahlke A.M. (1996). Impact of Staff Nurse Participation in Decision Making on Job Satisfaction and Organizational Commitment. *Journal of Nursing Administration*. 27(10), 30.
18. D'Amour D., Goulet L., Labadie J.F., Bernier L. and Pineault R. (2003). Accessibility, Continuity and Appropriateness: Key Elements in Assessing Integration of Perinatal Service. *Journal of Health Soc Care Community*. 11(5), 397-404.
19. Dana S.N. and Wambach K.A. (2003). Patient Satisfaction with an Early Discharge Home Visit Program. *Journal of Obstetrics, Gynaecology and Neonatal Nursing*. 32(2), 190-8.
20. Davis B. and Thorburn B. (1999). Quality of Nurses' Worklife: Strategies for Enhancement. *Canadian Journal of Nursing Leadership*. 12(4), 11-14.
21. de Jonge J., van Breukelen G.J.P., Landeweerd J.A. and Nijhuis F.J.N. (1999). Comparing group and Individual Level Assessment of Job Characteristics in

- Testing the Job Demand-Control Model: A Multilevel Approach. *Journal of Human Relations*. 52(1), 95-122.
22. de Oliveira M.I., Camacho L.A. and Tedstone A.E.(2001). Extending Breastfeeding Duration through Primary Care: A Systematic Review of Prenatal and Postnatal Interventions. *Journal Hum Lact*. 17(4), 326-43.
  23. Donabedian A. (1966). Evaluating the quality of medical care. *Millbank Mem Fund Q*. 44 (part 2); 166-203.
  24. Donabedian A. (1988).Quality assessment and assurance: unity of purpose, diversity of means. *Inquiry*.25, 173-192.
  25. Downe-Wambolt B. (1992). Content Analysis: Method Application and Issues. *Health Care for Women International* 13, 313-321.
  26. Dunham-Taylor J. (2000). Nurse Executive Transformational Leadership Found in Participative Organizations. *Journal of Nursing Administration*. 30(5), 241-250.
  27. Escobar G.J., Braveman P.A., Ackerson L., Odouli R., Coleman-Phox K., Capra A.M., Wong C. and Lieu T.A. (2001). A Randomized Comparison of Home Visits and Hospital-Based Group Follow-up Visits After Early Postpartum Discharge. *Journal of Paediatrics*. 108(3), 719-27.
  28. Fredriksson G.E.M., Hogberg U. and Lundman B.M. (2003). Postpartum Care Should Provide Alternatives to Meet Parents' Need For Safety, Active Participation, And 'Bonding'.*Midwifery*.19, 267-276.
  29. Fichard A.E., vanWyk N.C. and Weich M. (1994). The Needs of Postpartum Women. *Curationais*. 17(1), 15-21.
  30. Fishbein E.G. and Burggraf E. (1998). Early Postpartum Discharge: How are Mothers Managing? *Journal of Gynaecological and Neonatal Nursing*. 27, 142-148.

31. Gagnon A.J., Dougherty G., Jimenez V. and Ledduc N. (2002). Randomized Trial of Postpartum Care After Hospital Discharge. *Journal of Paediatrics*. 109(6), 107-80.
32. Gilford B.G., Zammuto R.F. and Goodman E.A. (2002). The Relationship Between Hospital Unit Culture and Nurses' Quality of Worklife. *Journal of Health Care Management*. 47(1), 13-25.
33. Gunther M. & Alligold M.R. (2002). A Discipline-Specific Determination of High Quality Nursing Care. *Journal of Advanced Nursing*. 38(4), 353-9.
34. Hodnett E.D. and Roberts I. (2000). Home-Based Social Support for Socially Disadvantaged Mothers. *Journal of Cochrane Database System Rev.* (2), CD000107.
35. Holloway I. and Wheeler S. (1998). Qualitative Research for Nurses. Blackwell Science Ltd, Oxford.
36. Irurita V. F. (1999). Factors affecting the quality of nursing care: Patient perceptive. *International Journal of Nursing Practice*. 5, (2) 85-94.
37. Johansson K. and Darj E. (2004). What Type of Information Do Parents Need After Being Discharged Directly From the Delivery Ward? *Ups J Med Sci*. 109(3), 229-38.
38. Katzenellenbogen J.M., Joubert G. and Abdool Karim S.S. (1997). Epidemiology A Manual for South Africa. Oxford University Press, South Africa.
39. Kendrick D., Elkan R., Hewitt M., Dewey M., Blair M., Robinson J., William D. and Brummell K. (2000). Does Home Visiting Improve Parenting and the Quality of the Home Environment? A Systematic Review and Meta Analysis. *Arch Dis Child*. 82(6), 443-51.

