

UNIVERSITY OF KWAZULU-NATAL

**DESCRIBING MIDWIVES' PERCEPTIONS OF MATERNAL POSTNATAL CARE
ROLE WITHIN A LEVEL ONE DISTRICT HOSPITAL IN ETHEKWINI,
KWAZULU-NATAL**

BY

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2017

DECLARATION

2017

I, Mercy King, student number 205504050, declare that

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2. This dissertation has not been submitted for any degree or examination at any other university.
3. This dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as sourced from other persons.
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 - a) Their words have been re-written but the general information attributed to them has been referenced;
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Date 27 February 2017

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Date 27 February 2017



Signature (A.A.H. Smith)

Date 27 February 2017



DEDICATION

I dedicate this dissertation to the loving memory of my parents Mr. & Mrs J. Alile' for giving me a sense of direction from childhood.

Also to Emmanuel Alile who was more than a brother to me. Your spirit lives within me. Finally, I dedicate this study to all midwives all over the world saying you are all special and that your selfless services to mothers are highly appreciated. May God bless you all.

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ABSTRACT

Background

The quality of maternal postnatal care is reported to have decreased resulting in maternal deaths (WHO, 2013: 722), with the majority that occurred in sub-Saharan Africa between 2000 and 2008 were as a result of complications that were further exacerbated by the compromised quality of postnatal maternal care particularly between 24-72 hours post-delivery (WHO, 2013: 721). Postnatal care, in the first 72 hours post-delivery, is crucial to the survival of mother (WHO, 2012a:18).

Aim/Purpose

The purpose of the study was to describe hospital based midwives' perceptions of their role within maternal postnatal care in a level one hospital in eThekweni, KwaZulu-Natal in order to improve maternal health outcomes.

Methodology

Motivated by constructivist paradigm, qualitative approach and descriptive research design were used to describe midwives' perception of maternal postnatal care role within a level one district hospital, in eThekweni, KwaZulu-Natal. A two-part sampling process involved convenience sampling for the level one hospital, followed by purposive sampling to select ten registered midwives working in the maternity unit. Through one-on-one interviews, an interview schedule guided an advanced psychiatric nurse to use open ended, probing questions to meet the three objectives. Data saturation was reached after eight interviews. Inductive approach of content analysis was used to analyse the data transcribed from the audio recordings. (Elo and Kyngäs, 2008: 107).

Results

The following categories and sub-categories emerged which address the objectives of the study.

Category 1 'care is good...but' described midwives' perceptions of their postnatal maternal care knowledge of the national guidelines. (**Sub-category A: Yes we know the guidelines**) however administrative tasks impacted on time spent with direct patient care (**Sub-category B: Paper work vs. Patient**). Category 2 '**(general responsibilities)**' reflected the midwives' perceptions of their role in providing postnatal maternal care to mothers to and student midwives (**Sub-category A: Teaching and supervision; Sub-category B: Post discharge advice and care; Sub-category C: Midwives responsibilities**). **Category 3** – described "the

other people involved in Postnatal Maternal Care”, such as HIV Counsellors and Social workers and their “**Reliance of Support**” (Sub-Category A). Category 4 and 5 answer the third objective in describing the factors affecting postnatal care in the level one hospital. **Category 4** described the “**Positive factors**” that facilitate midwives’ role in providing effective post-natal maternal care (Sub-category A: Language factor; Sub-category B: Team work), while **Category.5** described the “**negative factors**” that hindered midwives’ role in providing effective post-natal maternal care (Sub-Category A: shortage of staff; Sub-category B: Shortage of equipment).

Conclusion

In order for the realization of quality care outcomes, namely decreased maternal mortality and morbidity, the process standards need to be in place. Despite the presence of The Guidelines for Maternity Care in South Africa (2015) and midwives reporting themselves to know these guidelines gaps were evident that midwives descriptions of their practice that suggested a failure to reflect an awareness and preparation for postnatal dangers in the descriptions of their teaching function and other roles. Further structure standards of inadequate staffing and availability of beds and equipment were perceived to be lacking. It is concerning that National Guidelines for Maternity Care (2015) are not fully adhered to in the postnatal care the setting which is restricted by the process standards of administrative demands, in its contribution to South Africa meeting its international obligation to cutting maternal mortality. Despite the circumstances that midwives found themselves, this study has provided insight into midwives’ differing perceptions of postnatal maternal care in level one hospital in eTheknini KwaZulu Natal.

Key words: Maternal postnatal care, Midwives, Midwives’ perceptions, health care services and level one hospital.

ABBREVIATIONS

KZN DoH	KwaZulu-Natal Department of Health
LLMIC	Low and low-middle income countries
MDG	Millennium Development Goals
MHC	Maternal Health Care
NCC	Non Clinic Case
NDP	National Development Plan
PCOM	Process of Care and Outcome Model
PPH	Postpartum Haemorrhage
QHOM	Quality Health Outcome model
SDG	Sustainable Development Goal
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

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CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Globally, maternal mortality and morbidity represents one of the biggest challenges to public health, particularly in low and low-middle income countries (LLMIC) (Lawn, Cousens, Zupan, and Lancet, 2013:365). Yet until recently, those who set national and international priorities have ignored the problem, since those who suffer the most are often poor, illiterate and politically powerless [United Nations International Children's Emergency Fund (UNICEF, 2013:145)]. In LLMIC, the most common cause of maternal death is obstetrical hemorrhage, followed by hypertensive disorders of pregnancy which is in contrast to high income countries, for which the most common cause is thromboembolism (UNICEF, 2013: 145). Furthermore, maternal mortality can be viewed as the death of a woman during pregnancy or within 42 days after termination of pregnancy from any causes related to, or aggravated by the pregnancy or its management [United Nations Fund for Population Activities (UNPFA, 2014:120)].

High and middle income countries experience lower maternal deaths than LLMIC [United Nations Population Fund (UNPFA, 2015: 72)]. However, in the United States, over the last thirty years maternal death rate has shown an increase from an averaged 9.1 in 1979 to 18.5 maternal deaths per 100,000 live births in 2013 (WHO, 2013: 721). This occurrence is despite the inception of the Millennium Development Goals (MDG) in 2000 with goal five dedicated to the improvement of maternal health (UNICEF, 2013: 145). Lower-middle income countries account for ninety-nine percent of global maternal deaths with the majority of those deaths occurring in Sub-Saharan Africa and Southern Asia, with India's rate being the highest [World Health Organization (WHO), 2014: 55)].

South Africa is somewhat of an exception amongst the LLMIC and is showing improvements, with a reduction in maternal deaths from 189, 5 per 100 000 births in 2009 to 132, 9 per 100 000 in 2012/13, and a 30% reduction in postnatal maternal death rate since 2000; however, despite this positive change and the existence of the South Africa Department of Health Guidelines for Maternity Care (2015) and the National Core Standards, the fifth MDG was not met (WHO, 2014:55). South Africa is still far from meeting its international commitment to

cut maternal mortality to 38 deaths per 100,000 births (Health-e, 2013: 2). This study is guided by The National Guideline for Maternity Care (2015) standard which offers midwives a resource to allow coherent decisions in presenting circumstances with early detection of danger signs, by expanding and scaling up high-impact interventions for the complications in obstetric emergency leading to maternal mortality are well known as obstetric hemorrhage (primarily postpartum), severe pre-eclampsia and eclampsia, puerperal sepsis and unsafe abortion, as effective interventions to mitigate them. These interventions can be best delivered through quality maternity care provided by skilled health providers in facilities, throughout the antepartum, intrapartum, and postpartum periods and with back-up support through referral mechanisms. (NDoH, 2015: 32).

In examining global maternal deaths more closely, 11–17% of these deaths occur during childbirth itself, while 50–71% occurs in the postnatal period (WHO, 2013: 721). Globally about 529 000 women are estimated to die each year as a consequence of childbirth complications (Morestin, Bicaba, Serme and Fournier, 2012: 20). Save Motherhood Initiative (2013: 41) reported that more than half a million maternal deaths in the first 72 hours post-delivery are avoidable.

The postnatal or postpartum period is recognized to be from one hour after the placenta has been delivered to six weeks thereafter. Labour and postnatal periods account not only for the high burden of postnatal maternal deaths, but also for the associated stillbirths and early newborn deaths, often with countries with high rates of maternal deaths having corresponding high rates of infant mortality. The majority (99%) of maternal deaths which occurred in sub-Saharan Africa between 2000 and 2008 were as a result of complications that were further exacerbated by the compromised quality of postnatal maternal care, particularly between 24-72 hours post-delivery (WHO, 2013: 722).

Postpartum care, in particular the first 72 hours post-delivery, is considered to be crucial in the survival of mother. (WHO, 2012a:18). Difficulties ensuring survival are compromised health service (inclusive of family planning) and information provision to mothers relating to relevant postnatal management and risk identification in the first 72 hours post-delivery (Costello, Azad, and Barnett, 2006: 1477). Health education is more often omitted after delivery due to the shortage of midwives and the reportedly high workload (Warren, Daly, Toure and Mongi, 2006: 86). The early discharge home is one of the risk factor (within 24 hours after delivery),

in particular in women with limited access to emergency obstetric facilities (Warren et al., 2006:86). When midwives work in environments that do not enable them to consistently meet their nursing practice standards, patient safety is jeopardized (Winslow, 2012:28).

In a worldwide effort to reduce the crisis of maternal postnatal deaths, postnatal care interventions are strongly recommended (Titaley, Hunter, Heywood, and Dibley, 2014:1).

The World Health Organisation (WHO, 2013: 722) explains that the provision of health services is based on the availability of facilities, equipment, drugs and basic supplies as well as competent health care workers. Quality postnatal care is enshrined in the international standard that reproductive healthcare needs of clients must be attended to by professionals (Morestin et al., 2012:20). The availability of midwives on duty to meet the service requirements is a pre-condition for the provision of quality postnatal care [United Nation Food and Population agency (UNFPA), 2009]. Midwives are the backbone of the reproductive healthcare needs of women, and have a potential to provide quality maternal and newborn health services (UNFPA, 2014:120).

In an attempt to mitigate these post-natal complications, hospital policies, guidelines and protocols are in place with an emphasis on the reduction of maternal mortality. These documents offer midwives a resource to enable reasoned judgment and selection in managing presenting clinical situations (Dhaka et al., 2012: 1). Added to this, the National Development Plan (NDP) (2030) for South Africa has as an objective to reduce maternal mortality. It is concerning that despite the existence of the NDP (2030) objective, policy guidelines and protocol standards within midwifery service sites which are focused on saving mothers, a gap in service delivery appears to be present and seemingly midwives fail to familiarize themselves with these documents. However, the midwives' perceptions of their postnatal maternal care role need to be identified.

This study seeks to describe midwives' perceptions of maternal postnatal care role within a level one district hospital in eThekweni, KwaZulu-Natal. This study took place at a level one district hospital of 200 beds. It is one of KwaZulu-Natal's 37 level one hospitals (Health e-news, 2006:7), districts hospitals are categorized into small (no less than fifty beds and no more than one hundred and fifty beds), medium (more than one hundred and fifty beds and no more than three hundred beds) and large district hospitals (no less than three hundred beds and no more than six hundred beds). Nationally the Department of Health stipulates the functions of the district hospitals, namely:

1. Serve a defined population within a health district and supports primary health care
2. Provide a district hospital package of care on a 24-hour basis;
3. Have general practitioners and clinical nurse practitioners providing health services
4. Provide services that include in-patient and ambulatory health services as well as emergency health services
5. A district hospital receives outreach and support from general specialists based at regional hospitals (Health e-news, 2006:7).

The hospital is located on the outskirts of eThekweni, and, having been built in 1882 by missionaries because of the absence of health facilities in the community. The hospital now operates with the permission of KwaZulu-Natal Provincial Department of Health, amidst reports that due to such state aided hospitals are currently under review by the Department of Health as they are facing efficiency and sustainability challenges (Health e-news, 2006:7).

The facility of this hospital cared mainly for the needs of the people living in and around these semi-urban and rural areas.

1.2 POSITION OF THE RESEARCHER

The researcher is a registered midwife who obtained a Bachelor of Nursing Degree from a South African university, followed by six years working experience as a midwife. The researcher is, currently working in a level one health care facility in the maternity unit. The researcher is aware of the postnatal maternal deaths which have occurred as a result of a combination of factors that seemingly suggest care that is not in keeping with national best practice benchmark maternity care guidelines, specifically within the first 72-hour post delivery period (NDoH, 2015). This therefore, prompted and motivated the researcher to embark on this descriptive study to describe midwives' perceived maternal postnatal care role within a level one district hospital in eThekweni, KwaZulu-Natal.

1.3 PROBLEM STATEMENT

Global health vision states that: “no woman should lose her life when giving birth to another life” (Saving mothers, 2013:41). However, this is a major crisis in Sub-Saharan African countries (WHO, 2013: 721). South Africa as a Sub-Saharan African country has an international obligation to meet its commitment to cut maternal mortality from its current 140 to 38 deaths per 100,000 live births and strive to meet the Sustainable Development Goals by 2030 [Save Our Soul (SOS), 2014:12. This rate is lower than the South African national maternal mort

ality rate, but remains one of concern, given that the World Health Organization (WHO, 2014:59) requires that more needs to be done to reduce maternal mortality (WHO, 2014:59). Focus is concentrated on antenatal care, leaving a gap in discussions about postnatal care (Saving Mothers, 2013: 41). The evident gap in postnatal care offers concern in light of the maternal mortality rate in the research setting, four maternal deaths occurred between 2014-2015. This issue cannot be fully addressed without hearing the midwives’ voices. As a researcher in this study, the researcher realized that the midwives have different perception towards the health care rendered to mothers (Saving Mothers, 2013: 41). In order for the researcher to understand their varying perceptions of postnatal care to mothers, it was necessary to embark on a study seeking to describe midwives perceptions of postnatal maternal health care role in the level one eThekwini hospital.

1.4 PURPOSE OF THE STUDY

The purpose of the study is to describe hospital based midwives’ perceptions of their role within maternal postnatal care in eThekwini, KwaZulu-Natal in order to inform review of structure and process standards within the postnatal maternal care environments and ultimately improve maternal health outcomes.

1.5 RESEARCH OBJECTIVES AND QUESTIONS

The research objectives are threefold. The research questions are presented after each objective to aid readability.

1.5.1 Research objective one

To describe midwives' perception of postnatal maternal care in a level one eThekweni hospital, South Africa.

Research question one: What do midwives perceive as encompassing postnatal maternal care?

Research question two: Are midwives' perceptions of postnatal maternal care synchronized with national definitions of postnatal maternal care?

1.5.2 Research objective two

To describe the midwives' perceptions of their role in providing postnatal maternal care in level one district hospital.

Research question three: What postnatal maternal care practice activities do midwives perceive to be their responsibility?

Research question four: Do perceptions of their practice responsibilities synchronize with national nursing standards for post-natal maternal care?

Research question five: Do midwives' practice activity descriptions include maternal health post discharge?

1.5.3 Research objective three

To described factors affecting postnatal maternal care in a level one district hospital.

Research question six: What factors do midwives describe as facilitating and or hindering the midwives' role in providing effective postnatal maternal nursing care?

Research question seven: Do factors described relate to:

i. Structural standards such as demographic data, equipment availability; human resource availability; midwives' attitudes?

ii Process standards – midwives’ descriptions of postnatal practices?

1.6 SIGNIFICANCE OF THE STUDY

The study offers the possibility of benefiting the local department of health, policy makers, health institutions, health practitioners and maternal health care researchers as discussed below.

1.6.1 Policy development

In 2014 the WHO called for a reduction in country-level maternal mortality ratios to seven deaths per 100,000 live births per annum (WHO, 2014: 55). Maternal mortality is not only a significant indicator for the effectiveness of the public health system, but the reduction thereof contributes to the reduction of poverty and neonatal mortality (WHO, 2014: 55). In addition, it assists in the achievement of the NDP (2030) objective of reduced maternal mortality and the United Nations Fund for Population Activities’ objective of reduced maternal mortality (UNFPA, 2015:72). The result of this study may add value to policy discussion, specifically implementation of protocols designed to support policy and improve maternal health care outcomes in the local sector, ultimately influencing national goals.

1.6.2 Nursing education

The timing of this study is critical as nursing curricula are being revised, the landscape of nursing qualifications shifting, in light of the re-engineering of primary health care and the implementation of the Sustainable Development Goals (Health-e 2013: 2; Save our Soul (SOS), 2014: 12). The results from this study could offer insight into potential deficits within the midwifery curriculum, or continued education programs, designed to facilitate the implementation of best practice standards that are represented within policy and protocol.

1.6.3 Nursing practice

The National Core Standards were implemented in 2011, by the South African National Department of Health goaled towards quality care for patients (NDoH, 2013:15). Currently hospitals are being audited for implementation thereof. The auditing routinely measures the outcome, but not knowledge, attitudes or beliefs; hence this study offers an opportunity to identify the process of care delivery through how midwives describe their role in maternal post-natal care. Identification of their knowledge, attitudes and beliefs that underlie their practice is

important, as what a practitioner thinks and believes is not always translated into practice (Trautner et al., 2011:14). This study will add to the narrative of the midwife in the postnatal period.

1.6.4 Nursing Research

Furthermore, the findings will be helpful in identifying areas in postnatal care that require attention, which may improve the lives of mothers. Equally important, it will also provide the basis for further research in the same field.

1.7 OPERATIONAL DEFINITION OF TERMS

The following terms have been operationalized for this study and are presented below.

Perception

“Perception may be referred to as a belief or opinion, that is often held by many people and based on how things seem, the quality of being aware of things through the physical senses, more especially sight or someone’s ability to notice and understand things that are not understandable to other people” (Cambridge Advanced Learner’s Dictionary, 2008: 1054). Therefore, for the purpose of this study, perception will be defined according to the belief and opinion of the midwives interviewed in this study regarding post-natal care.

Midwife

“A midwife is a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery”. [International Confederation of Midwives (ICM), 2014:4].

Within this study a midwife is defined as a trained professional, registered with the South African Nursing Council according to 31 of the Nursing Act No.33 of 2007 with expertise and skills to “support and assist the health care user and in particular the mother and baby, to achieve and maintain optimum health during pregnancy, all stages of labour and the puerperium” (SA, 2005:6).

Advanced Practice Midwife

An Advanced Practice Midwife is a practicing registered nurse who has specialized education and training in midwifery, International Council of Nurses (ICN 2012:1). In this study advanced midwives practice solely as specialists in their unit of specialty such as the maternity/labour wards of the level one hospital in the study.

The reason for the inclusion of the above definition is because there are two Advanced Practice Midwives in the setting i.e. in labour ward and postnatal ward, despite not participating in the study – see sampling.

Mother

“A mother is referred to as a woman who gave birth to a child”. (Oxford English Dictionary, 2006:589). In this study it is a mother nursed in the post-natal ward in the research setting within the first 72 hours post-delivery.

Maternal post-natal care

“Maternal post-natal care is defined as the treatment received by a mother or services rendered by different health institution to mothers until six weeks after delivery” (Bandolier, 2007:133). Within this study maternal post-natal care refers to care provided to the mother in the hospital setting during the first 72 hours post-delivery. “Postnatal period is referred to as the first three days completed after the birth of the infant”. (WHO, 2012a:14). In this study postnatal period refers to the first three days after the birth of a baby.

1. 8 CONCEPTUAL FRAMEWORK

The conceptual framework for this study describing midwives’ perceptions of maternal postnatal care role within a level one district hospital in eThekweni, KwaZulu-Natal is Donabedian’s Model (1988).

1.8.1 Introduction to Donabedian’s model

Donabedian’s model (1988:1734) identifies three components for evaluating the quality of service. These three components include structure standards, process standards and outcomes standards. Donabedian outlined the structure-process-outcomes model as an interrelationship

between outcome standards (the technical and interpersonal results of interventions or output standards), and structure standards (professional and organizational resources associated with the provision of service) and process standards (the actual practice implemented) (Mitchell, Ferdrick, and Jennings, 1998:43). Donabedian further described the linear relationship between structures (having the right things), processes (doing things right) and outcomes (having the right things happen) (Mitchell et al., 1998: 43). In health care these standards would be described as professional and organizational resources associated with the provision of care (structure standards), activities carried out to, and for the patient by practitioners during the course of treatment (process standards) and results due to the course of treatment (outcome standards)

(Zinn and Mor, 1998: 37). See Figure 1: (Donabedian’s Model, 1988: 1734).

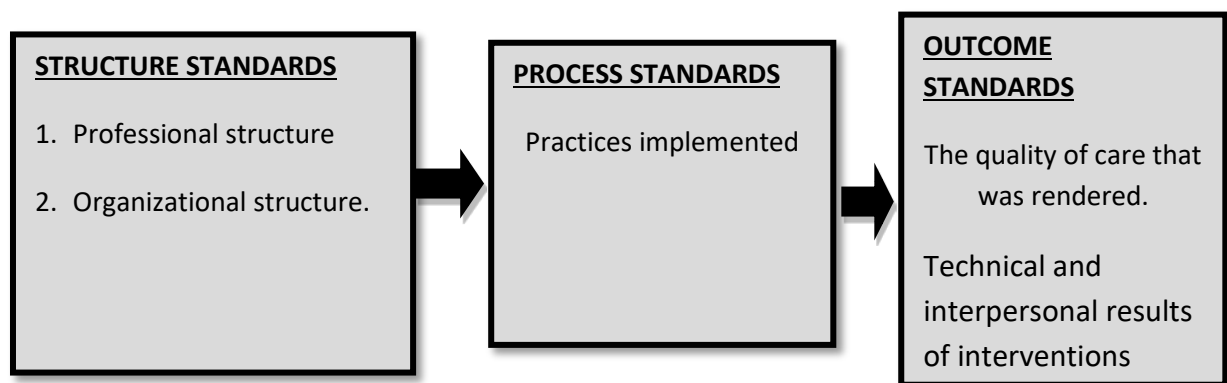


Figure 1: Donabedian’s Model (1988).

1.8.2 Application of Donabedian’s model to this study

The researcher selected this framework as its author – Donabedian suggests that to focus only on the outcomes could negate the opportunity to examine the factors that had an influence (Mitchell et al., 1998: 43). This study will make use of an application of two of the core components of Donabedian’s tripartite model (1988: 1734). The processes of care in the model will underpin this inquiry.

In this study the structure is composed of human resources, namely the midwives, which is inclusive of demographics, such as midwifery qualification and their perception towards postnatal care. While the material resources include the physical items needed to deliver obstetric services such as drugs and equipment and the organizational resources which are

guided by national and international benchmarks and policy documents, dictating nursing care standards and protocols. The researcher has selected to focus on the component of structure and in particular organizational structure in the postnatal context of the research setting which is guided by national and international benchmarks and policy documents. These core documents are inclusive of National Core Standards, National Development Plan, National Department of Health Guidelines for Maternity Care and WHO standard and guidelines for postnatal care to mothers (NCS, 2011:5, NDoH: 2015:27, WHO, 2015a: 64). The researcher wishes to elicit maternal care delivered within the first 72 post-natal hours that is reflective of core documents.

The process is the description of the midwives’ perceptions of post-natal care delivery. The outcome standards are the consequences of the aforementioned standards on the patient. In maternity services, in particular the outcome standards are linked to both the mother and the newborn, often measured in mortality and morbidity rates, but also include the mother’s satisfaction with the services. The outcome standards are not within the scope of this study. See figure 2 (Application of Donabedian’s Model to this study, pg.12).

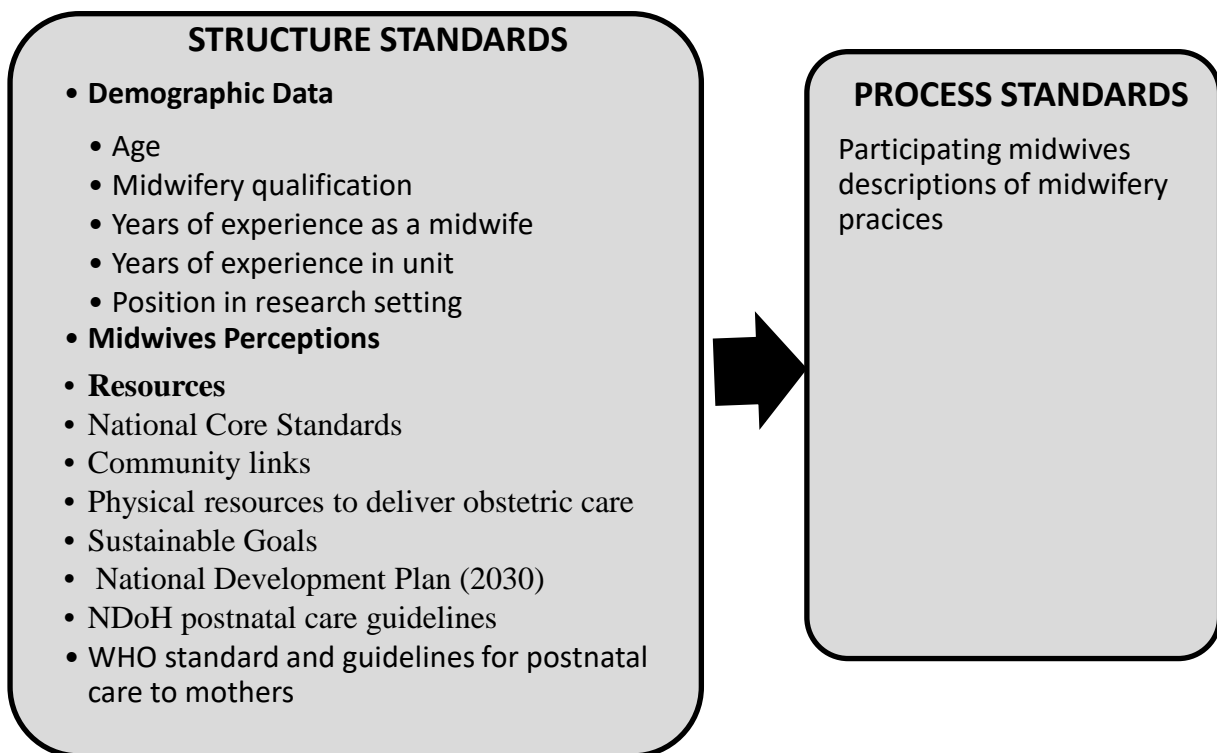


Figure 2: Application of Donabedian's Model to this study

1.9 SUMMARY OF THE CHAPTER

This chapter has served to provide an introduction to the study and highlighted the core problem and significance thereof. The introduction and background outlined global and national attempts to decrease maternal mortality with particular reference to postnatal care - often a neglected aspect. This led to the problem statement and the significance of the study with particular relevance to contributing towards the NDP (2030). The study is to be framed within two components of Donabedian's tripartite model. This leads to chapter two which presents the relevant literature.

CHAPTER TWO: LITERATURE REVIEW

Literature sources

Various strategies were adopted to review the literature in an organized written presentation of what has been disseminated by other researchers (Burns and Grove, 2009). The literature reviewed included the national and international literature through the following electronic databases: EBSCO-host, Pubmed, Science Direct, MEDLINE (Medical Literature on-Line), and Google Scholar. All titles and abstracts of journal articles found were read for their relevance to the topic and thereafter, relevant articles were retrieved.

Key words: Maternal Health Care, Postnatal Care, Maternal Health Care Services, And Maternal Deaths.

2.1 INTRODUCTION

This chapter presents the literature reviewed as relating to this study. The literature reviewed focuses on issues surrounding postnatal maternal health care with explanations on understanding maternal health care within a midwifery context, midwives perception of postnatal care role to mothers, utilization of maternal postnatal health care services, factors affecting the utilization of maternal care services among women, influence of postnatal service utilization on maternal mortality, relevance of postnatal maternal service delivery in maternal postnatal mortality and preventing postnatal maternal deaths.

Maternal health care services are important for both reducing pregnancy related complications as well as maternal and infant deaths (Tsawe, 2014:3). The purpose of providing maternal postnatal care to mothers is to save mothers and prevent maternal deaths after child delivery (WHO, 2013:727). Internationally, maternal mortality and morbidity represents one of the biggest challenges to public health, particularly in low and low-middle income countries (WHO, 2013:727). Limited access to standard obstetric equipment, shortage of staff, delay in women accessing health care facilities, lack of trained personnel and difficulties procuring essential drugs adds to the challenges faced by midwives, more especially when considering the South African context, in level one hospitals (Wiysonge, 2009:9). In addition, the reduction

in maternal mortality rates fell short of Millennium Development Goal five (MDG 5) aimed by 2015 to reduce maternal mortality ratio (MMR) by 75% in response to specific maternal health challenges (WHO, 2015a: 65).

Brink, Van der Walt and Van Rensburg (2014:67) state that the literature review enables researchers to gain knowledge about the research topic based on studies conducted on similar topics. This knowledge assisted the researcher to refine the problem statement, design and data analysis process and it provided a basis for interpreting the research findings.

2.2 UNDERSTANDING MATERNAL HEALTH CARE (MHC) WITHIN A MIDWIFERY CONTEXT

Authors differ in their definitions of maternal health care. Haridas, Wadde and Surwade, (2015:5) offer a broad definition suggesting that maternal and child health refers to the promotive, preventive, curative and rehabilitative health care offered to mothers and children. While Addisse, (2014: 2341) narrows the population and believes that maternal health care is the health service provided to mothers, namely women in their child bearing years, which Filippi and colleagues (2012a:7) state that it is between 15 and 49 years. It is thus understood from these definitions that maternal health care is inclusive of postnatal care. The postnatal period begins immediately after childbirth and lasts six weeks thereafter (WHO, 2015b:260).

Current statistics show that the global maternal mortality rate examined from 1990 to 2015, declined by 44 per cent (UNFRA, 2015: 81). This equated to a drop from 385 deaths to 216 deaths per 100,000 live births, according to United Nation inter-agency estimates (UNICEF, 2015:8). This translates into an average annual rate of 2.3% in reduction of maternal deaths. While possibly seen as impressive, this was less than half of the 5.5% annual rate needed to achieve the three-quarters reduction in maternal mortality targeted for 2015 in Millennium Development Goal 5 (UNICEF, 2015:8). As a result of this shortfall the Sustainable Development Goal (SDG) three was set which is goaled to ensure healthy lives, calls for achieving universal access to sexual and reproductive health care, and the reduction of global maternal death ratio to less than 70 per 100,000 live births (UNFRA, 2015: 81). The Sustainable Development Goals are targeted for 2030 (UNFRA, 2015: 81). The World Health

Organisation in 2014 made it clear that 88-89% of maternal postnatal deaths could have been averted with timely access to existing, emergency obstetric interventions. (WHO, 2014:57).

At a national level as early as 1994, South Africa started to address the disparities of the past, inclusive of maternal health care (Health-e, 2013:7). The South African government announced its policy of free health care to support the development of accessible, good quality and efficient primary health care (Health-e, 2013:7). Included in this policy were all public services (hospital and primary health care) to pregnant women, from point of confirmation of pregnancy until 42 days after delivery, as well as children under the age of six years (Schneider and Gilson, 2011:1).

The provision of service delivery is important as are midwives' perceptions of maternal health care (MHC) services. Okafor and Rizzuto (2012:1) when examining the perceptions of midwives (working in level one hospital in Nigeria) concerning postnatal maternal health care, identified a strong perception of postnatal maternal health care services, as being essential for both the women and their newborn babies. In the same view, according to a study carried out by Lohse (2012: 53), involving eight midwives in a level one hospital in Malawi, it was noted that midwives' perceived strong relationships between themselves and the mothers, emphasizing the importance of the connection between the two parties, as well as the desired attributes of the staff, and the environment of care. In midwife-led care where such professionals predominate, the midwife is the lead health-care professional responsible for the planning, organization, and delivery of care given to a woman from the initial booking of antenatal visits to care during the postnatal period (Wiysonge, 2009:7). The maternal health care provided by trained midwives is often similar to that provided by obstetricians, family physicians, or other physicians (Wiysonge, 2009:7). Yet despite this positive perception by the midwives towards maternal health care in the midwifery context Pettersson, Johansson, Pelembe, Dgedge and Christenson (2010:145) emphasised that mothers underestimate the importance of provided information about postnatal care.

2.2.1 Midwives' perception of maternal postnatal care role to mothers

Postnatal care involves the practice of routine postnatal check-ups by a health care professional for six weeks following childbirth (Gunn, Lumley and Young, 2013:1570). The postnatal check

involves a variety of activities involving the mother and the new-born (Gunn, et al., 2013:1570). Some midwives perceived their postnatal care role to include activities such as: Routine examination of the reproductive organs and structures as well as the abdomen, promotion and monitoring of the physical and psychological health of the mother, ensuring the establishment of successful infant feeding and to foster the development of good maternal-infant relationships (Gunn et al., 2013: 1570). This myriad of activities lends to the argument that the role of the midwife in postnatal care is largely undetermined and seen traditionally to involve routine observations and examinations of both mother and child after a certain period post-delivery (MacArthur, 2011: 12). Hence this study seeks to describe the midwives' perception of postnatal maternal care role in level one hospital.

2.3 UTILIZATION OF MATERNAL POSTNATAL HEALTH CARE SERVICES

When discussing maternal postnatal health care, it is essential to understand that maternal postnatal health care cuts across other health care service areas such as family planning (MacArthur, 2011: 12). There is a broad base of service offerings that encompass maternal postnatal care, yet it has been clearly argued and shown that the utilization of maternal postnatal health services available to both rural and urban populations is very low, especially among African and Asian countries (Chimanakar and Sahoo, 2011:12).

There are a number of factors responsible for the underutilization or non-use of postnatal maternal health care services provided for women both in rural settlements and those in urban settlements (Navaneetham and Dharmalingam, 2014: 1849; Chimankar and Sahoo 2011: 12). These factors have been named as: ignorance on the part of the mothers to identify some of the postpartum dangers signs, lack of support from their partners, lack of transport or monies for transport to access services, long walking distance to hospitals, long hospital queue, poverty and the attitude of the health care workers (Chimankar and Sahoo, 2011: 12). These factors call for attention to be given towards the provision of health care services in order to reduce maternal morbidity and mortality (Chimankar and Sahoo, 2011: 12).