40. Kitzinger J. (1995). Introducing Focus Groups. *British Medical Journal*. 311, 299-302.
41. Krefting L. (1991). Rigor in qualitative research: The Assessment of Trustworthiness. *American Journal of Occupational Therapy*, 45, (3), p214-222.
42. Lieu T.A., Braveman P.A., Escobar G.J., Fischer A.F., Jensvold N.G. and Capra A.M. (2000). A Randomized Comparison of Home and Clinic Follow-up Visits after Early Postpartum Hospital Discharge. *Journal of Paediatrics*. 105(5), 1058-65.
43. Long Term Vision for Botswana- Towards Prosperity for All. September, 1997. Government Printer: Gaborone.
44. Machola B. (2005). Principal Registered Nurse Midwife. Nyangabgwe Referral Hospital, City of Francistown, Botswana (Personal Communication).
45. Madden J. M., Soumerai S.B., Lieu T.A., Mandi K.D., Zhang F. and Ross-Degnan D. (2002). Effects of a Law against Early Discharge on Newborn Follow-up, Adverse Events, and HMO Expenditures. *N Engl J Med*. 347(25), 2031-8.
46. Madlon-Kay D.J., DeFor T.A. and Egerter S. (2003). Newborn Length of Stay, Health Care Utilization and the Effect of Minnesota Legislation. *Journal of Arch Paediatric and Adolescent Med*. 157(6), 579-83.
47. Makokha A.E., Khulumani P., Modisaotsile I. and Baakile B. (1994). Knowledge, Attitude and Practice of the Traditional Birth Attendant in Botswana. Government Printer: Gaborone.
48. Micevski V., Mulcahy V., Linda Belford L. and Kells L. (2004). University Health Network Framework for Advanced Nursing Practice: Development of a Comprehensive Conceptual Framework Describing the Multidimensional Contributions of Advanced Practice Nurses. *Nursing Leadership* 17(3).

49. Morrell C.J., Spiby, H., Stewart P., Walters S. and Morgan A. (2000). Cost Effectiveness of Community Post Natal Support Workers: Randomised Controlled Trial. *BMJ* 321(7261) 593-8.
50. Mounmouni H. (2000). An Investigation of Self Care and Infant Care Practices Among Post natal Women of Niamey, Republic of Niger. University of Natal: Durban, South Africa.
51. Mouton J.E.B. (2003). The Practice of Social Research. Oxford University Press: Cape Town.
52. National Health Policy (1995). Ministry of Health, Gaborone: Botswana.
53. Norr K.F., Crittenden K.S., Lehrer E.L., Reyes O., Boyd C.B., Nacion K.W. and Watanabe K. (2003). Maternal and Infant Outcomes at One Year for a Nurse-Health Advocate Home Visiting Program Serving African American and Mexican Americans. *Journal of Public Health Nursing*. 20(3) 190-203.
54. Nurses and Midwives Act (1995). Government Printer: Gaborone, Republic of Botswana.
55. Nyangabgwe Referral Hospital Annual Report (2003-2004). City of Francistown: Botswana.
56. Olds D., Hill P., Robinson J., Song N. and Little C. (2000). Update on Home Visiting for Pregnant Women and Parents of The Young Children. *Current Problems in Pediatrics*. 30, 109-141.
57. Olds S.B., London M.L. and Ladewig P.A. (6<sup>th</sup> Ed.) (2000). Maternal and Newborn Nursing: A Family and Community-Based Approach. Upper Saddle River N.J.: Prentice-Hall Inc.
58. Patients' Charter (1995). Government Printer: Gaborone, Republic of Botswana.



59. Paul I.M., Phillips T.A., Widome M.D. and Hollenbeak C.S. (2004). Cost-Effective of Postnatal Home Nursing Visits for Prevention of Hospital Care for Jaundice and Dehydration. *Journal of Paediatrics*. 114(4), 1015-22.
60. Population Reports (1998). Mother's lives matters: Maternal Health in the Community. Baltimore: USA.
61. Proctor S. (1998). What Determines Quality in Maternity Care? Comparing the Perceptions of Childbearing Women and Midwives. *Birth*. 25(2), 85-93.
62. Quinlivan J. A., Box H. and Evans S.F. (2003). Postnatal Visits in Teenage Mothers: A Randomized Control Trial. *Lancet*. 361(9361), 893-900.
63. Robson C. (ed). (2002). Real World Research. Oxford: Blackwell.
64. Saunders M., Lewis P. and Thornhill A. (2003). Research Methods for Business Students. Oxford: Blackwell.
65. Sibanda J.Q., Saungweme I., Nleya C., Mutyambizi M.P. and Rutgers R.A. (2001). Post Natal Care in Bubi District Deserves More Attention. *Cent. Africa Journal of Medicine*. 47(4), 103-8.
66. Silverman D. (2002). Doing Qualitative Research A Practical Handbook. Sage: Thousand Oaks.
67. Sobey W.S. (2002). Barriers to Postpartum Depression Prevention and Treatment: A Policy Analysis. *Journal of Midwifery and Women's Health*. 47(5), 331-336.
68. Standards of Midwifery Practice (2001). Nurses Association of *Botswana*. Printing and Publishing Co Botswana (Pty) Ltd: Gaborone.
69. Siu A. and Albert, L. (1992). Choosing of care measures based on the expected impact of improved care on health. *Health Service Research*. 27(5), 619-650.
70. The safe motherhood initiative- the maternal morbidity and mortality monitoring system in Botswana. (1998). Ministry of Health. Government Printer: Gaborone.