2.4 FACTORS AFFECTING THE UTILIZATION OF MATERNAL CARE SERVICES AMONG WOMEN

Many authors have argued that the low utilization of maternal health care services are due to a number of factors (Thomas and Taiwo, 2014: 157; Tsawe, 2014:2; Chimankar and Sahoo, 2011:12; Matsuoka, Aiga, Rasmey, Rathavy and Okitsu, 2010:255; Lubbock and Stephenson, 2008:25). Lubbock and Stephenson (2008: 26) argued that maternal health care services and its utilization among women could be influenced not only by poor access to care, but also by individual and community knowledge and acceptance of maternal health services. Finances add to the barriers towards the utilization of maternal health services (Somefun and Ibisomi, 2016: 2; Matsuoka et al., 2010:255; Lubbock and Stephenson, 2008: 26). According to Matsuoka et al., (2010:255) financial barriers have been identified by midwives to be a lack of transport monies and money to pay for the services of maternal health care providers. Apart from finances a knowledge deficit is a barrier as during the study of barriers towards the utilization of maternal postnatal care in Tanzania, the findings of the study revealed that 15 of the mothers who claimed to be housewives, domestic workers and self-employed, believed that since they had a healthy delivery, postnatal maternal health care services are not needed, but only needed by those with abnormal or complicated deliveries (Matsuoka et al., 2010:255).

Lubbock and Stephenson (2008:25) further maintain that other factors may determine the women's decisions to seek care and thus the level of utilization of postnatal maternal health care service, these include: partner support, previous postnatal maternal health care experiences, and the degree of communication with other women and health care workers. Somefun and Ibisomi (2016: 2) utilizing the 2013 Nigerian Demographic and Health Survey (NDHS) examined over a 12-month period from July 2014 to June 2015, the factors related to the non-utilization of postnatal care among mothers in Nigeria. The findings of the study showed that 63 % of the 50 mothers did not utilize postnatal care services (Somefun and Ibisomi, 2016: 2). The predominant age group in the NDHS study who had not utilized postnatal care was those between 25 and 34 years, representing 42% of the study population and 61 % of the women who had not utilized postnatal care had no education. (Somefun and Ibisomi, 2016: 2). The study by Somefun and Ibisomi (2016:2) concluded through the use of multinomial logistic regression that the core contributors to failure to utilize postnatal care are: "distance, education, place of delivery, region and wealth status". Education level among women is a serious factor prohibiting effective provision of maternal postnatal care especially in developing countries (Somefun and Ibisomi, 2016:2).

In the same view, the United Nation Population Fund Agency (UNFPA, 2015:75) declares that there are significant variations worldwide with regard to postnatal maternal mortality, especially in nations with large equality gaps in income and education and high healthcare disparities. Women living in rural areas experience higher postnatal maternal mortality than women living in urban and sub-urban centers because those living in wealthier households, having higher education, or living in urban areas, have higher use of healthcare services than their poorer, less-educated, or rural counterparts (UNFPA, 2015:75).

Despite the findings from the UNFPA (2015:75) a study from South African showed a different result (Tsawe, 2014: 3). Tsawe (2014:3) investigated the in relationship between maternal education and maternal health care utilization in level one health care institution amongst 28 mothers. The study aimed to explore the rates of postnatal maternal health care use, the reasons for non-use of maternal health services, as well as the determinants of maternal health care use (Tsawe, 2014:3). The results of the study showed that although women with higher levels of education reported higher rates of postnatal care utilization, those with lower levels of education reported higher rates of postnatal care utilization (Tsawe, 2014: 3). Other factors that played a significant role in the use of maternal postnatal health care services included access factors, such as transport and distance to health facilities (Tsawe, 2014: 3).

From the discussions above, it is evident that there are numerous factors responsible for poor utilization of maternal postnatal health care services among women, especially in the poorer parts of the world. Maternal postnatal deaths need to be prevented and postnatal service delivery aligned with the Sustainable Development Goal three. Reproductive health problems are a leading cause of ill health and death for women of childbearing age in developing countries (UNFPA, 2015:81). The United Nations Fund for Population Activities has strengthened health systems, including the training of midwives, who when properly trained are suggested to avert two thirds of maternal and neonatal death. (UNFPA, 2015: 81).

2.4.1 Influence of postnatal service utilization on maternal mortality

According to the World Health Organization (WHO, 2015b:259), postnatal care service utilization is the key for maternal health services and can significantly reduce postnatal complications and maternal mortality. In low-income countries, almost 40% of women experience complications after delivery and an estimated 15% develop potentially life-

threatening problems (WHO, 2015b:259). Maternal postnatal health care services are a fundamental element of the continuum of essential obstetric care that decreases postnatal maternal mortality in low- and middle-income countries (WHO, 2015b:259). The low use of maternal postnatal services could be explained by the notion that women tend to believe that it is not necessary to go back for check-ups after delivery, unless complications arise. It is at this level that most maternal mortality could occur; therefore, maternal postnatal care is an important dimension of maternal health care that should not be overlooked (WHO, 2015b: 259).

Mekonnen and Mekonnen (2011:374) gave a clear explanation for poor health outcomes among women and children as the non-use of postnatal maternal health care services by 55%. The report issued by World Health Organization (WHO 2010:20) indicated that the main contributing factors leading to maternal mortality are post-partum hemorrhage, pre-eclampsia, eclampsia, infection and unsafe abortions.

Despite international focus on the mother and child health four years later the WHO (2014: 58) report showed similar results for causations of maternal mortality. The majority of maternal deaths were clustered around labour, delivery and the first 24 hours postpartum (WHO, 2014:58). It was estimated that just five conditions, namely postpartum haemorrhage, puerperal sepsis, pre-eclampsia and eclampsia, obstructed or prolonged labour, and complications of unsafe abortion, account for at least 60% of all maternal mortality (WHO, 2014:58). Ronsmans, Graham and Lancet Maternal Survival Series steering group (2012:1) claimed that the maternal death rate in the poorest parts of the world is one in six compared with about one in 30 000 in Northern Europe. The authors pointed out that the causes of maternal deaths in the poorest of the parts of the world can be grouped around labour, delivery, and the immediate postpartum period, with obstetric hemorrhage being the main medical cause of death (Ronsmans et al., 2012:1).

According to Saving Mothers (2013: 6) the quality of postnatal maternal care received in the South African health system in Every Death Counts present a unified call for action to save the lives of South Africa's mothers. In South Africa half of all postnatal maternal deaths occur during the first week after delivery (Saving Mothers, 2013: 6). The leading cause of postnatal maternal mortality in South Africa accounting for 34% of deaths is haemorrhage, the majority of which occurred immediately post-delivery; sepsis and infection claim another 10% of

postnatal maternal deaths (Saving Mothers, 2013: 6). In addition, during the maternal postnatal period mothers who are HIV positive are at a greater risk of postnatal maternal death due to non-compliance of anti-retroviral treatment (Saving Mothers 2013, 6).

2.4.2 Relevance of postnatal maternal service delivery in maternal postnatal mortality

The provision of appropriate postnatal maternal health care remains one of the main challenges in developing countries (WHO, 2015a: 62). It is clear that the views held by midwives concerning the significance of the utilisations of maternal postnatal health care services amongst women are not always aligned to the mother /service user. (WHO, 2015a: 62). Therefore, the understanding and the opinion of maternity care staff on postnatal maternal health care, is important in the development of effective maternal postnatal service delivery, which by all indication is in line with current Saving Mothers' policy recommendations worldwide (WHO, 2015a: 62). It further adds significance in the implications for risk management and improving the quality of postnatal care at all levels of health care delivery (Matsuoka et al., 2010:22).

2.5 PREVENTIVE MEASURES AGAINST POSTNATAL MATERNAL DEATHS

Arguably, finding ways to reduce maternal death is the top priority in all stake holders listed in the field of medicine. According to WHO (2013:723) “reducing the rate of maternal mortality by 75% in 2015 was the top order in the development targets that was endorsed at numerous internal meetings”. More so, Clark and Hankins (2012: 360) are of the opinion that, addressing the issue of obstetric emergencies in all health care institutions will improve health care delivery and will help reduce the likelihood and effect of error and maternal mortality. However, the debate on the best practices or ways to reduce maternal mortality has shown to be a complicated one (Clark and Hankins, 2012: 360). Goodburn and Campbell, (2010: 917) believe that to prevent maternal deaths all the technical support or interventions need to be improved, such as providing quality postnatal care and the training of midwives.

According to Van Selm M, Kanhai HH, & Keirse MJ (2015:272) .Postpartum Haemorrhage is generally defined as blood loss greater than or equal to 500 ml within 24 hours after birth, while severe PPH is blood loss greater than or equal to 1000 ml within 24 hours. PPH is the most

common cause of maternal death worldwide. Most cases of morbidity and mortality due to PPH occur in the first 24 hours following delivery and these are regarded as primary PPH whereas any abnormal or excessive bleeding from the birth canal occurring between 24 hours and 12 weeks postnatally is regarded as secondary PPH. PPH may result from failure of the uterus to contract adequately (atony), genital tract trauma (i.e. vaginal or cervical lacerations), uterine rupture, retained placental tissue, or maternal bleeding disorders. Uterine atony is the most common cause and consequently the leading cause of maternal mortality worldwide. (Van Selm M, et. el, 2015:272). The causes of maternal deaths during postnatal period includes but not limited to; postpartum haemorrhage (PPH), early discharged, lack of essential steps in the managements of obstetric emergency (ESMOE), lack of adequate health care resources, shortage of staff, and delay in referral during the postnatal period (WHO, 2015:64).

The South African National Department of Health adopted various strategies to address postnatal health needs. The National Core Standards (NCS) were established in 2011, by the South African National Department of Health for the purpose of quality care for patients in health care institutions (NDoH, 2013:15). The Public Health domain 4 of NCS emphasized that patients who need to be referred or transferred must receive the care and support they need to promote health; prevent illness and reduce further complications (NDoH, 2011: 11).

In an effort to alleviate post-natal complications, hospital policies, guidelines and protocols were established with the aim to decrease maternal mortality (NDoH, 2015:15).

South Africa recognised the need for health care workers to improve their skills in managing obstetric emergencies when in 2009 Essential Steps in the Management of Obstetric Emergencies (ESMOE) was introduced as a training package for doctors and midwives alike in a scale up process (Moran, Naidoo and Moodley, 2015:1102). Kwa-Zulu natal was a significant province in the scale up process (Morean et al., 2015:11040)

Further when examining postnatal stay, it has two main objectives; the firstly to identify any complication for both mother and new-born and secondly to provide the necessary support to the new mother for her home return. Mothers discharged from hospital between 6 - 24 hours postpartum are more likely to be re-admitted to hospital than those discharged at after 48 hours. Maternal re-admissions from vaginal births or for caesarean sections due to excessive bleeding, puerperal sepsis, or postnatal depression, appropriate detection by midwives, managements and

referrals are necessary to save mothers in the events of life-threatening complications. (WHO, 2015:65).

In recognition of the above the Guidelines for Maternity Care (NDoH, 2015: 32) serve to provide guidance and mitigate against complications that can lead to death. The complications are: postpartum hemorrhage (primarily postpartum), severe pre-eclampsia and eclampsia, puerperal sepsis and unsafe abortion. These postnatal interventions can be best delivered through quality maternity care provided by skilled health providers in facilities, throughout the antepartum, intrapartum, and postpartum periods and with back-up support through referral mechanisms. (NDoH, 2015: 32). Swift management can lead to meeting National objectives.

The National Development Plan (2030) for South Africa has as an objective to reduce maternal mortality in a downward trend past 100 per 100,000 live births. NDP goal three has as its aim to reduce maternal mortality by improving the quality of antenatal and postnatal maternal care, and using health information to follow up on patients can contribute to reducing unnecessary postnatal maternal mortality (NDoH, 2013: 334). The NDP (2030) objectives and maternity care guidelines and the NCS within the midwifery service sites are focused on saving mothers (NDoH, 2013: 334; NCS, 2011:1).

2.6 SUMMARY OF THE CHAPTER

This chapter has presented national and international literature on the issues surrounding postnatal maternal health care to mothers. It examined factors that illuminate an understanding of the topic of study, inclusive of maternal post-natal care as it is nestled in maternal health care. It has been shown that international and national attempts are in place to reduce maternal postnatal deaths and that midwives are centrally placed to remove or reduce the barriers towards the delivery of this significant aspect of health care. (Wiysonge, 2009: 9). Furthermore, the subheadings in this chapter have reflected the specific objective of the study, which is to describe midwives perception of maternal postnatal care. In the next chapter, the methodology employed for this study will be discussed in detail.

CHAPTER THREE: METHODOLOGY

3.1 INTRODUCTION

In the previous chapter, local and international literature was reviewed on the issues that surround midwives' perception of postnatal care to mothers. This chapter discusses the research methodology, including the research design, the setting, the population and sampling framework, data collection and analysis, measures to ensure trustworthiness, and ethical considerations, stated that a methodology is a plan for conducting a study, which involves a series of steps as already mentioned (Creswell 2009:147; Gillis and Jackson, 2002:708).

3.2 RESEARCH PARADIGM AND APPROACH

3.2.1 Research paradigm

A paradigm is a set of assumptions and practices that structure inquiry within a discipline by providing lenses, frames and processes through which investigation is performed (Weaver and Olson, 2006: 459). Theoretical paradigm is understood according to three basic sets thus; Ontology, Epistemology and Methodology (Henning, Van Rensburg and Smit, 2004: 13).

This research was underpinned by a social constructivist paradigm which holds that 'individuals seek understanding of the world in which they live and work' (Creswell 2009: 147). To achieve the research objective a qualitative inductive approach, and descriptive design, was employed and facilitated by individual interviews. This was in order to develop a deeper understanding of participants' conceptualisation of their roles as midwives in the research setting (Erlingsson and Brysiewicz, 2012: 94).

The ontological perspective of this paradigm is based on the belief that reality is subjective and multiple (Morse, 1994). This study takes the stance that midwives' reality about post-natal care is subjective and contextually influenced by the setting and constructed over time through interaction with fellow midwives. Specifically, within this study reality about the work setting is suggested to be constructed through midwives interacting with each other.

Epistemology, is how reality is known and within constructivism is how knowledge is socially constructed (Strelitz, 2005:16). This study takes the stance that knowledge is socially constructed among the midwives through their interaction with each other. In this way they construct how they perceive their role during postnatal maternal care, highlighting the dynamic fluid nature which is capable of change according to how midwives make meaning of their world.

Methodology perspective of this paradigm is that, the understanding of an insider's view, values are acknowledged and subjectivity of interpretation is allowed. (Henning et al., 2004: 14). In this study this paradigm allows the researcher to understand the insider's (midwives) view regarding their perception of postnatal maternal care rendered to mothers. Moreover, the researcher acknowledged the midwives' values and the subjectivity of their interpretation and perception (Henning et al., 2004: 14).

3.2.2 Research approach

According to Biggam (2008:40) a qualitative approach is used in order to find in-depth information. Therefore, a qualitative approach was deemed necessary to inquire of in-depth information from the midwives about the postnatal care delivered. This was in order to identify if, in their view, quality care was being provided to mothers or being hindered from delivery. The findings could help to understand and evaluate the postnatal care rendered to patients in a level one district hospital and possibly will allow for recommendations that could influence services rendered to their patients in the level one health care facility.

3.3 STUDY DESIGN

An exploratory descriptive qualitative research design was used for this study to describe midwives' perception of maternal postnatal care role within a level one district hospital, in eThekweni, KwaZulu-Natal. Exploratory and descriptive in this study simply means that the researcher applied the use of probing and open-ended questions, in order to extract in-depth

information from the midwives on their perception of the standards of postnatal care in the facility in which they work (Burns and Grove, 2009:52).

3.4 RESEARCH SETTING

This study took place at a level one district hospital in KwaZulu-Natal, Durban. The care delivery is further underpinned by religious beliefs, but these do not compromise care as referral letters to local clinics are given for services not provided. There are 24 postnatal beds in the postnatal ward with one midwife and two junior category nurses (One Enrolled nurse and one ENA) allocated to work in the postnatal ward of the setting. However all the Midwives and other category of nurses usually rotates from time-to-time between maternity ward, labour ward and postnatal ward, in order to get familiarized with all the routines in the wards and they also work in team so that they will be able to render quality health care to mothers. There are Advanced Midwives in Labour/maternity ward in the setting, and one advanced midwife agreed to participate in this study but during the data collection she was not available due to some circumstances beyond her control, her expertise and the value of her role would have contributed greatly to the study.

3.5 POPULATION, SAMPLE AND SAMPLING STRATEGY

The population, sample and the strategy adopted in this research are discussed next.

3.5.1 Population

The target population was all the nurses working within the maternity unit of the selected hospital in South Africa. In this study, the registered midwives rendering postnatal care to mothers in the level one health facility were the study population.

3.5.2 Sample and Sampling

The sampling was a two-part process as follows:

Firstly, both convenience and purposive sampling was used. Convenience sampling was applied to select the specific level one hospital based on the researcher's existing relationships with the hospital management, and geographical accessibility. Secondly, purposive sampling

was used in the selection of participants to ensure the involvement of key informants. Further this was not problematic as the researcher did not conduct the interviews.

The inclusion criteria as the characteristics that the prospective *participants* needed to have for inclusion in the study were thoroughly established. Firstly, in this study the researcher only identified key informants specifically focusing on specialist midwifery, secondly, the participants were all qualified midwives, thirdly, the participants were all working in the labour/maternity ward, fourthly, all the participants understood what it means to render postnatal care to mothers and finally, all the selected participants were all working as midwives in the eThekweni, Kwazulu-Natal level one hospital. The researcher selected ten participants, but stopped at eight when data saturation was reached.

There are two Advanced Practice Midwives in the setting i.e. in labour ward and postnatal ward, but only one of the two Advanced Midwife agreed to participate in the study, but during the period of the interview unfortunately she lost her only child and she was not in the setting for the duration of four months, during the data collection

3.6 DATA COLLECTION

All ethical approvals, inclusive of gate keeper's permission were achieved prior to data being collected.

The researcher identified the most suitable venue where privacy was provided as the research setting. All interviews took place in the setting during visiting hours so as not to interfere with post-natal activities. As the researcher is a midwife from the select setting, the researcher prevented bias of the data and engaged the services of an advanced psychiatric nurse. The researcher selected this discipline of nursing as it is not midwifery and interviewing is a recognized specialist skill of a psychiatric nurse. The researcher ensured that the psychiatric nurse was available for the duration of the data collection, able to access the research site, familiar with the research objectives and questions and interview schedule, comfortable with using the voice recorder as well as being prepared to take field notes. Further, to ensure credibility the data collector needed to have at least five years of experience as a psychiatric nurse and be registered with the South African Nursing Council, of which the select data collector met these requirements. The data collector was briefed on all ethical requirements

pertaining to the study with a strong emphasis on anonymity and confidentiality. The researcher negotiated a fee with the data collector.

The researcher approached each prospective participant and verbally explained the purpose of the study as well as providing them with an information sheet (see annexure 4: information sheet, pg. 95). In addition, the researcher informed the prospective participants that in order to prevent the Hawthorne effect and increase the anonymity. The researcher would not be the one to collect the data. The researcher explained that a nurse from outside the hospital with a master's degree in psychiatric nursing would be the data collector. If they were in agreement with participating, informed written consent was obtained (see annexure 6: informed consent, pg. 89). Initially five midwives agreed to participate, while the other five midwives needed time to consider participation. Three out of the five midwives decided to participate in the interview. The total midwives that finally agreed to participate in the interviews were eight in number and informed consent was obtained from each participant prior to the commencement of each interview. The eight midwives agreeing to participate were introduced in person by the researcher to the data collector prior to the start of the interviews. The data collector collected all the participants' names and contact numbers to make arrangements with them for interviews to ensure they would be in the setting on the day of data collection. The data collector alone chose who to contact to ensure anonymity from the researcher.

After the first interview was conducted, it was transcribed and analyzed by the researcher and sent together with the tapes to the supervisor and co-supervisor who co-coded it. A meeting was convened involving the research team, inclusive of the data collector. The data collector was approached to increase the use of probing with greater exploration of questions and how to clarify issues arising. Small changes were made to the interview guide in order to generate the suitable information needed for the study (see annexure 1b: Interview guide, pg. 78). This was done in order to promote an objective and unbiased approach allowing for themes to be identified.

The interviews were done on a one-on-one basis with only one participant per day in a closed office in the setting with the data collector, who after obtaining written consent, commenced the interview recording all interviews on a voice recorder. The interview guide (see annexure 1b: Interview guide, pg. 78) was used to structure the interview. Data was collected in English as this is the language that is used in the hospital amongst the staff, the language of instruction and the language of reporting and record keeping. The interviews were expected to be no longer

than one hour, but duration ranged between 30 minutes to 1 hour. The data collector decided on whom to start with and not as per the list provided by the researcher. This was done to ensure anonymity. The data collector attempted to set up two interviews per day to increase anonymity. Interviews two and three were conducted on the same day as were interviews four and five and interviews six to eight. Saturation was evident at interview seven; hence for confirmation an eight interview was conducted. The data collector returned for member checking, Supervisor and co-supervisor checking, the tape recordings were cleared from the recorder and stored on a compact disc. On completion of analysis all information was stored on a compact disk and all information was deleted not only from the programme files in the computer but also from the recycle bin. Following transcription analysis and transfer to the compact disc, the hard copies of the transcriptions and field notes were shredded. The compact disc was given to the research supervisor for safe storage.

To start with, demographic data was obtained from each participant in relation to age group, highest nursing qualification, years of experience in midwifery and length of time working in the maternity unit of the research site. This was followed with open ended questions as per the interview guide that focused on midwives' perception of maternal postnatal care. The interview guide was used to start the discussion and the appointed psychiatric nurse used prompts to encourage elaboration and clarification as indicated to explore in more depth the responses of participants.

3.7 DATA ANALYSIS AND MANAGEMENT

In this study, the information obtained during the data collection phase from the interviews was recorded and transcribed and coded by the researcher. The transcripts and recordings were given to the research supervisor and co-supervisor who coded the data independently. Thereafter a meeting occurred to discuss the coding and agreement we reached. This was done in order to promote an objective and unbiased approach allowing for themes to be identified.

3.7.1 Content analysis

The inductive approach of content analysis by Elo and Kynas (2008: 107) was used because it's a systematic technique for compressing many words of text into fewer content categories

based on explicit rules of coding. The process of the analysis consists of three phases: preparing, organizing, and reporting data (Elo and Kyngäs, 2008: 107).

Preparation phase: The audio tape recording was transcribed verbatim. To get an overall picture of the content and allow for immersion in the data, all records were read several times by the researcher, supervisor and co-supervisor (Elo and Kyngäs, 2008: 107).

Organizing phase: To organize the data, probable headings or codes were written in the margin of the transcription - open coding (Elo and Kyngäs, 2008: 107). Information was grouped. Corresponding categories were given codes that were generated from the key words.

According to the research objectives of the study, each transcript describing midwives' perception on maternal postnatal care was extracted and coded (Elo and Kyngäs, 2008: 107). These were transcribed verbatim onto coding sheets and categories were generated, followed by the identification of themes (Elo and Kyngäs, 2008: 107). In this study the themes were based on the participants' perception on maternal post-natal care.

Abstraction phase: This was performed by searching for suitable sub-themes linked to maternal post-natal care (Elo and Kyngäs, 2008: 107).

Reporting phase: In this phase, the categories were described in relation to the research objectives and questions (Elo and Kyngäs, 2008: 107).

3.7.2 Data management

Following data collection, transcriptions were checked for completeness by the research supervisor and co-supervisor listening concurrently to the recordings and reading the transcripts. The researcher stored the transcribed data on a computer that was password locked with only access being the researcher. The transcriptions, field notes and audio recordings were stored under lock and key in the safe custody of the researcher. After transcription, member checking and supervisor and co-supervisor checking, the tape recordings were cleared from the recorder and stored on a compact disc. On completion of analysis all information was stored on a compact disc and all information was deleted not only from the programme files in the computer but also from the recycle bin. Following transcription analysis and transfer to the compact disc, the hard copies of the transcriptions and field notes were shredded. The compact disc was given to the research supervisor for safe storage under lock and key for five years.

After five years, the compact disc (CD) will be destroyed by crushing. This is according to the research university's ethics policy as it serves as the primary data for the study. No cloud storage was used for the project.

3.8 TRUSTWORTHINESS

The trustworthiness of this qualitative research study was ensured through the following of the principles listed below (Lincoln and Guba, 1985:290).

3.8.1 Credibility

To establish credibility in this study, the researcher appointed a psychiatric nurse, as someone from another discipline of nursing who was considered skilled at getting rich data through interviews. This was done in order to ensure objectivity so that the researcher as a midwife would not interpret findings according to her own values, beliefs and preconceptions. The data collector used the participants' own words to recap, illustrate and clarify points, in order for the study to be informed by participants and not the data collector's bias, inspiration or interest.

The researcher kept the research supervisor and co-supervisor informed at each stage of the process, providing the original tapes. The researcher provided tapes and transcripts and analysis at each interview batch. The researcher received the research supervisor and co-supervisor's indication that saturation has occurred before interviewing was terminated.

Transcription of data involved close observation of data through repeated careful listening of the audio tape interviews as an important part of the first step in data analysis (Bloomberg and Volpe, 2008:80). This familiarity with data was to really understand what was actually expressed rather than what was expected and thereby facilitated realizations of ideas which emerged during the analysis. All transcripts can be found (see annexure 8: transcription of recordings, pg. 78). The data gathered from the participants during tape recordings, were deleted after the data has been transcribed and checked by the supervisor and co-supervisor for accuracy.

3.8.2 Transferability

The researcher has facilitated the readers to assess the transferability to their own contexts (Bloomberg and Volpe, 2008:80; Scott and Morrison, 2006:12; Krefting, 1991:222).

An interview schedule used in the study is provided as an annexure that other researchers can use, should they choose to repeat as closely as possible, the procedures of this study (see annexure 1b: Interview guide, pg. 88).

To further establish transferability, sufficiently dense descriptions of the findings are provided such that the reader can assess the transferability of the study and applicability to his/her own context (Bloomberg and Volpe, 2008:82). In addition, the importance of using a theoretical framework to organize data and demonstrating how data analysis was guided by concepts or certain models has been recognized (Bloomberg and Volpe, 2008:80). Detailed descriptions were provided of the setting and the methodology inclusive of the data analysis and time frames of data collection (Bloomberg and Volpe, 2008:80).

3.8.3 Dependability

Dependability is when the findings in a study are consistent, reliable and can be repeated (Holloway and Wheeler, 1998: 38). To allow for auditing of the study, the tape recordings were listened to by the research supervisor and co-supervisor. Data was collected in the English language from the participants through audio recordings. After transcribing, the transcriptions were given to the participants for validation by the data collector and they were satisfied and confirmed that it was fair reflection and no changes were made thereafter. A detailed description of the data analysis through the steps of content analysis as described by Elo and Kynas (2008: 107) is found in the section titled data analysis.

3.8.4 Confirmability

Confirmability of data was ensured by keeping all data collected, confirmed data collected with participants, analyzed data, formation of the findings, and the development of the measures used for study review to verify the findings from the data gathered (Holloway and Wheeler, 1998: 33).

3.9 ETHICAL CONSIDERATIONS

All ethical principles were adhered to. Permission to conduct this research was requested and granted by the Research Ethics Committee of the study university, as well as by the National Department of Health, the management of the research setting, and participants through informed consent (see annexure 6: Informed consent, pg. 99).

The researcher was aware of her position in the research and took every measure to decrease the possibility of data contamination, bias as well as maintaining confidentiality and anonymity of participants. (Henning et al., 2004: 72). Interaction with the participants was through an advanced psychiatric nurse as a data collector.

The participants were fully informed about the research by the data collector and given an assurance of confidentiality of their names and recordings and sensitivity were protected during the interview (Henning et al., 2004: 72). The researcher explained to them that their responses would remain anonymous and confidential with number codes where the link was only known by the data collector (Kumar, 2005:131). These codes were used when transcribing (Kumar, 2005:131). To decrease the possibility of linking information to the participants, the data collector pre-coded recordings before handing the voice recordings to the researcher. From the information obtained by the data collector it was not possible to directly identify any of the research participants. All recordings were only available to the researcher; supervisor and co-supervisor, with transcripts being coded and after transcription and verification, the recordings were deleted from the voice recorder (American Nurses Association, 1996:10).

The respect for autonomy was ensured through the provision of the correct information about the study in the information sheet (see annexure 4: Information sheet, pg. 95) (Kumar, 2005:131). The right to choose was guaranteed to the participants and potential participants through the option to participate in the research study and the right to withdraw at any time with no negative consequences in or out of the workplace (Kumar, 2005:131). The purpose, benefits and risk of the research was fully discussed with the potential participants prior to agreement to participate (Coughlin, Beauchamp and Weed, 2009:117). Information provided underwent member checking to ensure accurate reflection of disclosed information (Coughlin et al., 200:117).

Beneficence/non-maleficence in this study was that participants were protected by the use of coding of transcripts, the data collector choosing who to call and thereby, not having their

identity exposed. This recognized their right not to be harmed (Kumar, 2005:131). Further, beneficence was ensured by the researcher obtaining permission and support from the gatekeepers as well as the participants (see annexure 2: Permission for gatekeeper, pg. 89 and annexure 6: Informed consent, pg. 99). In addition to ensure non-maleficence the data collector included the members for checking for accuracy as a true reflection that no harm came to them (Fouka, and Mantzorou, 2011: 4). The beneficiaries of the research are the community, that is, the postnatal mothers using the health facility as well as the health facility involved, because it could help the health facility to introduce an improved health policy that might prevent and reduce maternal and neonate mortality.

Justice in this study signifies that all the participants in this study were obliged to be treated fairly and equitably before, during and after the research study and was achieved by fair selection of the study population (Kumar, 2005:131). The conduct of the researcher was honest, fair and transparent as validated through research supervisor and co-supervisor checking transcripts. Selection of potential participants was based on the criteria as set out in the methodology of the study. The researcher was honest in the transcriptions as well as about the limitations of the study. To prevent bias of data and to decrease the need for bracketing in the initial phases the researcher selected a competent advanced psychiatric nurse who treated the participants fairly (Coughlin et al., 2009: 85). It is recognized that bracketing occurred for the researcher in the transcription and analysis. To meet this requirement, the research supervisor and co-supervisor were given copies of the audio-recordings and transcriptions to note for any personal influences over the analysis.

Veracity in this study was to tell the participants the truth and that they were not to be deceived about any aspect of the research procedure (Coughlin et al., 2009: 85). Veracity was achieved when first meeting the potential participants and explaining the research, Fidelity was also put in place to foster a trusting relationship, meaning that the researcher recognized the inconvenience to the participants for participating in the study and they were each compensated with a gift by the researcher (see annexure 8: Transcription of recordings, pg. 105).

The principle of voluntary provision of information was observed. No participant was forced to give information. Informed consent is an ethical requirement that was ensured before the midwives could participate in the study (see annexure 6: Informed consent, pg. 76.) (Hulley, Cummings, Browner, Grady, and Newman 2007:228).

Prior to obtaining consent the researcher ensured that the participants had an understanding of the research topic, and the research focus and they were given time to consider participation and an opportunity to ask questions. The potential participants received a verbal explanation of the study from the researcher and were provided with an information sheet (see annexure 4: Information sheet, pg. 95). The researcher ensured that the privacy and anonymity of the participants was protected (Hulley et al., 2007: 229). Also the researcher did not know the names of the respondents who had been coded by the data collector, and in addition coding was used when transcribing the tape recordings. The risk of participation in the study was considered low and only linked to disclosures, but harm was prevented through the recognition and implementation in research principles as stated above.

Preparation was made in the event of unforeseen circumstances or inconvenience experienced by the participants in collecting data, such as sickness, accident or a strike action. The planned provision was for the interview to be postponed until a more suitable date, time and venue that was agreed by the researcher, data collector and the participant/s unless the participant/s was no longer interested in taking part in the interview. It was accepted that the participants were free to withdraw without any fear or favour. Therefore new participants would be chosen, explained as to what the research was about, obtain written consent and a new arrangement was to be reached to carry out the interview. This was not necessary for this study as no eventualities occurred.

3.10 DISSEMINATION OF RESULTS

The print and digital version of the research will be sent to research university's library for reference purposes and to assist students who are doing research on postnatal care. Compiled research reports were distributed to all involved in the research settings as well as the Department of Health. Should any publication arise from this study the stipulations of the selected journal will be followed.

3.11 SUMMARY OF THE CHAPTER

This chapter has served to provide information on the qualitative methodology used to guide this study. The social constructivist paradigm, qualitative approach as well as the exploratory, descriptive study design, population and two-part sampling procedure involving convenient and purposive sampling, and the research setting of a level one hospital have been presented. The data collection instrument of an interview guide has been described and the extent to which the measurement is credible was displayed. Ultimately, the discussion of the data collection procedure, data analysis, and ethical considerations and data management closed this chapter. This leads to chapter four which presents the data analysis and interpretation of the dissertation.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.1 INTRODUCTION

The preceding chapter of the study explained the research methodology used in the study. This chapter begins with a presentation of the implemented analysis process. This is followed by a description of the participants, followed by the findings of the study with links to current research findings. Analysed data is presented according to the study objectives and contains extracts from transcribed raw data to illustrate categories and sub categories.

4.2 THE PROCESS OF DATA ANALYSIS

The data analysis process was presented in Chapter three (point 3.8.1, pg.29). The inductive approach of content analysis by Elo and Kynas (2008:107) was used because it is a systematic technique for compressing many words of text into fewer content categories based on explicit rules of coding. The process of the analysis consists of three phrases: preparing, organizing and reporting data (Elo and Kynas, 2008: 107). The researcher initially transcribed verbatim from the audio recordings of each interview, immediately after each interview, in this way the researcher became familiar with the raw data. The researcher then became immersed in the data by reading and re-reading several times through the transcribed data, before analysis.

Significant statements relating to the objectives in particular: midwives' perception of post-natal maternal care, midwives' responsibilities in postnatal maternal care, factors facilitating/hindering the midwives' role in providing effective post-natal maternal care, were identified and placed into categories and sub categories (see table 1: Objectives, categories and sub-categories, pg.37).

The codes were compared based on similarities and differences and sorted into a set of six categories and nine sub-categories, which were then reviewed by the researcher's supervisor and co-supervisor in order to ensure both accuracy and objectivity (Silverman, 2002: 7).

Table 1: Objectives, categories and sub-categories

OBJECTIVES	CATEGORIES (C)	SUB-CATEGORIES (SC)
Objective 1 To describe midwives' perception of post-natal maternal care.	Category 1 – The care is good, But....	Sub-category A: Yes we know the guidelines
		Sub-category B: Paper work vs Patient
Objective 2 To describe midwives' responsibilities in postnatal maternal care.	Category 2 - General responsibilities of the Midwife	Sub category A: Teaching and supervision
		Sub-category B: Post discharge advice and care
		Sub-category C: Midwives responsibilities
	Category 3. – Other people involved in Postnatal Maternal Care.	Sub-category A: Reliance of Support.
Objective 3 Factors facilitating/hindering the midwives' role in providing effective post-natal maternal care	Category 4 - Positive factors that facilitate midwives' role in providing effective post-natal maternal care	Sub-category A: Language factor
		Sub-category B: Team work
	Category 5: Negative factors that hinder midwives' role in providing effective post-natal maternal care	Sub-category A: Shortage of staff
		Sub-category B: Shortage of equipment

4.3 PRESENTATION OF FINDINGS

The presentation of findings for this study which includes; the participants' demographic, objectives, categories and sub-categories are presented next.