71. Vance A. and Davidhizar R. (1997). Strategies to Assist Students to be Successful the Next Time Around on the NCLEX-RN. *Journal of Nursing Education*. 36(4s), 190-192.
72. Wager K.A., Lee F.W., Bradford W.D., Jones W. and Kilpatrick A.O. (2004). Qualitative Evaluation of South Carolina's Postpartum/Infant Home Visit Program. *Journal of Public Health Nursing*. 21(6), 514.
73. Webb C. and Kevern J. (2000). Focus Group as a Research Method: a critique of some Aspects of Their Use in Nursing Research. *Journal of Advanced Nursing*, 33(6), 789-805.
74. Woods N.F. and Catanzaro M. (1988). Nursing Research, Theory and Practice. C.V. Mosby Company: St Louis, MO.
75. World Health Organization (1995). The Prevention and management of Puerperal Infection. WHO, Geneva. WHO/FHE/MSM/96:24
76. World Health Organization (4<sup>th</sup> Ed.) (1997). Coverage of Maternity Care: A Listing of Available Information. WHO/RHT/MSM/96:28
77. World Health Organization (1978). Principles of Primary Health Care. Declaration of Alma Atta. Geneva: Switzerland.
78. Winslow W. (2004). Creating Quality Practice Environments: Not Easy, But Essential. *Health Care Management Forum*. 17(4), 28-33.
79. Wipada K., Robert L.M. Wichit S., Ratanawadee C., Ramual N. S. and Orapan P. (2001). Study on development of quality of nursing care in Thailand. *Journal of Advanced Nursing*. 36 (6) 776-800.

## **Annexure A**

### **INFORMATION DOCUMENT**

**Study title:** The factors influencing the implementation of the post natal home visit program by nurses in an urban health district, Botswana.

Greeting: Good morning/ afternoon!

I, Omphemetse Sephala Mouti, am doing research on the factors influencing the implementation of the post natal home visit program by nurses in an urban health district, Botswana. Research is just the process to learn the answer to a question. In this study I want to determine the factors influencing implementation of the post natal home visit care program by nurses and to make suggestions to resolve the problem with the overall goal of promoting safe motherhood.

I am inviting you to participate in this research study.

This is a descriptive exploratory study which will use checklists and focus group discussions as data collection methods. The study will be conducted in the Health District 16, City of Francistown, Botswana. The study population will be 107 practicing Registered Nurses and Registered/Enrolled Nurse Midwives who have worked in the City of Francistown clinics for a period not less than six months by September, 2005 who will be sampled through purposive selection.

Participants will be divided into two focus groups for Registered Nurses and another two for Registered/Enrolled Nurse Midwives. The groups will consist of 6-8 members each. Participants will be drawn from the twelve clinics.

The focus group discussions led by the researcher will be conducted at the identified clinics in the City of Francistown, Botswana on different dates lasting for forty-five minutes to one hour. Group discussions will be held during working hours on weekdays. Participants will be transported to and from the identified venue for the discussions.

Your participation will require you to participate in a group discussion. The discussion will explore the implementation of the post natal home visit program.

You will not benefit directly from this study; however, the results will improve the quality of the life of mothers and their babies in the community. To the researcher's knowledge there are no harmful effects you will encounter during your participation in the study.

Your participation in this study is voluntary, and you are under no obligation to participate. You are free to withdraw from the group discussion at any time, without any penalty or loss of any benefits you are entitled to in your employment. You have the right to refuse to give any information and you may ask for clarification for better understanding on any aspect of the research. You will receive a copy of the research results at the end of the study and be given any information pertaining to the study at any time while participating in the study if you so wish. Significant new findings developed during the course of the research which may relate to your willingness to continue participation will be provided to you.

The discussion will be tape recorded, and only the researcher will have access to the recorded information. The discussions will only be used for the purpose of this study. Your name will not be used and your contributions will not affect your work in any

way. Information given will be kept confidential. You are obliged to keep all information from the discussion confidential and not to cite or quote any member of the group. All information discussed belongs to the whole group and thus no one will be singled out in anyway.

Permission to conduct this research was requested from the ethics committee of the University of KwaZulu-Natal through the supervisor of this research project and as well as from the Botswana Health Research Unit, the Establishment Secretary of the Department of Local Government Service Management, and the City Clerk of the City of Francistown City Council.

For further information contact me on;

Locally;

Cell phone number: 09267 71648933.

P.O.Box 11944

Tatitown

Botswana

**Or**

University of KwaZulu-Natal

Faculty of Health Sciences

School of Nursing

Howard College Campus

Durban 4041

You may also contact the Medical Research Office at the Nelson R Mandela School of Medicine at 031-260 4604 if you have questions about your rights as a research subject.

Thank you.

## **Annexure B**

### **THE CONSENT FORM**

**Study title The Factors Influencing the Implementation of the post natal home visit program by nurses in an urban health district, Botswana.**

#### **Consent to Participate in Research**

You have been asked to participate in a research study.

You have been informed about the study by **Omphemetse Sephala Mouti**.

You may contact **Omphemetse Sephala Mouti** at **00267 7164893** any time if you have questions about the research. You may also contact the Medical Research Office at the Nelson R Mandela School of Medicine at 031-260 4604 if you have questions about your rights as a research subject.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop. If you agree to participate, you will be given a signed copy of this document and the participant information sheet which is a written summary of the research.