4.3.1 Demographic characteristics of participants

Eight registered midwives participated in the study. Seven midwives were qualified with a diploma in midwifery and only one was a degree holder amongst the eight participants. The youngest midwife was thirty years, while the oldest midwife was forty-three (43) years old. The average age was thirty-seven (37) years. The years of experience as a midwife ranged from

one year to nineteen years with the average being six years. The majority eight participants had obtained their midwifery experience in the unit, with the average being four years.

4.3.2 OBJECTIVE 1: To describe Midwives' perception of post-natal maternal care

Four of the participants stated that post-natal maternal care is rendered according to the National Department of Health Guidelines for Maternity Care and that post-natal maternal care is good and of an acceptable standard. However, participants' comments revealed concerns over possible neglect to patients due to time spent with administrative functions, specifically paperwork.

Category 1 – The care is good, But....

Sub Category A: Yes, we know the guidelines

Participating midwives reported postnatal maternal care, specifically midwives' interventions and collaboration with doctors, in level one hospital reflected National Department of Health guidelines (NDoH, 2011:6). Participants were specific in describing their actions related to specific hospital protocols that related to admission, referral and discharge as well as midwives' actions to facilitate continuous assessment and avert a crisis.

“So far (uh), I don't see a problem, especially, after I will start talking post normal vaginal delivery of the mothers but (hem...) According to DoH guidelines, postnatal maternal care is that if a mother deliver normally and there are no problem, she needs to be checked after 6 hours to see if she is fit to go home so, so far we've been adherent to that guideline. (P1:1A).

“...should, may we come across any problem during the checking, postnatal checking's, they get to be seen by the doctor, and nursed accordingly” (P1: 1A)

“And with regards to post caesarean mother they are kept up to 3 days, depending on their conditions as well, problem they came with, depending on what nursing management they would be giving, or interventions that would be done to them, or if they are ok, then they are discharged home by the doctor, they need to be checked by the doctor, checking the wound, checking the bleeding, checking the uterus contractions, and checking their babies then they are discharged home”(P1:1A).

In line with the National Department of Health (NDoH, 2011:6) postnatal guidelines that opine that the postnatal health care program is a set of actions and services administered to aid women after delivery. The above findings in this study corroborate with the Department of Health guidelines. The Department of Health guidelines make provision for postnatal care services and how they should be located in every hospital in South Africa (NDoH, 2013:4).

Sub-Category B: Paper work vs. Patient

While participants considered the post-natal maternal care, which they provided to their patients, to be good and of an acceptable standard, nonetheless, their comments indicated some concerns. Changes in service provision, specifically the administrative role of the midwife, were reported as affecting the availability of the midwife to care adequately for the mother.

“they’ve introduce a lot of things, a lot of paper work, which is taking us away from the patients most of the time and seemingly we are concentrating more on paper work rather than the patient, so the patient gets neglected sometimes” (P4:1B).

“making it difficult I think is paper work, paper work unfortunately it has to be done but paper works sometimes make us not to be able to give quality or proper patient care” (P5:1B).

What emerged clearly from the excerpt is that in this level one hospital, the participants perceived postnatal maternal care as not being flawless. The participants were aware of the change in the locus of care which had detracted from their ability to provide the desired level of postnatal care. Yet despite the level of awareness, the paperwork took precedence over the patient and practice requirements. Christensson and colleagues (2006:58) described similar concerns in a Mozambique study of perinatal practices where interaction with the mother was inadequate and best practices were not implemented. Whilst in Matsuoka et al., (2010: 258) Cambodian study, decreased post-natal care was not unfamiliar and existed as a barrier to mothers accessing maternal health services.

4.3.3 OBJECTIVE 2: To describe midwives’ responsibilities in postnatal maternal care.

In health care settings, roles are assigned according to a nurse’s qualifications and scope of practice. Maternal postnatal care assigns numerous roles to a midwife, but in the maternal postnatal care services of the study setting, there were specific roles that the midwives expected

of themselves to perform. They indicated their role to include; supervision of junior categories of staff, specifically students, and non-specialist nursing staff to make sure that appropriate care and services are rendered to the post-natal mother. They made a distinction between general responsibilities that could be implemented by a student or general trained nurse, and midwives' responsibilities. Within their responses was the perception that they were responsible to ensure that the students and or general trained staff were confident to perform required activities.

Category 2 - General responsibilities of the Midwife

Sub Category A: Teaching and supervision

Participants referred to general nursing responsibilities that did not require a specialist, while emphasizing their role in training, and overseeing that these nursing activities were carried out correctly.

“Yes, we also supervise staff nurses when they are checking the wounds” (P2:2A).

“there is some time, the student midwives, because we've got student here, they come as sister, they are sister, I orientate them on what to do when we are bringing the baby to the mother, like checking the ID bands” (P2: 2A), ...before you give the mother, if the mother corresponds with the mother, so that you don't give the wrong baby to the wrong mothers. So it is also done by midwives, and student midwives supervised by the midwives” (P2:2A).

“Then we also teach them how to wake up on the bed, because they've got fresh scar, when they go out, they already know how to wake up, just to wake up, just to lie on the side first, and then stand up, not vigorously. (P2:2A) ...So we teach them all of that, then we go to the taking of medication, because usually we discharge them with oral antibiotics just to treat infection and pain killer” (P2:2A).

Based on the above participant responses, the midwives engaged in teaching the student-midwives on how to render quality care service to mothers in the postnatal ward. The midwives engaged in teaching the mothers on various broad aspect of maternal health that would improve their general health post-discharge. Dempsey, Wojcrechowski, McConville and Drain (2014: 517) stated that patients' experiences play an increasingly critical role in quality

outcomes with midwives tasked with teaching and supervising the student-midwives in performing their roles to improve maternal postnatal care.

Sub-category B: Post discharge advice and care

Participants also perceived their role as extending beyond immediate physical care of the maternal mother, and beyond discharge.

“But I think it doesn’t end, it doesn’t because if the mother is discharged they still come back with problem and we have to attend to them” (P3: 2B).

“like health education, family planning, give them all the types of family planning, we have because this hospital doesn’t offer any, we don’t offer family planning here, what we do is just give you ideas, we just give you all the types, injectable, tablets, IUCD, all the type of family planning, then what we do is we refer you to your local clinic” (P6: 2B).

All participants agreed that they give health education to mothers, related to care of self and the baby when they are home, before discharge from the hospital; this was reflected in the statement below by a participant:

‘...(eem) we encourage them to mobilised, because that helps with the healing, and we encourage them to eat proper diets, because it helps with the healing and (uh...) production of milk, hygiene, (uuh) what else (she laughs) maternal health, it is important to go to clinic because when we discharge them we tell them to go to clinic after 3 days, so they have to go for check-up for the mother and the baby” (P3:2B).

Despite evidence of discomfort in talking about sexual intercourse post-delivery one participant mentioned the provision of this information upon enquiry from the mother as opposed to provided routinely:

“Yeah... (She laughs) you do talk about a lot of things. You talk about sometimes like thing like because some of them do ask so when should I have sex (she laughs) when should I have sex (she laughs)” (P4:2B).

Post-discharge advice included considerations of HIV status

“...if the mother is HIV positive, we tell them that we’ve done the PCR because we do the (buhm..) PCR at birth,... and then we tell them at 6 weeks when that take the baby

to the clinic, they should be performing a PCR again, and 18 months they should be asking for the result of that. We also emphasized the exclusive breastfeeding, or formula if they opted because we do get those who opt for formula and when to introduce the liquid on the baby, and then since we give them NVP and then we tell them when they automatically it shouldn't because it 100ml but should something happen or drops or whatever, then they can go to their local clinic to get another dose again”(P4.2B).

The participants highlighted the inclusion of numerous activities in the performance of their daily activities to render postnatal care to the mothers. MacArthur (2011: 5) recognises the main role of maternal postnatal care to include: promote and monitor the physical and psychological health of the mother, ensure the establishment of successful infant feeding and monitor various aspects of infant health as well as to foster the development of good maternal-infant relationships. This care extends to that of the newborn and for a period of six weeks post discharges (MacArthur, 2011:5). In line with the participants' responses, Gunn et al., (2013:3) state that during the period after childbirth a routine examination of the abdomen, blood pressure, perineum, vaginal, pelvic floor and breasts is usually carried out.

It is significant to note that the two greatest contributors to postnatal maternal mortality are postpartum haemorrhage and puerperal sepsis (WHO, 2014:58); yet in the presence of premature discharge, prevention, identification and emergency management thereof they were not routine nodal points of discussion. These conditions are possibly nebulously incorporated in the mention of the three-day checkup and antibiotic “cover”. In reference to sexual activity post-delivery reference is seemingly not provided to the mothers in relation to the cautions to be exercised in the presence of an episiotomy - clearly mentioned in the NDoH Guidelines for maternity care in South Africa, (NDoH, 2015:169). It is significant that HIV is acknowledged, however regardless of the substantial attention provided to this condition and its contribution to maternal mortality in the National Department of Health Guidelines on Maternity Care in South Africa (2015), discharge advice is focused on the newborn. Possibly this can be explained by task shifting to HIV counselors (P3.3A).

Sub Category C: Midwives responsibilities

The data of this study category shows that despite having general duties, some duties were perceived by participating midwives as specifically for the midwives to perform.

'but we as midwives, we give IVI meds to patients. (P2:2B).

“we check their, we do vulva swabbing, we check the bleeding, how is the bleeding, is it moderate, is it not (huh) normal one so that we can call the doctor to come and see if it is PPH (postpartum haemorrhage) or whatever, we involved the doctor there, and also another thing which we check is the wound site (P6:2B).

Unlike the discussion earlier pertaining to omissions in discharge advice, whilst the mother is *in the unit* the participants recognised their specialist activities. Lohse (2012:53) agrees that the midwife specialises in providing health care services to women after delivery. The findings of the study indicate that mothers whilst receiving post-natal care in the unit are observed for potential risks that could contribute to maternal mortality.

Category 3 – Other people involved in postnatal maternal care

Sub-Category A: Reliance of support

Some of the participants agreed that support is also drawn from other people such as the HIV Counsellors, social workers and physiotherapists in postnatal maternal care as stated below:

“We have the counsellors they also go to the mothers and help them, then they do the CD4 counts if the mothers are HIV positives and they do follow ups” (P3:3A).

‘If there is like may be a social problem, we do involve social worker as well, we work with them a lot because if they are social problems, we have to refer those cases to the social workers for assistance or for whatever interventions that need to be done to those cases (P1:3A).

‘Those one are done by those people who do Physio, if you find out that the patient has got a problem which doesn’t need medication, but she needs physio, we need to call a physio therapist to come and exercise the patient and so that the patient can go a little, because some time you give antibiotics is not going away is a not or nil problem, she need exercise that would be done, we call those physio people to come and do that to the patient” (P7:3A).

According to Safe Motherhood Initiative, (2013: 44) and Spence, Zhu and Read, (2016:656) agree that midwives can obtain reliable advice through referral to other health care professionals who were trained to handle complications displayed by mothers, such as: HIV Counsellors, Social Workers, Physiotherapists, Psychologists and Medical doctors. The National Department of Health, (NDoH, 2015:175) confers that professional communities are an influential source of support that can produce significant insight and contributions over time to the development of their services to their patient – a system that will be especially helpful to newly qualified inexperienced midwives.

The midwives not only identified their post-natal responsibilities, but they also reported factors that facilitate/motivate them to render postnatal care, and those that hinder them from carrying out their responsibilities. Participants' comments are presented in two categories: positive factors and negatives factors.

4.3.4 OBJECTIVE 3: Factors Facilitating/Hindering the Midwives' Role in Providing Effective Post-Natal Maternal Care

Category 4 - Positive factors that facilitate midwives' role in providing effective post-natal maternal care

The data from the study revealed that language and team work were the factors that contributed to the effective implementation of midwives' duties:

Sub- Category A: *Language factor*

The participants of this study reveal that access to the local language is among the factors that facilitated their duties in the level one hospital. The findings reveal that most of the midwives are isiZulu speakers, as are the majority of the level one hospital users, which facilitates healthcare delivery:

“What makes it easy is, I think most of the time (um...) the clients that come here, the patients are Zulu speaking patients so it is easy to explain and to educate them” (P3: 4A).

Sub-Category B: Team Work

According to the midwives, they work as a team; helping one another and “covering the ward” for one another which in this face of unity makes their duties appear easier. The participant’s emphasis that:

‘What makes it easy is that we work as a team. If you are working as a team, you don’t leave things unattended, because as you are delegating, you are also supervising as a midwife, you are also working, so the job become very easy, if you’ve got that team spirit’ (P2:4A).

“we go extra mile, if they are many we increase also speed, we work together, sometime it doesn’t mean if that sister is allocated, she is the one, when they are many we go as a team, to help” (P7:4A).

The findings indicate that, the midwives worked as a team and confirmed that language (both parties being able to communicate in local dialect) played a significant role in assisting midwives to accomplish their jobs (Lubbock and Stephenson 2008:75). The healthcare workers took the initiative to work collegially as a team in order to render care to mothers post-delivery. Thomas and Taiwo (2014:157) agree that teamwork among the midwives improves the quality and safety of patient care and the quality of teamwork brings about positive outcomes in the health care facility.

Category 5: Negative factors that hinder midwives’ role in providing effective post-natal maternal care

Participants reported factors like shortage of staff, bed space and equipment as seriously affecting their work performances in the level one hospital.

Sub Category A: Shortage of staff

The participants for this study identified the shortage of staff members as among the factors that hindered them from adequate performance of their duties. The participants have this to say:

“we are short staffed, sometimes we don’t do everything we are supposed to do because we have a lot to do and so we usually end up rushing of other things’ (P3:5A).

“...the staff is not enough for us to provide quality care, or to give a proper care, and education because we want to push, to push in other for them to go” (P5:5A).

“...but sometimes we finding it difficult because the nurses are not enough, the quality of patient-nurse ratio is not enough, because in postnatal ward, there is a lot of things that we do, so it need a lot of people like” (P7:5A).

Despite the one-to-one interviews commencing with the midwives expressing content with the level of care delivered, as the interviews progressed they admitted to care not being of an optimal standard. The lesser staff quotas caused the staff to work under pressure, almost on a daily basis.

Sub-Category B: Shortage of Bed/Space

Shortage of equipment, and more specifically hospital beds, resulted in restrictions in admitting patients and premature discharge practises, as illustrated below:

“...sometime you find out that the mother is like sleeping in awkward position because they are trying to run away from this baby now, but if we have space where we can push in cots or crimps so that when the mother is sleeping, at least the baby is sleeping (P4:5A).

“...sometimes we end up not having enough space for those mothers to sleep especially the new ones” (P1:5A).

The responses about factors hindering the midwives’ ability to execute their role hinged on factors beyond the confines and control of the midwife in the unit. The findings highlight factors prohibiting the smooth delivery of the midwives’ responsibilities. Mothers are sent home not because they are due to go home or that they want to go home, but because the demand for bed occupancy exceeds the bed space available. This missing structure standard influences patients who need post-natal care services, not receiving adequate care in this level one hospital and is contrary to the South African Maternity Care Guidelines (2015:169) and International postnatal guidelines (WHO 2015a:61). The WHO (2015a:61) advises midwives and other health care providers to ensure that healthy women and their newborns stay at a health

facility for at least 24 hours and are not discharged early. Moreover, the WHO (2015a:61) suggests that discharge is acceptable only if a mother's bleeding is controlled, mother and baby do not have signs of infection or other diseases, and the baby is breastfeeding well (WHO, 2015a:62).

The prohibiting factors are in accordance with Navaneetham and Dharmalingam (2014:1849) who advise that the factors that determine the level of utilization of post-natal maternal health care services is not only associated with the issues around reproductive, socio-economic, cultural and program factors; rather it also includes the type of health service available to the users.

With regards to the National Core Standard; Domain No. 5, Access to care, and competencies are essential to the smooth running of any organizational structure. In the healthcare sector core standards and competencies give effect to and are interlinked to the quality of service provision (NCS, 2011:5). In the setting they were guidelines in each unit.

4.4 SUMMARY OF THE CHAPTER

Three themes obtained from the content analysis of the participants' responses were: midwives' perceptions of post-natal maternal care, midwives' responsibilities in post-natal maternal care and factors facilitating/hindering the midwives' role in providing effective post-natal maternal care. It is evident that some of the postnatal maternal care practices occurring in the select level one hospital do not go hand in hand with international and national postnatal maternity care guidelines, created in an effort to safeguard mother and child during and after delivery (NDoH, 2015:163, WHO, 2015a:64).

Thus, the findings unveiled some gaps in the activities in the hospital which inhibit the provision of quality postnatal maternity care to the communities it serves. The next chapter provides, the summary, discussion, conclusions and recommendations of this study.

CHAPTER FIVE:

DISCUSSION OF RESULTS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

The study commenced with recognition given to South Africa's international commitment to reducing maternal mortality. In this attempt, the study was driven by its purpose of improving maternal health outcomes through the description of hospital based midwives' perceptions of their role within maternal postnatal care in eThekweni, KwaZulu-Natal. Three objectives were met using a qualitative approach involving face-to-face interviews, which were analysed through content analysis, arriving at five categories. The discussion of the findings, recommendations and limitations are presented in this chapter.

5.2 DISCUSSION OF THE FINDINGS

In discussing the findings, it is vital to note that globally maternal mortality is unacceptably high. The WHO (2015c) estimates the global daily count of women dying from pregnancy and childbirth related complications is about 830. Annually in Africa a minimum of 125 000 women die in the first postnatal week (Warren, 2015:1). The 2010 World Health Organization report stated that the only viable solution to prevent unnecessary deaths during and after pregnancy is to offer adequate maternity care (WHO, 2010:21). Internationally, maternal mortality and morbidity represents one of the biggest challenges to public health, particularly in low and low-middle income countries (WHO, 2015c:260).

At the turn of this century the international adoption of the Millennium Development Goals (MDGs), in particular MDG five recognised not only that maternal mortality needed to decrease by 75%, but that this reduction was proposed to be achievable by 2015 (UNFRA, 2015: 81). Unfortunately, in 2015 the proposed MDGs were not achieved and this led to the transition and replacement by the Sustainable Development Goals (UNFRA, 2015:81). In particular, MDG 5 was replaced by SDG 3, which is aimed at ensuring healthy lives and promoting well-being for all, at all ages and reducing the global maternal mortality ratio to less

than 70 per 100 000 live births (UNFRA, 2015: 81). South Africa's alignment to the international health agenda is reflected in a number of policy documents.

The National Core Standards (NCS) Domain No. 5 emphasizes that access to care and competencies are essential to the smooth running of any health care institution, which are interlinked to the quality of service provision (NCS, 2011:5). The NCS bring into the spotlight questionable maternity practices in their requirement of the reduction of unintended harm to health care users who are identified as cases of greater clinical risk (NCS, 2011:5). In addition, the NCS require the prevention and management of problems or adverse events, including health care associated infections (NCS, 2011:5). Chapter ten of the National Development Plan in relation to maternal health has its goal, an increase in life expectancy and decrease in maternal mortality from 500 to less than 100 per 1000,000 live births (NDP, 2014:298). More explicitly the South African Maternity Care Guidelines (NDoH, 2015) in keeping with the principles of a guideline provide clear direction to midwives caring for postnatal mothers.

The National Maternity Care Guidelines for Maternity Care (NDoH, 2015) is an example of a well laid out document that serves as an ideal blueprint to help midwives to render quality health care services to mothers. These guidelines if followed explicitly could offer a valuable contribution towards decreasing maternal mortality. Spence (2016:656) emphasized that adherence to nursing policies, guidelines and supportive professional practice behaviour among midwives, acts as an important mechanism that influences quality patient care, treatments and prevents postnatal complications which may lead to maternal mortality. However, consideration needs to be given as to how these guidelines can be converted into nursing actions. The consumers of healthcare (mothers) may suffer the adverse effects of health personnel (midwives) who operate without evidence of implementation of guidelines and standards.

5.2.1 Midwives' perception of postnatal maternal care

The study showed that the midwives in the *in-patient* setting were able to follow the Guidelines for Maternity Care in South Africa (NDoH, 2015), but this level of service delivery was not consistent with the extension of care into the discharge setting with mothers being discharged earlier than suggested (NDoH, 2015). It is concerning that the midwives perceived that they were adherent to the South African Department of Health Maternity Guidelines (2015), but

complained about concentrating more on paper work than patient care - not part of the maternity care guidelines (NDoH, 2015), and paper work has been shown not to improve care (Cain and Haque, 2014: 31;Clark and Hankins 2012:360). Paper work demands superseded and compromised patient care outcomes in the setting.

There are various possible explanations for this selective adherence to guidelines. Chatfield et al., (2013:140) recognized that the implementation of the ideals in guidelines is often thwarted by competing priorities. Further explanation is provided by Grol (2001:46) who suggests that there are two major barriers to guideline adherence by health care practitioners. The first barrier identified by Grol (2001:46) is that bulky paper manuals are likely to sit on the shelf and go by unused; secondly, guidelines do not allow for easy access when the provider wishes to pinpoint suggested deliverables. It is questionable if this is applicable in the setting, where guidelines were audited to be available, and that routine postnatal care is a small chapter in the guidelines; being the last chapter it could be seen as easy to access (NDoH, 2015:162). The South Africa government has adopted an ambitious outcomes-based strategy that seeks to improve the effectiveness in relation to key national objectives.

The formal expression of this is in a national charter of the NDP chapter 10. Furthermore, the Negotiated Service Delivery Agreement reflects the commitment of key sectoral and intersectoral partners involved in the delivery of identified outputs to achieve a long and healthy life for all South Africans (NDP, 2014:296). The vision for promoting health 2030 by NDP Chapter 10 concerning the quadruple burden of disease of which maternal mortality is the first on the list, is to reduce maternal mortality from 500 to less than 100 per 100,000 births. (NDP, 2014:298). Reflection thereof is absent in the midwives' perceptions of post-natal maternal care.

Despite the extensiveness of the role suggested by various authors (Gunn et al., 2013:3; Mac Arthur, 2011:5), the recognition by the WHO (2014:58), the NDoH maternity guidelines (2015:163) and how the participants perceived their role, Gunn et al., (2013:2) argued that the role of midwifery within postnatal care is largely undetermined. Perceptions are traditionally based on routine observations and examinations of both mother and child within a certain period after delivery (Gunn et al.,2013:3). This void of specialist maternity care is evident in the setting. A question can be raised as to whether the midwives have unknowingly adopted this discourse of under-value, regardless of the imminent dangers?

5.2.2 Midwives responsibilities in postnatal maternal care

The study identified gaps in the midwives' responsibility towards their postnatal maternal role. Lohse (2012:53) agrees that the midwife specialises in providing quality health care services to women during and after delivery. This is reflected in the scope of practise of registered midwives according to SANC regulation 2598 as amended which requires the scientific execution of midwifery related acts or procedures in order for the mother to attain optimal physical and mental health. The Midwifery Scope of Practise (R2598) further requires that the midwife prevents puerperium related diseases and promotes health *through teaching and counselling* of the mother and the family as well as *monitors for complications*. Adherence of the midwife to their scope of practice will not only enable the provision of quality maternal care, but also result in the prevention of maternal morbidity and mortality.

In discharging their responsibilities, the midwives ensured that they checked vaginal bleeding of the mothers routinely, and were sensitive *in the ward* to any danger signs that could arise such as postpartum haemorrhage and to be able to treat these (NDoH, 2015:171). However, this was isolated *to their* activities and despite the requirements in the midwifery scope of practise, the knowledge was not transferred to the mothers who were provided with very general postnatal advice, despite their premature discharge. Postpartum haemorrhage and sepsis are leading contributors to postnatal maternal mortality (WHO, 2014:58). Globally postpartum haemorrhage is responsible for an estimated 127 000 deaths annually (WHO, 2012a:15). Postpartum hemorrhage can pose as an obstetric emergency up to six weeks post-delivery; similarly, the signs of sepsis need to be identified early (WHO, 2014:58). These remain exceptionally unaddressed in developing countries (Mazia et al., 2009:269), which is concerning as they are preventable. Of added concern is South Africa's high HIV prevalence, where women living with HIV are at a greater risk of postpartum haemorrhage and sepsis (Sebitloane and Mhlanga, 2007:495). This underlines the need for comprehensive maternity focused health education, with the acknowledgement of HIV, as a measure to prevent maternal mortality and morbidity.

Simultaneously as the maternal mortality and morbidity is spotlighted so too is the quadruple burden of disease. The health transition that South Africa finds itself in is characterized by a quadruple burden of disease, faced with a heavy burden of perinatal and maternal disorders, striving to reduce perinatal and maternal mortality in 2030 (NDoH, 2013:934). The midwives'

discussion about their perception of practise and role appeared to under recognise the space that HIV needed to occupy.

The role of postnatal intercourse in maternal mortality cannot be ignored, yet the discomfort by midwives to engage this topic in conversation was evident. After childbirth the vagina wall usually appears oedematous and may have small lacerations incurred during delivery, hence mothers should wait for about 6-8 weeks to resume sexual intercourse (Anzaku and Mikah, 2015:210). Early sexual intercourse after childbirth may eventually lead to urinary tract infection, puerperal sepsis or other sexual morbidity which could lead to obstetric shock or even death (Anzaku and Mikah, 2015:210). Emphasis on sexual and contraceptive education during the immediate postpartum period is therefore imperative and ways for nurses to address their discomfort in discussing the topic need addressing.

Ideally the mothers need to feel comfortable with accessing the maternity services when there is a problem. Various authors (Somefun and Ibisomi 2016:5; Chimanka and Sahoo 2011:12; Matsuoka et al., 2010:255) concur that low utilization of post-natal maternal health care services is due to a number of factors, such as; partner support, previous maternal health care experiences, lack of knowledge about postnatal care, long waiting queues, long walking distance to hospital and the level of poverty experienced by the mothers (Titaley et al., 2014:7). All need to be given consideration in the research setting in the light of premature discharge and the incumbent risks attached.

The World Health Organization (WHO, 2015b:260) emphasizes that the days and weeks following childbirth, namely the postnatal period, are a critical phase in the lives of mothers and newborn babies, and that appropriate attention should be made available to the mothers at this crucial period – lacking in specificity for the post-discharge period in the research setting.

5.2.3 Factors hindering/facilitating the midwives' role in providing effective post-natal maternal care

Earlier it was identified that administrative demands could interfere with patient care delivery. The American Hospital Association (AHA, 2014:3) emphasized that paper work adds at least 30 minutes to every hour of patient care provided, which in its cumulative effect results in a burden that is simply too heavy, at the expense of patient care. Therefore, maternal mortality

might increase due to a shift in the midwives' focus to administrative demands, hindering the attainment of SDG three in 2030.

An additional interference with optimum care being provided was the premature discharge of mothers due to the shortage of bed space. International and national documents advise that midwives and other health care providers ensure that healthy women and their newborns stay at a health facility for at least 24 hours and are not discharged early (NDoH 2015; WHO, 2015a:6). Earlier studies were already showing that 60% of maternal deaths happen within 48 hours of childbirth (Lewis, 2003:67), yet it remains the subject of concern today regarding maternal health care deliverables. Early postnatal discharge inhibits postnatal care which is focused on routine observations and examinations to monitor physical recovery from birth, leading to undesirable outcomes (Malkin, Garber, Broder & Keeler, 2010: 183). Early discharge may prevent quality care to mothers that may further lead to potential postpartum complications such as postpartum haemorrhage, puerperal sepsis and maternal mortality (Malkin et al., 2010: 183).

Furthermore, the midwives highlighted the shortage of staff as hindering themselves from providing quality postnatal care to mothers. According to Gerin, Green and Pearson, (2006:40), in a situation of staff shortage in the health care facilities, midwives or other health care practitioners may experience increased workloads and job dissatisfaction, and may have to undertake tasks for which they are not trained. This research setting is no exception.

Moving to the factors facilitating the midwives in providing effective postnatal maternal care to mothers, it is recognized that despite the shortage of staff, team work amongst the midwives was evident as a major factor facilitating maternal postnatal care. According to Thomas and Taiwo (2014:157) the midwives in health care facilities work together as a team to provide quality health care to the mothers, as they chose to work not as an individual but as a team with other co-workers. Teamwork among the midwives has a potential to improve the quality and safety of care provided to mothers and facilitates the achievement of NDP 2030 vision, chapter ten (NDP, 2014:298).

An additional factor facilitating quality maternal postnatal care is communication in the same language. Effective communication could be a bridge linking information to health literacy,

knowledge and awareness for shared decision making, particularly within maternity user satisfaction (Frayne, Burns and Hardt, 2012:40). The midwives confirmed that same language spoken by both midwives and mothers (isiZulu language) enabled them to communicate fluently with one another. Earlier studies by Watson and Kimberly (1997:37) maintain that poor communication has led to a lack of efficiency in rendering quality care to mothers. Lubbock and Stephenson (2008:75) discuss good communication playing a significant role in assisting midwives to accomplish their jobs and produce good results in their service provision to mothers. Given the above midwives response regarding same language communication which enables them to carry out their job efficiently, questions are raised: will the same quality of postnatal care be provided to non-isiZulu speaking mothers and will it lead to inequalities in quality service provision among mothers who speak languages other than the core spoken language? This might also contribute to maternal morbidity, mortality and slow down the attainment of NDP 2030. Therefore, midwives who are fluent in other languages should support other midwives in interpretations of other languages.

The disciplinary action from the South African Nursing brings to the fore the need for midwives to advocate the process of providing support, referral, liaison, representation and protection of the interests of mothers who may or may not be aware of the need or are unable to coordinate or arrange health care for themselves. It is obligatory that midwives adhere to rules, guidelines, standards and all aspects of relevant legislation (SA, 2005).

The litigation from SANC (Nursing Act no. 33 of 2005) further highlighted that midwives should be responsible for the decisions made in the course of their professional maternal post-natal care to mothers. In addition, midwives should be able to give reasons for the decisions they make in their professional practice, especially their maternal post-natal care role to mothers and should justify their decisions in the context of professional and ethical conduct (SA, 2005). This implies that individuals have competence to make informed decisions and that they should not be coerced or forced during the decision-making process. Furthermore, the midwives should advocate and maintain the strength of human rights e.g. safe motherhood as a human right, informed consent, and continuity of care in midwifery to evaluate and reinforce basic midwifery ethical practice and enforce implementation of the National Core Standard (NCS 2011:5).

5.4 LIMITATION OF THE STUDY

It is commonly known that any scientific investigation has its limitations and strengths. Hence, this study faced mainly methodological issues articulated as follows.

Firstly, this study was conducted in only one level one district hospitals in Durban and as it is not representative of the estimated 37 level one district hospitals in KwaZulu Natal, it therefore may not be extrapolated.

Secondly, the Advanced Midwife who agreed to participate in this study couldn't make it due to some circumstances beyond her control during the data collection she was not available due to some circumstances beyond her control, her expertise and the value of her role would have contributed greatly to the study.

Thirdly, although the data collector was not known to participants and strived to reduce desirability bias through a data collection procedure that ensured privacy, it is likely that participants' responses did not represent their actual perceptions. And fourthly, the major gap identified in the literature review was that it could not describe how midwives perceived their postnatal maternal care role to mothers. However this research has bridged that gap through face to face interview which enable them to describe how they perceived their roles to mothers. The data collected was further analyzed and necessary recommendations were made.

The strength of this study was that the researcher took the initiative to conduct an investigation related to midwives' perception of their roles within maternal postnatal care, an issue which is not only difficult to explore, but is also underexplored due to its sensitivity.

5.5 RECOMMENDATIONS

Based on the results of this study, the following recommendations are made. The recommendations are two-fold: Recommendations for the research setting and recommendations for further study.

5.5.1 Recommendations for research setting

1. The management in collaboration with the Department of Health should provide level one hospitals with more beds in maternity units of health care facilities because the midwives complained of shortage of beds as the reason for early discharge of mothers from the postnatal ward, even when the mothers are not due for discharge. This might prevent early discharge of mothers and quality maternal care service can be rendered to the mothers that might promote good health and prevent morbidity and maternal mortality.
2. The capacity of the health systems needs to be increased through the employment of more professional midwives for the provision of care that meets the postnatal needs of the mothers, as shortage of staff was also identified by the midwives in the maternity unit, that is slowing down their daily routine for the mothers. Adding more professional midwives will contribute to the provision of quality postnatal health care to the mothers which will eventually assist in preventing morbidity and maternal mortality.
3. Creation of a tick off list for discharge planning to ensure pertinent information that will ensure maternal health post-delivery is not omitted in maternity units. This will facilitate quality care in health care facility.
4. Exploration with midwives on their ability to discuss sexuality with the mothers and addressing the difficulties.
5. Measures to be put in place to assess midwives' knowledge, understanding and capacity to implement South African maternity care guidelines such that they are converted into nursing actions.

5.5.2 Recommendations for further study

This study has researched only the midwives' perceptions of maternal postnatal care at a level one hospital, using only midwives from a level one hospital, and one method of data collection. In this regard, a further and larger study is needed to be conducted that could cut across other level one hospitals, examining further the challenges to utilisation of maternal postnatal care in KwaZulu-Natal. In future should this study be repeated, I suggest that the Advanced Midwife Practitioner is included in the participant.

5.6 CONCLUSION

The study's purpose was to describe hospital based midwives' perceptions of their role within maternal postnatal care in a level one hospital in eThekweni, KwaZulu-Natal in order to improve maternal health outcome. In order for the realization of quality care outcomes, namely; decreased maternal mortality and morbidity, structural and process standards need to be in place. The findings and analysis of data in this study revealed that the structural standards of the maternity care guidelines were in place in the maternity units of the study setting, however further structure standards of adequate staffing numbers and availability of beds and equipment were lacking (Chimankar and Sahoo, 2011:12). In addition, maternal postnatal care was hindered by the process standards (Donabedian, 1988:1734). It was concerning that National Guidelines for Maternity Care in South Africa (NDoH, 2015) were selectively adhered to in the postnatal care setting, which is restricted by the process standards of administrative demands and limited postnatal discharge preparation of the mothers by the midwives.