**The research study, including the above information, has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate.**

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

## **Annexure C**

### **THE INTERVIEW SCHEDULE**

There will be an ice breaker led by the researcher before commencement of the discussions.

#### **QUESTIONS**

1. Are there any problems likely to occur to mothers and their babies following an early discharge from a maternity ward? If yes, which ones?
2. Have you witnessed any of the problems you have just mentioned on mothers or their babies?
3. What are the resources needed for post natal home visit program?
4. What are your views about the post natal home visit care program?
5. Have any of you ever carried out a post natal home visit?

If yes, when was the last post natal home visit? Why did you carry out the home visit? Can you please describe your experiences of the visit?

If no, why have you not carried out the visit?

6. Do you think there is anything lacking in the provision of post natal care for mothers who are discharged early from the maternity wards?

If yes, what do you think is lacking?

7. Does post natal home visit program have any benefits for the mothers and their babies?

If yes, what are the benefits?

If no, why?

8. What do we need to do to promote the implementation of post natal home visit care to mothers and their babies?

**Thank you for your participation.**



## ANNEXURE D

### CHECKLIST FOR THE STRUCTURE FACTORS WITHIN THE THIRTEEN CLINICS

ITEM	YES	NO	COMMENTS
Transport			
Policies			
Procedures			

CATEGORY OF NURSES	NUMBER
1. Registered nurse midwives	
2. Enrolled Nurse midwives	
3. Registered nurses	
4. Total Nurses	
5. Total deliveries April 2004- March 2005	
6. Total number of Ante Natal Clients registered April 2004- March 2005 (new and repeat visits)	
7. Total number of post natal visits (Six to eight weeks post delivery).	

## **Annexure E**

### **TRANSCRIPTION OF DATA**

#### **PROCESS FACTORS**

##### **FIRST GROUP DISCUSSION (MIDWIVES)**

###### **Introduction**

The participants consisted of one Principal Registered Nurse, who had thirty one years of experience and was in charge of a clinic, two Senior Registered Nurses with nursing experience of twenty seven years and eleven years respectively. The last two participants, who were Registered Nurse Midwives, had a similar length of experience of six years each. Participants were represented with numbers to identify them during data analysis.

**Number of participants:** 5

**Duration of discussion:** 60 minutes

**Researcher:** *Are there any problems likely to occur to mothers and their babies following an early discharge from a maternity ward?*

**Respondent 1:** Yes, yes, there are problems...

**Researcher:** *Yes, which ones?*

**Respondent 1:** There are complications... complications such as puerperal psychosis and also infections like infected cord stump, conjunctivitis and gaping episiotomies.

**Respondent 2:** Mothers are discharged early from the ward before they can be... eh... given proper health education on what to expect when they get home.

**Respondent 3:** They are literally sent away from the ward and we expect them to come after six weeks. When they get home, sometimes.... sometimes they do not know what to do, they even forget the instructions they were given.

**Respondent 2:** Some mothers do not follow instructions when they reach home, but do what their mothers or care takers tell them to do, eh... which is usually contradictory to modern medicine like, like using ash on the cord stump.

**Respondent 1:** Yes, even these mothers on the program (Prevention of mother to child transmission) forget the instructions concerning the administration of AZT to the babies, they usually come back to ask for more supply when in actual fact the treatment is supposed to have been completed.

**Respondent 5:** You see, these are the ones who are mostly at risk. Hee...! and I wonder if they stick to exclusive breast feeding, yo! With these in-laws... who are so, so inquisitive.

**Respondent 4:** The common problem is un-conducive home environment for the new mother and her baby especially for mothers from the low socio economic income areas where... eh... overcrowding is a prevalent.

**Respondent 2:** The most dangerous is, is... umm... post partum haemorrhage which is rare but traditionally women are expected to bleed for what is taken for a thorough cleansing. Now, you know, these mothers are left to bleed and only brought to the clinics when they are in a critical stage.

**Respondent 5:** Don't forget engorged breasts; this one is found in almost all the mothers. Yes there are so many problems that the mother can encounter.

**Researcher:** *Have you witnessed any of the problems you have just mentioned on mothers or their babies?*

**Respondent 1:** Yes, all the problems that were just stated occur and are seen in our consulting rooms!

**Respondent 5:** We have seen mothers with gaped episiotomies... yo! episiotomies that even warranted secondary suturing.

**Respondent 3:** Some mothers come with puerperal sepsis, abnormal lochia, fever in both mothers and their babies.

**Respondent 2:** Mothers on the program... (Referring to the prevention of mother to child transmission program) have problems with formula feeding.

**Respondent 4:** Not all mothers know how to prepare the formula. When they are given instructions in the ward, they do not grasp the details well...

**Respondent 5:** yes, as they will still be tired and overwhelmed.

**Respondent 4:** They end up giving the babies feeds, feeds which are either too dilute or prepared with water at boiling point instead of cooling the boiled water first.

**Respondent 1:** Due to stigma imposed on people living with HIV/AIDS, mothers on the Prevention of Mother To Child Transmission Program end up not sticking to either exclusive breastfeeding or infant formula.