However, same language and team functioning acted as counter measures (Lubbock and Stephenson 2008:75), but questionably strong enough to positively contribute to South Africa meeting its international obligation to cutting maternal mortality (Lawn et al., 2013:891). This study has provided insight into midwives' differing perceptions of postnatal care rendered to mothers, and their current on-going endeavours. It is questionable if these are enough to contribute to the achievement of the Sustainable Development Goal 3 and chapter ten of the NDP (2030) (NDP, 2014:205). Sight must not be lost of the first week post-delivery as a crucial period in the life of the mother (Warren, 2015:1), nor the adoption by midwives in postnatal care of a discourse of under value, such that focused postnatal care can be delivered. The Sustainable Development Goals should not be a pipe dream of global decision makers, but a reality of every service provider as well laid out guidelines of care are converted into nursing actions that allow for the extension of care from the hospital ward into the community.

REFERENCES

- Addisse, M. 2014. Knowledge, Perception and Utilization of Postnatal Care of Mothers in Gondar, University of Gondar. *Maternal and Child Health Care*, 18(10), 2341-2351.
- American Hospital Association (AHA) 2012. Patients or Paper Work. One North Franklin. Chicago Illinois 60605. 1-29. Retrieved from: www.aha.org. (Accessed 18/10/16).
- American Nurses Association 1996. *Nursing Quality Indicators. Guide for Implementation*, American Nurses Publishing, Washington, DC, USA. 10.
- Anzaku A.S, & Mikah S.2014. *Postpartum Resumption of Sexual Activity*; Sexual Morbidity and Use of Modern Contraceptives among Nigerian Women, 4, 210–6. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4653924/> (Accessed 18/10/16).
- Bandolier J. 2007. Evidence Based Thinking about Health Care. *Health postnatal care*, (6), 133-138. Retrieved from: <http://www.jr2.ac.uk/bandolier/booth/hliving/healpona.html>. (Accessed 12/09/15).
- Biggam J. 2008. *Succeeding with your Master's Dissertation: A step-by-step handbook*. Berkshires, Open University Press. (5) 40-48.
- Bloomberg, L. D., & Volpe, M. 2008. *Completing your qualitative dissertation: A Road Map from Beginning to End*. London: Sage Publications, Inc. (3) 80-88.
- Brink H. I., Van der Walt I., & Van Rensburg G., 2014. *Fundamentals of Research Methodology for Health Care Professionals*. 9, 67-98 South Africa: Juta.
- Burns, N., & Grove, S. 2009. *The Practice of Nursing Research: Conduct critique and utilization*. 2nd edition, Cape Town: Juta.
- Cambridge Advanced Learner's Dictionary 2008. 3rd Edition. New York: Cambridge University Press Publishers.1058.
- Cain, C., & Haque, S. 2014. *Organizational Workflow and Its Impact on Work Quality*. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (4), 31-98. Retrieved from: <https://www.ncbi.nlm.nih.gov/books/NBK2638/>, (Accessed 17/10/16).
- Chatfield, A., Caglia, J.M., Dhillon, S., Hirst, J., Cheikh Ismail, L., Abawi, K., Kac, G., Al Dhaheri, A.S., Villar, J., Kennedy, S. and Langer, A. 2013. Translating research into practice: the introduction of the INTERGROWTH-21st package of clinical standards, tools and guidelines into policies, programmes and services. *BJOG: An International Journal of Obstetrics & Gynaecology*, 120(s2), 139-142.
- Chimankar, D. A., & Sahoo, H. 2011. Factors Influencing the Utilization of Maternal Health Care Services. *Uttarakhand*, 3, 12-15.
- Christensson, K., Petterson, K.O., Bugalho, A., Manuela, M., Dgedge, C., Johansson, E. and Bergstrom, S. 2006. The Challenge of Improving Perinatal Care in settings with Limited Resources Observations of Midwifery Practices in Mozambique. *African Journal of Reproductive Health*, 10(1), 47-61.
- Clark, S. L., & Hankins, G. D. 2012. Preventing Maternal Death: 10 *Clinical Diamonds*. *Obstetrics & Gynecology*, 119 (2, Part 1), 360-364.

- Costello, A., Azad, K., & Barnett, S. 2006. An Alternative Strategy to Reduce Maternal Mortality. *The Lancet*, 368 (9548), 1477-1479.
- Creswell, J. W. 2009. *Research Design: Qualitative, Quantitative and Mixed Approaches*. 2nd Ed. Sage Publication: London. 147.
- Dempsey, C, Wojczechowski, S, McConville, E & Drain M. 2014. Reducing Patient Suffering through Compassionate Connected Care. *Journal of Nursing Administration*, 44 (10) 517-524.
- Department of Health 2014. “*Towards Quality Care for Patients*”. National Development Plan Standards for Health Establishments in South Africa. (1) 1-98. Retrieved from: www.kznhealth.gov.za/ndp (Accessed 11/10/16).
- Dhaka, S. G., Chapman, N., Simkhada, P. P., VanTeijlingen, E. R., Stephens, J., & Raja, A.E. 2012. *Determinants of Postnatal Care Use at Health..1*. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4628262/> (Accessed 30/10/2015).
- Donabedian A. 1988. The Quality of Care, How Can It Be Assessed? *Journal of American Medical Association*, 260, 1734-1748.
- Elo, S., & Kyngas, H. 2008. The qualitative Content Analysis Process. *Journal of Advanced Nursing*, 62(1), 107-115.
- Erlingsson, C. & Brysiewicz, P. 2012. Orientation among multiple truths: An introduction to qualitative research. *Africa Journal of Emergency Medicine*, 92-99.
- Filippi, V., Ronsmans, C., Campbell, O. M., Graham, W. J., Mills, A., Borghi, J., & Osrin, D. 2012. Maternal Health in Poor Countries: The Broader Context and a Call for Action. *The Lancet*, 368(9546), 7-8.
- Frayne, S., Burns, R., & Hardt, E. 2012. The Exclusion of Non-English Speaking Persons from Research. *Journal of Internal General Medicine*, 11,39-43.
- Fouka, J., & Mantzorou, M. 2011. What are the Major Ethical Issues in Conducting Research? Is there a Conflict between the Research Ethics and the Nature of Nursing? *Health Science Journal*, 5(1), 3-14.
- Gerin, N., Green, A., & Pearson, S. 2006. *The Implications of Shortages of Health Professionals for Maternal Health in Sub-Saharan Africa*. Retrieved from: [http://dx.doi.org/10.1016/S0968-8080\(06\)27225-2](http://dx.doi.org/10.1016/S0968-8080(06)27225-2) (Accessed 13/10/16)
- Gillis, A & Jackson, W. 2002. *Research for nurses: Methods and interpretation*. Philadelphia, PA: FA Davis. (17), 705-708.
- Guidelines for Maternity Care 4th edition. Dept of Health, Pretoria, 2015, 1-174. Retrieved from <https://www.health-e.org.za/wp.../maternal-care-guidelines-2015> (Accessed 6/02/17).
- Goodburn, E., & Campbell, O. 2010. *Reducing Maternal Mortality in The Developing World: Sector-Wide Approaches may be The Key*. *British Medical Journal*, 322(7291), 917.
- Grol, R. 2001 Successes and Failure in the Implementation of Evidence Based Guidelines in Clinical Practice. *Medical Care*, 39, Suppl 2; 46-54.
- Gunn, J., Lumley, J., & Young, D. 2013. The Role of the General Practitioner in Postnatal Care: a Survey from Australian general practice. *Br J Gen Practice*, 48(434), 1570-1574.

- Haridas, S., Wadde, S., & Surwade, J. 2015 Assessment of Utilization of Various Antenatal Services Provided to Pregnant Women in Rural Area of Maharashtra. *International Journal of Social and Preventive Medicine*, 1(1), 1-7.
- Health-e 2006. *Fact on Maternal Death*. 5, 2-11. Retrieved from: www.health-e.org.za/.../South-Africa-Far-Targets-Reduce-MaternalInfant-Mortality. (Accessed 10/03/2015).
- Health-e 2013. *Fact on Maternal Death*. 5, 1570-1585. Retrieved from: www.health-e.org.za/.../South-Africa-Far-Targets-Reduce-MaternalInfant-Mortality. (Accessed 25/06/16.)
- Henning, E., Van Rensburg, W., & Smit, B. 2004. *Finding Your Way in Qualitative Research*. Pretoria: Van Schaik Publishers. (3), 0-637-02545, 1-179.
- Holloway, I. & Wheeler, S. 1998. *Qualitative Research for Nurses*. Blackwell Science Ltd, Oxford. (2), 33-38.
- Hulley, S. B., Cummings, S.R., Browner, W.S. Grady, G.D.G, & Newman T.B. 2007. *Designing Clinical Research*. 3rd Ed, Philadelphia: Lippincott Williams & Wilking, 228.
- International Confederation of Midwives (ICM), 2014. *International Definition of the Midwife*. The Hague. 1.
- International Council of Nurses (ICN). 2012. *International Definition of the Nurses*. Taipei. 1.
- Krefting, L. 1991. Rigor in quantitative research: The Assessment of Trustworthiness. *American Journal of Occupational Therapy*, 45 (3), 214-222.
- Kumar, R., 2005. *Research Methodology: A Step by Step Guide for Beginners* (2nd ed.). London: SAGE, 131-134.
- Lawn, J. E, Cousens S., Zupan J, & Lancet 2013, *Neonatal Survival Steering Team; reducing neonatal death in South Africa*. Pretoria: Tshepesa press. 365:891.
- Lewis, G. 2003. Beyond the numbers: reviewing maternal deaths and complications to make pregnancy safer. *British medical bulletin*, 67(1), .27-37.
- Lincoln, Y. S. & Guba, E. G. 1985. *Naturalistic Inquiry*. Beverly Hills, CA: Sage.290.
- Lohse, G.L. 2012. A Cognitive Model for Understanding Graphical Perception. *Human-Computer Interaction*, 8(4), 53-88.
- Lubbock, L.A. & Stephenson R.B. 2008, *Utilization of Maternal Health Care Services in the Department of Matagalpa*, Nicaragua. *Revista Panamericana de Salud Publica*,24(2):25-75.
- MacArthur, C. 2011. What does postnatal care do for women's health? *The Lancet*, 353(9150), 5-12.
- Malkin, J.D, Garber, S., Broder, M.S., & Keeler, E.2010. *Infant mortality and early postpartum discharge*. *Obstetric Gynecol.* 96(2):183-8.Retrieved from: <http://www.scielo.br/pdf/reeusp/v45n3/v45n3a30.pdf>. (Accessed 18/10/16).
- Matsuoka, S., Aiga, H., Rasmey, L. C., Rathavy, T., & Okitsu, A. 2010. Perceived Barriers to Utilization of Maternal Health Services in Rural Cambodia. *Health Policy*, 95(2), 255-263.

- Mazia, G., Narayanan, I., Warren, C., Mahdi, M., Chibuye, P., Walligo, A., Mabuza, P., Shongwe, R., & Hainsworth, M., 2009. Integrating quality postnatal care into PMTCT in Swaziland. *Global Public Health*, 4(3), 253-270.
- Mekonnen, Y., & Mekonnen, A. 2011. Factors Influencing the Use of Maternal Healthcare Services in Ethiopia. *Journal of Health, Population and Nutrition*, 374-382.
- Mitchell, P. H., Fedrick, S., & Jennings B.M. 1998. Quality health outcome model: Image. *Journal of Nursing Scholarship*, 30 (1), 43-46.
- Morestin, F., Bicaba, A., De Dieu Sermé, J., & Fournier, P. 2012. Evaluating Quality of Obstetric Care in Low-Resource Settings: Building on the literature to Design Tailor-Made Evaluation Instruments-an Illustration in Burkina Faso. *BMC Health Services Research*, 10(1), 20.
- Moran, N.F., Naidoo, M. and Moodley, J., 2015. Reducing maternal mortality on a countrywide scale: The role of emergency obstetric training. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 29(8), 1102-1118.
- Morse J. M. 1994. *Critical Issues in Qualitative Research*. Thousand Oaks, Sage.
- National Core Standards for Health Establishments in South Africa National Department of Health. 2011. Towards Quality Care for Patients (1-7). Retrieved from: www.amnesty.org/maternaldeath. (Accessed 19/07/2015).
- National Department of Health. 2007. *Saving Mothers*. (2) 10-40. Retrieved from: www.kznhealth.gov.za/savingmothers.pdf (Accessed 2/08/2015).
- National Department of Health 2011. "Towards Quality Care for Patients". National Core Standards for Health Establishments in South Africa, (1) 1-11. Retrieved from: www.amnesty.org/maternaldeath. (Accessed 19/07/2015).
- National Department of Health. 2013. *Saving Mothers*. (2) 15-23. Retrieved from: www.kznhealth.gov.za/savingmothers.pdf (Accessed 2/03/2015).
- National Department of Health. 2013. Strategic Plan for the Prevention and Control of Non-Communicable Diseases. Pretoria: 17, 934-944. Retrieved from: www.kznhealth.gov.za/thequadupleburdenofdisease.pdf. (Accessed 18/10/2016).
- National Department of Health. 2014. *Saving Mothers*. (2) 25-60 Retrieved from: www.kznhealth.gov.za/savingmothers.pdf (Accessed 2/03/2015).
- National Department of Health. 2015. *Saving Mothers*. (5) 171-182. Retrieved from: www.kznhealth.gov.za/savingmothers.pdf (Accessed 2/03/2015).
- National Department of Health. 2016. *National Development Plans*. (5) 205-323. Retrieved from: www.kznhealth.gov.za/ndp.pdf (Accessed 14/10/2016).
- National Planning Commission. 2011. *National Development Plan. Chapter 10. Promoting Health*. 1-444. Retrieved from: www.kznhealth.gov.za/ndp.pdf (Accessed 18/10/2016).
- Navaneetham, K., & Dharmalingam, A. 2014. Utilization of Maternal Health Care Services in Southern India. *Social Science & Medicine*, 55(10), 1849-1869.
- National Planning Commission 2014, National Development Plan, Health Promotion. *South African Health Review Health System Trust* (10) 295-323.
- Okafor, C.B., and Rizzuto, R.R. 2012 Women's and Health Care Providers' Views of Maternal Practices and Services in Rural Nigeria. *BMC Health Services Research*, 1, 1-14.

- Oxford English Dictionaries 2006; 589. Retrieved from www.oxforddictionaries.com (Accessed 12/09/2015).
- Pettersson, K. O., Johansson, E., Pelembe, M. D. F. M., Dgedge, C., & Christensson, K. 2010. Mozambican Midwives' Views on Barriers to Quality Perinatal Care. *Health Care for Women International*, 27(2), 145-168.
- Ronsmans, C., Campbell, O. M., Graham, W. J., Mills, A., Borghi, J., & Osrin, D. 2012. *Maternal Health in Poor Countries: The Broader Context and a Call for Action*. *The Lancet*, 368(9546), 1-12.
- Safe Motherhood Initiative, 2013. (7) 41-46. Retrieved from: <http://www.acog.org/About-ACOG/ACOG-Districts/District-II/SMI-Project-Overview/045963/en/> (Accessed 15/11/15).
- Save Our Soul {S.O.S.} 2014. *What is next after the Millennium Development Goals?* (2) 12-18, Retrieved From: www.soschildrensvillages.org.uk/2014/what.next.after.themillennium.deve...on (Accessed 15/06/2015).
- Sebtloane, H, M., & Mhlanga R. E. 2014. Changing Pattern of Maternal Mortality (HIV/AIDS related). 1. 22, (3), 489-499.
- Schneider, H., & Gilson, L. 2011. The impact of free maternal health care in South Africa. *Health Science Journal*, 2, 1-8.
- Silverman, D. 2002. *Doing Qualitative Research*. A Practical Handbook. Sage: Thousand Oaks. 7.
- Somefun, O. D., & Ibisomi, L. 2016. Determinants of Postnatal Care Non-Utilization among Women in Nigeria. *BMC Research Notes*, 9(1), 1-11.
- South Africa (SA): Nursing Act No.33 of 2005. Retrieved from: <http://www.sanc.co.za/pdf/Nursing%20Act%202005.PDF>.
- South African Department of Health 2013. Department of Health. Retrieved from: www.kznhealth.gov.za/savingmothers.pd. 5. (Accessed 06/07/2015).
- South African Nursing Council. 2014. *Code of Ethic for Nursing Practitioners in South Africa*. Excellent in Professionalism and Advocacy for Healthcare. Users. SANC, Pretoria. Act. No. 56 of 2014. Retrieved from: www.sanc.co.za/regulat/reg.cmi.htm. (Accessed 18/10/2016).
- South African Nursing Council, 2005. Act No. 56 of 2005. Retrieved from: www.sanc.co.za/regulat/reg.cmi.htm. (Accessed 20/06/2016),
- South African Nursing Council, 1974. Act No. 56 of 1974. Retrieved from: www.sanc.co.za/regulat/reg.cmi.htm. (Accessed 20/06/2016),
- South African Nursing Council, 1978. Regulations Relating to the Scope of Practice of Persons Who are Registered or Enrolled under the Nursing Act, 1978. Chapter 3. Retrieved from: <http://www.sanc.co.za/regulat/Reg-scp.htm>. (Accessed 14/10/2016).
- Spence, L., Zhu, J., & Read, E. 2016. Nurses' Perceptions of Professional Practices Behaviours, Quality of Care, Job Satisfaction and career Retention. *Journal of Nursing Management*, 24 (5) 656-665.
- Strelitz, L. 2005. *Mixed reception: South African youth and their experiences of global media*. 5(3)14-68 Unisa: Pretoria: UNISA Press.