**Respondent 3:** There is a problem I have witnessed... yes... of wrong dosages of the AZT given to babies. Mother will come back after some days to request for more of the AZT when the prophylaxis is supposed to have been completed. The mother will tell you that she is still left with enough the drug for two days when the drug should have been finished a week ago! Honestly!

**Respondent 5:** You are right. The other thing is that health education is lacking , we do not adequately educate the mothers as they are discharged too early, this must be a contributing factor to problems such as poor utilization of post natal home visit at six weeks.

**Researcher:** *What then are the resources needed for post natal home visit program?*

**Respondent 4:** Transport which is exclusively for the program if the program is to be successful...

**Respondent 5:** More staff, yo! Eh... this is the main factor. You know we are running midwifery services with an inadequate staffing; we are compromising the clients care as it is difficult to provide all services when there is an acute shortage of staff.

**Respondent 1:** Yes, we also need a home visit kit comprising of a bag containing; blood pressure machine, stethoscope, measuring tape, vaginal examination pack, eh... a thermometer, spirit swabs, gloves, soap, pads, and registers that will be completed during the visits.

**Respondent 5:** To be serious, this is a very important program... a program that needs attention, its like... like if we are to implement the safe motherhood initiative; it needs a coordinator and staff who are mainly for the program, like any other program.

**Respondent 1:** You can say that again... The advent of HIV/AIDS has overridden this program and is of a great concern. But this program also provides support for the Prevention of Mother To Child Transmission program.

**Respondent 5:** They don't know... or maybe they are just not aware... otherwise the program would be active.

**Respondent 2:** I think the midwives are responsible for the program's natural death. How can we just ignore our responsibility and blame other programs! Maybe we should start to do our work.

**Researcher:** *What are your views about the post natal home visit care program?*

**Respondent 3:** Mothers and their babies are discharged early... I mean... I mean within the first twenty four hours following delivery and you know... anything can happen to these mothers and their babies, yes anything. Complications like post natal sepsis, haemorrhage, psychosis for mothers and... and... for babies, ophthalmia neonatorum, cord bleeding, cord infections, sepsis, diarrhoea, pneumonia and malnutrition since most of them are fed on formula.

**Respondent 5:** And... and these conditions are preventable and easy to arrest when detected in time.

**Respondent 1:** There is urgent need to implement the program as mothers are discharged early from maternity wards and only return to the clinics with complications.

**Researcher:** *Have any of you ever carried out a post natal home visit?*

**Respondent 5:** Yes... yes, that was during training, but we no longer carry out the visits. We have left the home visiting to Family Welfare Educators who do not have any knowledge on what to do with these mothers and their babies.

**Respondent 1:** At least they do their part which cannot substitute a midwife's visit.

**Researcher:** *When was the last post natal home care visit you carried out?*

**Respondent 5:** The program is in place only for students to do their academic requirements in training institutions during training.

**Respondent 4:** We all did the visits then, but...

**Respondent 5:** But when we started working, the program was not in place, so we joined the others and did not even ask about the program.

**Respondent 2:** With me, the program is actively in place back home (Kenya), but like she said, when we came here and it was not done, we joined in and never questioned.

**Respondent 3:** Oh! I remember we used to do it a long time ago while working in another district in Princess Marina Hospital in Gaborone... that, that should be more than twenty years ago. I don't know if they still go home visiting.

**Researcher:** *Why did you carry out the home visit?*

**Respondent 5:** It was part of midwifery training. You had to do the visits or fail the course!

**Respondent 2:** It was part of the nursing duties that we had to do. You were allocated for domiciliary and that was your area of work for that duration until the next rotation.

**Researcher:** *Can you please describe your experiences of the visit?*

**Respondent 3:** It was a good exercise with... with visible benefits. We used to use a register... a register that we got from the maternity ward... which, which had a list of mothers who had delivered and discharged home and their addresses. We were a team which did the visits on a daily basis and had no other responsibilities other than the program. When we got to the homes, various problems were identified and attended to immediately such as... umm... overcrowding, environment not conducive for lying in period, also... eh... no food, no pads, poor hygiene of the mother and the baby. Sometimes... sometimes we used to find mothers using harmful traditional substances on the cord stump. We would then... then examine the mother and her baby... then advice accordingly.

**Respondent 5:** The program is beneficial to the mother I tell you... and her... her baby and even the relatives in the home.

**Researcher:** *Have you carried out any visits since working in the City of Francistown?*

**Respondent 2:** No... no, we would be lying; there is nothing like that here. We come on duty, conduct ante natal and post natal services, admit, deliver and discharge these mothers. Period. It has just become routine.

**Respondent 5:** Oh no! Even if we wanted to go home visiting... who would do the normal duties in the clinic or in the maternity ward? There is...we are literally short staffed.

**Respondent 1:** We run all these services in the clinic and maternity ward with very limited staffing. Midwives are gone! They went for greener pastures. No..., for now it is difficult for us...

**Researcher:** *Any more reasons why have you not carried out the visit?*

**Respondent 4:** There is shortage of staff, so it is not possible for the few staff members to do additional tasks such as home visits.

**Respondent 2:** This program is not in place in Francistown... Ever since I came to work here three years ago... eh... eh... I have never heard it (the program) mentioned.

Mmm... the other thing is that most of the mothers after delivery go to villages which are not in our catchment area and it becomes a... a... problem to follow them up.

**Respondent 4:** And yes... usually they do not tell that they will be going to the village but give a wrong address...

**Respondent 2:** But... because we are not even following them, it goes unnoticed unless in cases of emergency when the mother has to be followed; like if, like if they forget to take AZT for their babies.



**Respondent 3:** I think transport is a problem..., because the ambulances we have cannot run the program and at the same time do clinic activities. The program needs transport...

**Respondent 5:** Yes transport that will be out for as much as it is needed by the staff on home visits and not to be disrupted by being called back when there is an emergency in the clinic.

**Respondent 1:** And... and of late there has been a proliferation of new programs which we are expected to implement, especially the ones on HIV/AIDS. These are given priority over old programs like post natal home visit care program... yes its true... and all recognition and support has turned to the new "brides" who came in with a lot of attractive incentives.

**Respondent 3:** This is why we do not do the program anymore (sigh).

**Respondent 5:** The other thing is... (Inaudible as talking at the same time followed by a short pause as if to give one a chance to speak).

**Respondent 4:** We have... we have experienced a natural death of the program. Midwives have just decided not to go home visiting for no apparent reason.

**Respondent 1:** Surely, all these other reasons are secondary; had we kept the program going... eh... the government could have done something about it. Yes.

**Respondent 5:** Yes, that is true. (Mumblings in agreement) We are to blame; we have decided to please these ministry people by implementing their programs at the expense of our program.

**Respondent 3:** And these days... hei...there are just too many diseases and conditions developing in our population leading to increased workload for the nurses and....

**Respondent 2:** Yes, the nurses are also sick and cannot cope, hence compromised care to our patients

**Respondent 5:** Ah! Some of us have been here time immemorial, and are still 'marching' at the same sport. What management is interested in is the output; there is no concern for us!

**Respondent 4:** We have reached a point of either giving in or giving up.

**Respondent 5:** We are not promoted because we are told there are no posts, eh... neither are we sent for further training. All we have to do is work. And... and this is why the younger nurses are leaving for greener pastures. They cannot cope with all these hardships. Mmm...

**Respondent 1:** There is also no support from co-workers; if you do it (the home visit care program) then other nurses say you are trying to be smart or worse still, you want to run your own errands.

**Respondent 2:** There is lack of co-operation among the nursing staff as you can see... eh... if you try to do right, then you are labelled.... thereafter life will never be the same again...

**Respondent 5:** It can be a real torture I tell you, laugh....

**Respondent 3:** There is... there is no of support by management also, for instance, if, if the midwife wants to use the ambulance to follow up patients, the "boss" would... would instead of providing transport to the midwife, would use the same ambulance to go for a meeting or to do management issues, when she could have easily walked to the meeting or called for another vehicle from either the offices or other clinics!

**Respondent 5:** It can be really frustrating... We are forced to dance to the music, no questioning...

**Respondent 1:** “Do what the Romans do!” (Laugh)

**Researcher:** *Do you think there is anything lacking in the provision of post natal care for mothers who are discharged early from the maternity wards?*

**Respondent 3:** Yes, umm... there is no continuity of care to mothers and their babies following early discharge, yes... because (short pause) which should be provided by the midwives to complete the care they provide to these mothers and their babies including their care takers and relatives.

**Respondent 2:** You can feel for some of these mothers.... You can see they still need hospitalisation, not because they are not well but... eh... as a midwife you can see that they have problems.

**Respondent 4:** You know, some of these mothers do not have a... a proper place to stay. Most mothers need more time with midwives... like eh... they need health education on such topics as care of the baby, care of the cord stump and episiotomy and so forth.

**Researcher:** *Does post natal home visit program have any benefits for the mothers and their babies?*

**Respondent 2:** Certainly yes, the benefits are numerous.

**Researcher:** *What are the benefits?*

**Respondent 2:** The program is meant to prevent complications before they start and to...

**Respondent 5:** To address the mothers' concerns and problems in their home environment... it is practical.

**Respondent 3:** Yes, using available resources.

**Respondent 1:** Health educating the mother on, on the relevant topics identified during the visit and, and also... the need for post natal check up at six weeks post delivery.

**Respondent 4:** Ummm... health education is also given to the care givers on health issues related to the post natal period.

**Researcher:** *What do we need to do to promote the implementation of post natal home visit care to mothers and their babies?*

**Respondent 5:** Increase the number of midwives! Yes, that is the most important issue here.

**Respondent 1:** I think the District Health Team should form the Post Natal Home Visit Program Team and assign specific staff to the program...

**Respondent 2:** Yes, it will to come with its package.

**Respondent 1:** This team will also have a coordinator for the program... eh, a coordinator, who will be responsible for the day to day running of the program.

**Researcher:** *Mm... mm...*

**Respondent 3:** The other thing is that, is that the program, the program itself... eh, should be done exclusively by midwives not registered nurses as they are not trained in the specialty of midwifery.

**Respondent 5:** We don't want "on the job training" in our specialty! They will only compromise care...

**Respondent 4:** What about... eh... yes, policies and procedures? These should be readily available in each clinic for all to see and reference.

**Respondent 5:** We don't have them, you know?

**Respondent 3:** My opinion is that seminars and workshops should be held more frequently to sensitize and motivate the midwives on the program.

**Respondent 2:** Mmm... this is very important... you know we can learn from others during these workshops!

**Respondent 4:** The, the program should be given the priority it deserves... you see... and not to be overridden by other programs.

**Researcher:** *Mm... mm...*

**Respondent 3:** And, and... eh... midwives should advocate for the program of their specialty.

**Respondent 5:** Yes, yes... it's very true. We have to do something about this.

**Respondent 2:** Also, also we need to discuss this problem of not having the program in place and determine how we can commence the program as it is very important.

**Respondent 1:** Ooh yes, yes, it is the responsibility of the midwives to do these visits as an essential part of midwifery... as mothers are discharged within the first twenty four hours of delivery. This is because any thing can happen, eh... eh... things like, I mean immediate and delayed complications to the mother and her baby.

**Respondent 2:** Okay, let's include the visits in the allocation of duties... you see... When duties are allocated to midwives, the visits should be included so that it can not be considered as an extra duty; it should be incorporated into the midwives' duties because that is what it is. Then you will see...

**Respondent 5:** It will be done.

**Respondent 4:** Yes, transport should be allocated for the team so that the program suffers, otherwise it won't work.

**Researcher:** Uh ha...*Mm... mm...*

**Respondent 1:** Maybe if we can...we should also empower our mothers to claim the visit by educating them on their right for the visits and hei... an increase in the number of law suits (laugh).

**Respondent 3:** There is need for flexibility in management; be free with the staff and allow them to practice what is right. Mmm... the bosses should not feel threatened... we are just doing our work.

**Respondent 2:** Midwives should be sent for further training to develop and advance them in midwifery in order to be motivated and thus perform their duties without any reservations.

**Respondent 5:** That will be an incentive.... for the demotivated midwives...

**Respondent 1:** just to give them a boost (laugh).

**Respondent 2:** This will also help us to be committed to our work as midwives and do our duty towards the mothers and their babies, we need not be reminded.

**Respondent 3:** There is need to develop managers on management and leadership skills so that they may ensure that the government health policies are followed... otherwise if the leaders are quiet, who will question them?

**Respondent 5:** No one and the program will suffer.

(Silence)

**Researcher:** *Mm... mm...Anything else?*

**Respondent 4:** We should also keep records and follow up our clients as required... and, and those mothers going out of the city to the villagers should be referred to the nearest clinics as should be. (Silence)

**Researcher:** *Do we have any more suggestions?*

**Respondents:** Uh... uh... (In unison).

**Respondent 5:** I don't think there is anything more... yes this was a very good discussion, yes...

(Silence)

**Researcher:** *If there are no more suggestions, thank you very much for participating in the group discussion. Your deliberations will help me very much in this research and will probably help rectify the problem. Thank you once more.*

**Respondent 5:** I was a bit unsure at first but I should confess... (Laugh) I really enjoyed the discussion, ah!

**Respondent 3:** You know... it is both an eye opener and very educative.

**Respondent 1:** Thank you, you have helped us face reality, we are neglecting our patients... (Others laugh)

**Respondent 2:** Oh yes, it's a fact. We can't deny it now... we have been saying it ourselves!

**Respondent 4:** Mrs. Mouti should come back from school so that we can start the program!

**Respondent 1:** No, no, no... we do not have to wait for someone at school, she has done her part by showing us this... it's up to us midwives to pull up our socks and do the right thing.

**Respondent 5:** Thank you mma!

**Researcher:** It's a pleasure!

**Annexure F (Letters of permission and ethical clearance)**

Faculty of Health Sciences  
School of Nursing  
University of KwaZulu Natal  
Durban. 4041  
03/09/05

The Head of Department  
Health Research Unit  
Gaborone  
Botswana

**Permission to Conduct a Research Study in Botswana**

Dear sir/madam

I am Omphemetse S. Mouti, a student at the University of KwaZulu Natal, in the Faculty of Health Sciences, School of Nursing. As part of the requirements towards my degree, I have to undertake a research project entitled:


**The Factors Influencing the Implementation of the post natal home visit program by nurses in an urban health district, Botswana.**

In view of the above, I am kindly asking you to grant me permission to conduct the research study in Francistown.

I will adhere to all laws, regulations and ethical guidelines of the country. Please find attached ethical clearance from the University of KwaZulu Natal.

Thank you for your kind consideration and I await a speedy response.

Sincerely yours,

  
.....

O. S. Mouti

Approved: .....

Prof. Patricia McInerney

Research Supervisor, University of KwaZulu Natal.





RESEARCH OFFICE (GOBAN MBEKI CENTRE)  
WESTVILLE CAMPUS  
TELEPHONE NO.: 031 – 2603587  
EMAIL: ximbap@ukzn.ac.za

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25 OCTOBER 2005

MRS. OS MOUTI (203506348)  
NURSING

Dear Mrs. Mouti

ETHICAL CLEARANCE APPROVAL NUMBER : HSS/05142A

I wish to confirm that ethical clearance has been granted for the following project:

"The factors influencing the implementation of the post natal home visit program by registered nurses in an Urban Health District, Botswana"

Yours faithfully

  
.....  
MS. PHUMELELE XIMBA  
RESEARCH OFFICE

PS: The following general condition is applicable to all projects that have been granted ethical clearance:

THE RELEVANT AUTHORITIES SHOULD BE CONTACTED IN ORDER TO OBTAIN THE NECESSARY APPROVAL SHOULD THE RESEARCH INVOLVE UTILIZATION OF SPACE AND/OR FACILITIES AT OTHER INSTITUTIONS/ORGANISATIONS. WHERE QUESTIONNAIRES ARE USED IN THE PROJECT, THE RESEARCHER SHOULD ENSURE THAT THE QUESTIONNAIRE INCLUDES A SECTION AT THE END WHICH SHOULD BE COMPLETED BY THE PARTICIPANT (PRIOR TO THE COMPLETION OF THE QUESTIONNAIRE) INDICATING THAT HE/SHE WAS INFORMED OF THE NATURE AND PURPOSE OF THE PROJECT AND THAT THE INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL.

cc. Faculty Officer  
cc. Supervisor (Dr. P McInerney)

TELEPHONE: 3914467  
FAX: 3914467  
TELEGRAMS: RABONGAKA  
TELEX: 2818 CARE BD



MINISTRY OF HEALTH  
PRIVATE BAG 0038  
GABORONE  
BOTSWANA

REPUBLIC OF BOTSWANA  
MINISTRY OF HEALTH

REFERENCE No: PPM&E 13/18 PS Vol I (2) October 20, 2005

Omphemetse Sephala Mouti  
P.o. Box 11944  
Francistown

**Research Permit: "The factors influencing the implementation of the post natal home visit program by registered nurses in an urban health district, Botswana".**

Your application for a research permit for the above stated research protocol refers. We note that you have satisfactorily revised the protocol as per our suggestions. **Permission is therefore granted to conduct the above-mentioned study.** This approval is valid for a period of 1 year, effective October 20, 2005.

This permit does not however give you authority to collect data from the selected facilities without prior approval from the facilities. Permission will therefore be required from the participating facilities. Similarly, consent should also be sought from all participants.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal will need to be resubmitted to the Health Research Unit in the Ministry of Health.

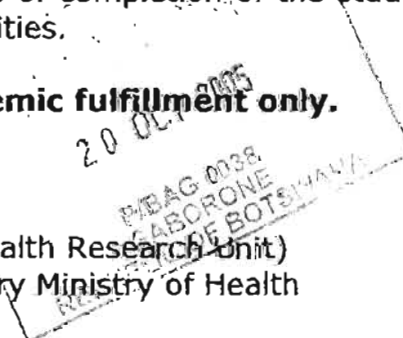
Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research Unit, Ministry of Health within 3 months of completion of the study. Copies should also be sent to relevant authorities.

**Approval is for academic fulfillment only.**

Thank you,

A handwritten signature in black ink, appearing to be 'S. El-Nalabi'.

S. El-Nalabi (Head - Health Research Unit)  
For Permanent Secretary Ministry of Health



**FRANCISTOWN**  
PRIVATE BAG 40  
FRANCISTOWN BOTSWANA



**CITY COUNCIL**  
TELEPHONE : 211050  
TELEFAX 212427

24/10/05

Omphemetse Sephala Mouti  
P.O.Box 11944  
Tatitown  
Francistown

**Permission to conduct a research study utilizing the nurses in the council health clinics in the City of Francistown, Botswana**

Dear Madam

This serves to inform you that permission has been granted for you to conduct the study entitled **The Factors Influencing the Implementation of the post natal home visit program by registered nurses in Francistown, Botswana.**

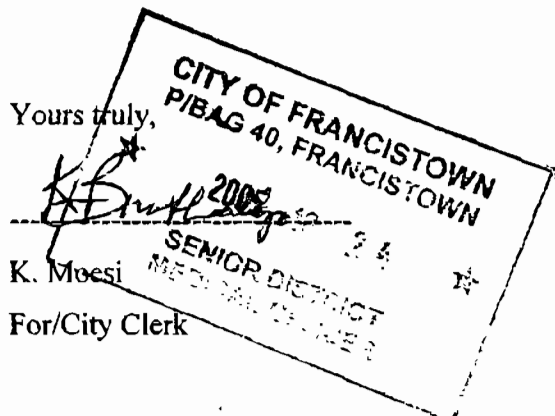
Conditions of the permission are that you should carryout the data collection as indicated in your proposal and no changes should be done without first soliciting permission from the research unit.

Wishing you success in your endeavor.

Yours truly,

K. Moesi

For/City Clerk



**FRANCISTOWN**  
PRIVATE BAG 40  
FRANCISTOWN BOTSWANA



**CITY COUNCIL**  
TELEPHONE : 211050  
TELEFAX 212427

24/10/05

Omphemetse Sephala Mouti  
P.O.Box 11944  
Tatitown  
Francistown

**Permission to conduct a group discussion with nurses in Itekeng clinic  
Francistown, Botswana**

Dear Madam

This serves to inform you that permission has been granted for you to conduct group discussions in our clinic.

You can come and discuss with me the times and venue for discussions when convenient for you.

Wishing you success in your endeavour.

Yours truly,

*U. Letsholathebe*

U. Letsholathebe

Principal Registered Nurse