- Thomas, K.A., & Taiwo, A.O. 2014. Determinants of Maternal Health Care Services Utilization in Rural Communities of Osun State, Nigeria. *In South Africa International Conference on Education*, 157.
- Titaley, C.R, Hunter, CL, Heywood, P. & Dibley, M. J. 2014. *Why don't some women attend antenatal and postnatal care services? A qualitative study of community members' perspectives in Garut, Sukabumi and Ciamis districts of West Java Province, Indonesia. BioMed Central Pregnancy and Childbirth* 10(61):1–12. Retrieved from: www.biomedicalcentral.com/1471-2393/10/61 (Accessed 4/03/2016).
- Trautner B. W; Kelly P. A; Petersen N; Hysong S; Kell H; Liao K. S; Patterson J. E & Naik A. D. 2011. A hospital-site controlled intervention using audit and feedback to implement guidelines concerning inappropriate treatment of catheter associated asymptomatic bacteraemia. *Journal of Advanced Nursing*, (3) 14-28. Retrieved from: <http://www.implementationscience.com/content/6/1/41> (Accessed 19/07/2015).
- Tsawe, M. 2014. Utilization of Health Care Services and Maternal Education in South Africa. *BMC Health Services Research*, (5) 3-10.
- United Nations Population Fund (UNFPA) 2009. *Trends in maternal mortality: 1990 to 2008*. Geneva: WHO.
- United Nations Population Fund (UNFPA) 2014. A Universal Pathway. *Woman's Right to Health*. 20, 120-129. Retrieved from: www.unfpa.org (Accessed 11/07/2015).
- United Nations Population Fund (UNFPA) 2015. A Universal Pathway. *Woman's Right to Health* (4) 72-81. Retrieved from: www.unfpa.org (Accessed 01/01/2016).
- United Nations Population Fund and the World Bank. In 2013. *Estimates developed by WHO, UNICEF, UNFPA and the World Bank*. Geneva: WHO.18, 202-208
- Van Selm M, Kanhai HH, & Keirse MJ 2015. Preventing the recurrence of atonic postpartum hemorrhage: a double-blind trial. *Acta Obstetrica et Gynecologica Scandinavica*, , 74(4):270–274.
- Warren, C.P., Daly, P., Toure, L., & Mongi, P. 2006. Postnatal Care: Opportunities for Africa's Newborns. *Advances in Nursing Science*, 8 (6), 80-90.
- Warren, C.E., 2015. Exploring the quality and effect of comprehensive postnatal care models in East and Southern Africa (Doctoral dissertation, Faculty of Medicine and Health Sciences, Ghent University).
- Watson, C. & Kimberly, M. 1997. Keeping Patient Safe: Transforming the Work Environment of Nurses. Retrieved from: <http://www.nap.edu/catalog/10851>.(Accessed 13/10/16). 37-50.
- Weaver, K., & Olson, J.K. 2006. Understanding Paradigms Used for Nursing Research. *Journal of Advanced Nursing*, 53, 459-469.
- WHO, UNICEF, UNFPA & WB. 2013. World Health Organization, *United Nations Maternal mortality Children's Fund*, 11, 135-150.
- Winslow, W. 2012. Creating Quality Practice Environments: Not Easy, But Essential. *Health Care Management Forum*, 17(4), 28-33.
- Wiysonge, C.S. 2009. Midwife-led versus other models of care for childbearing women: RHL commentary. The WHO Reproductive Health Library; (4) 7. World Health Organization Geneva.

- World Health Organization (WHO) 2010. *Maternal Mortality*.20-22 Retrieved from: www.who.int/factsheet (Accessed 30/08/2015).
- World Health Organization (WHO) 2012a. *Coverage of Maternity Care: Listing of Available information*. (13) 14-20. Retrieved from: www.WHO/RHTMSM/96:28/geneva. (Accessed 10/10/2015).
- World Health Organization 2012b. *Recommended Interventions for Improving Maternal and Newborn Health*. (8) 20-35. Retrieved from: www.WHO/MPS/07.05/ Geneva. (Accessed 10/10/2015).
- World Health Organization (WHO) 2013. Rating Maternal and Neonatal Health Services in Developing Countries. *Bulletin of the World Health Organisation* 80, (6) 721-727.
- World Health Organization (WHO) 2014. *Key Elements of Postnatal Care at the Community Level Based on WHO Guidelines*. 17, (8) 55-63. Retrieved from <http://www.pathfinder.org/publications-Mbabane>: Printpak. (Accessed 12/09/2015).
- World Health Organization (WHO) 2015a. *Key Elements of Postnatal Care at the Community Level Based on WHO Guidelines*. (20), 61-66. Retrieved from: <http://www.pathfinder.org/publications-tools/pdfs/CATALYST-Key-Elements-of-Postpartum-Care>. (Accessed 06/09/2015).
- World Health Organization (WHO) 2015b. *Inequities in Postnatal Care in Low- and Middle-Income Countries: a Systematic Review and Meta-Analysis*, (93), 259-270. Retrieved from: <http://dx.doi.org/10.2471/BLT.14.140996>. (Accessed 18/09/2016).
- World Health Organisation, 2015c. Global Health Observatory (GHO) data. Retrieved from: http://www.who.int/gho/maternal_health/mortality/maternal_mortality_text/en/. (Accessed 19/10/2016).
- Zinn J.S., & Mor, V. 1998. Organizing for Nursing Home Quality; Qualitative. *Management Health Care*. Summer; 3 (4); 37-46.

ANNEXURE 1a: Interview guide

The following are the interview questions:

1. Demographic data:
 - a. How old are you please
 - b. What is your highest nursing qualification?
 - c. How many years of experience do you have as a midwife?
 - d. How many years have you worked in the maternity unit of this hospital?
 - e. What is your position in this hospital?
- B. Interview questions
 1. What is your perception of post natal care?
 2. Describe your role in rendering post natal care to mother in your unit from delivery to discharge.
 3. Where do you see the greatest risks in midwifery practice – antenatal, labour or post-natal?
 4. What is the reason for your choice?
 5. There is suggestion that post-natal care is more important than ante-natal care. What do you think?
 6. What are the problems you encountered during the provision of post natal care to mothers?
 - 7 How do you think these problems can be solved?

ANNEXURE 1b: Interview guide

Date: _____

Participant code: _____

Enquire from the participant the following demographic information:

0. How old were you at your last birthday?
1. What is your highest nursing qualification?

General nurse and midwife (diploma)	General nurse and midwife (degree)	General nurse and advanced midwife	Masters in Midwifery
-------------------------------------	------------------------------------	------------------------------------	----------------------

2. How many years of experience do you have as a midwife?
3. How many years have you worked in the maternity unit of this hospital?
4. What is your position in this hospital?

Before starting the interview begin the recoding by stating the participant code

Questions open and probing

5. What do you think generally about post-natal maternal care by hospitals in South Africa?
6. How do you render maternal postnatal care in this hospital?
7. What is your perception of postnatal maternal care as a midwife?

Potential probing questions

1. Give me your overview of what activities is part of post-natal maternal care.
2. Which of these activities is your responsibility as a midwife?
3. What maternal health education do you give to mothers post discharge?
4. Tell me about what makes it easy or difficult to provide care to postnatal mothers.

ANNEXURE 2: Letter to CEO requesting provisional gate keeper permission and letter providing provisional permission



School of Nursing and Public Health
Discipline of Nursing
Howard Campus,
UKZN,
Durban, 4041.
20/01/16

The CEO
St. Mary's Hospital
Marianhill, Durban.

REQUEST FOR PROVISIONAL GATE KEEPER PERMISSION TO CONDUCT REASERCH IN YOUR HOSPITAL

I, Mrs. Mercy Itohan King am a registered student at the University of KwaZulu-Natal pursuing a Master degree in Nursing Management. I hereby write to seek for your provisional approval in your healthcare setting to conduct research on post- natal care by midwives. My research study is titled: **Describing midwives' perception of maternal postnatal care role within a level one district hospital in eThekwini, KwaZulu-Natal.**

I am aware of my position in the setting and in order to gather the least contaminated data I will be utilizing the services of an advanced psychiatric nurse. He will be conducting the interviews to ensure uncontaminated data that can best add value to St Mary's. Once permission is received from all parties involved and full ethical clearance I will introduce this person to you. I would like the data gatherer to interview ten midwives (possibly less depending on when saturation is reached) in your hospital for the maximum of one hour per participant and then a further thirty minutes to verify information gathered. Participants will each receive an information sheet and be requested to sign informed consent to establish their willingness in participating in the research. All data collection will occur in off duty time and the participating midwives will be provided with transport home.

Upon receipt of your provisional approval I will also request for gate keeper permission to the KZN Provincial Health department.

I have attached the consent form, and the information sheet and my proposal if needed, for your perusal.

Upon receipt of your provisional approval, KZN DoH and UKZN ethical approval I will return to you for full approval, followed by a meeting with the nursing services manager and unit managers to plan data collection with regards to selection of possible participants at their convenient time and venue, preferably during their off duty. The data collector will make contact with the participants for the logistics of data collection.

Please do not hesitate to contact me or my supervisor / co-supervisor if there is any more information you need. My contact details, my two supervisors, and the UKZN HSSEC research office are listed below. Thanking you in advance.

Regards

CEO's Signature/Hosp. Stamp

Mercy I. Ojuri-King.

Cell – 0839674784 mercy4soji2002@yahoo.com

Supervisor: M A Jarvis: jarvism@ukzn.ac.za (031 2601135)

Co-supervisor: A. Smith smitha1@ukzn.ac.za (031 260 2499)

HSSREC RESEARCH OFFICE

Full Name: Prem Mohun
HSS Research Office
Govan Bheki Building
Westville Campus
Contact: 0312604557
Email: mohunp@ukzn.ac.za



ST. MARY'S HOSPITAL

MARIANHILL

Practice No.: 5706386

Administration: Office of the Chief Executive Officer

Private Bag X16; Ashwood; KwaZulu Natal; South Africa; 3605
Tel: 27 31 717 1184; Fax: 27 31 700 3375; E-mail: drbtouthelezi@stmarys.co.za

TO	: MS. M.I. OJURI-KING: MASTER'S DEGREE STUDENT: UNIVERSITY OF KWAZULU-NATAL
FROM	: DR B.T. BUTHELEZI: CHIEF EXECUTIVE OFFICER: ST. MARY'S HOSPITAL MARIANHILL
DATE	: 21 JANUARY 2016
RE	: REQUEST FOR PROVISIONAL GATE KEEPER PERMISSION TO CONDUCT RESEARCH AT ST. MARY'S HOSPITAL MARIANHILL

Dear Madam

Your letter dated 20 January 2016 anent the above-cited matter has reference.

Your request is approved provided that you can furnish us with the letters of approval from the UKZN and KZN Department of Health Research Ethics Committees.

Kind regards


DR B.T. BUTHELEZI
CHIEF EXECUTIVE OFFICER
ST. MARY'S HOSPITAL MARIANHILL



ANNEXURE 3: Letter requesting provisional support from nursing services manager with signature of support



School of Nursing and Public Health

Discipline of Nursing

Howard Campus,

UKZN,

Durban, 4041.

16//02/16

The Nursing Manager

St. Mary's Hospital

Marrianhill, Durban.

REQUEST FOR A SUPPORT TO CONDUCT REASERCH IN YOUR HOSPITAL

I, Mrs. Mercy Itohan King am a registered student at the University of KwaZulu-Natal pursuing a Master degree in Nursing Management. I hereby write to seek for your support in your healthcare setting to conduct research on post- natal care by midwives my research study is titled: **Describing midwives' perception of maternal postnatal care role within a level one district hospital in eThekwini, KwaZulu-Natal.**

I am aware of my position in the setting and in order to gather the least contaminated data I will be utilizing the services of an advanced psychiatric nurse. He will be conducting the interviews to ensure uncontaminated data that can best add value to St Mary's. Once permission is received from all parties involved and full ethical clearance I will introduce this person to you. I would like the data gatherer to interview ten midwives (possibly less depending on when saturation is reached) in your hospital for the maximum of one hour per participant and then a further thirty minutes to verify information gathered. Participants will each receive an information sheet and be requested to sign informed consent to establish their willingness in

participating in the research. All data collection will occur in off duty time and the participating midwives will be provided with transport home.

Upon receipt of your provisional approval I will also request for gate keeper permission to the KZN Provincial Health department.

I have attached the consent form, and the information sheet and my proposal if needed, for your perusal.

Upon receipt of your provisional approval, KZN DoH and UKZN ethical approval I will return to you for full approval, followed by a meeting with the nursing services manager and unit managers to plan data collection with regards to selection of possible participants at their convenient time and venue, preferably during their off duty. The data collector will make contact with the participants for the logistics of data collection.

Please do not hesitate to contact me or my supervisor / co-supervisor if there is any more information you need. My contact details, my two supervisors, and the UKZN HSSEC research office are listed below. Thanking you in advance.

Regards

Mercy I. Ojuri-King.

Cell – 0839674784

mercy4soji2002@yahoo.com

Supervisor: M A. Jarvis : jarvism@ukzn.ac.za (0312501135)

HSSREC RESEARCH OFFICE

Full Name: Prem Mohun

HSS Research Office

Govan Bheki Building

Westville Campus

Contact: 0312604557

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ST. MARY'S HOSPITAL

MARIANNHILL

Administration: Nursing Management

Private Bag X16, Ashwood, KwaZulu Natal, South Africa, 3605
Tel: 27 31 717 1174 Fax: 27 31 7003375 email: charlotte@stmarys.co.za

TO	: Ms. M.I.OJURI- KING:MASTER'S DEGREE STUDENT: UNIVERSITY OF KWAZULU-NATAL
FROM	: Mrs. C.Raman- Nursing Manager ST MARY'S HOSPITAL MARIANNHILL
DATE	: 16 FEBRUARY 2016
RE	: REQUEST FOR SUPPORT TO CONDUCT RESEARCH AT ST.MARY'S HOSPITAL MARIANNHILL

Dear Madam

Your letter dated 20 January 2016 anent the above-cited matter has reference.

Your request is approved provided that you can furnish us with the letters of approval from the UKZN and KZN Department of health Research Ethics and Committees.

Kind regards

Mrs.C.Raman
Nursing Manager
ST MARY'S HOSPITAL MARIANNHILL

Nursing Administration
ST. MARY'S HOSPITAL
PRIVATE BAG X16
ASHWOOD 3605
TEL: (031) 717 1000

ANNEXURE 4: Information sheet



School of Nursing and Public Health
Howard College, UKZN
Durban, 4041.

The Midwives
St. Mary's Hospital

INFORMATION SHEET.

I, Mrs. Mercy Itohan King am a registered student at the University of KwaZulu-Natal pursuing a Master degree in Nursing Management. I hereby write this information sheet to inform you about my study such that you can make an informed choice to participate. I am requesting an hour of your time to participate in a 1:1 interview. The title of my study is: **“Describing midwives’ perception of maternal postnatal care role within a level one district hospital, in eThekweni, KwaZulu-Natal”**. The purpose of the interview is to gather information relevant to maternal postnatal care role perceived by midwives.

I believe that your input will be valuable to my study. I will require one hour of your off duty time for the data collector to interview you one on one, asking you some questions related to the topic and then a further 30 minutes to verify the data gathered. To compensate for any inconvenience transport will be provided home and you will receive a gift.

I will also like to bring to your notice that I will not be doing the data collecting myself, but will appoint an advanced psychiatric nurse to collect the data. I believe that this will be in the best interests of the research process and provide you with greater confidentiality. You will not provide your name and the data collector will attempt for greater anonymity to collect data from two persons per day. Pseudonyms will be used when transcribing.

I will explain to the data collector the research process and questions such that the richest data is obtained. Data will be collected in English as this is the language that is used in the hospital among the staff for instruction, reporting and recording.

Confidentiality of information will be observed and you as respondents will not be asked to identify yourself by your real names as pseudonyms names will be used. To allow for accurate transcription, such that the data collector does not miss any important information of the interview, with your permission, he would like to audio-record. He will undertake to keep the interview data confidential. Only my research supervisors will have access to it and when the study is completed, the data (audio and written) will be stored securely for five years, after which it will be destroyed by fire. Please be aware that you are free to withdraw your participation from this research at any time you wish to do so.

Two months after completion of the study I will provide you with a written report of the findings

Should you have any further queries please do not hesitate to contact me or my supervisors.

Kind regards,

Mercy I. Ojuri-King.

Cell – 0839674784

mercy4soji2002@yahoo.com

Supervisor: M A Jarvis : jarvism@ukzn.ac.za (031 2601135)

Co-supervisor: A. Smith smitha1@ukzn.ac.za (031 2602499)

UKZN HSSREC Protocol ref: HSS/0261/016M

HSSREC RESEARCH OFFICE

Full Name: Prem Mohun
HSS Research Office
Govan Bheki Building
Westville Campus
Contact: 0312604557
Email: mohunp@ukzn.ac.za

ANNEXURE 5: Letter requesting gate keeper permission from Department of Health



Discipline of Nursing
School of Nursing and Public Health
Howard Campus,
UKZN,
Durban, 4041.

KZN Provincial Department of Health
KwaZulu-Natal
Durban.

REQUEST FOR GATE KEEPER PERMISSION TO CONDUCT REASERCH IN A LEVEL ONE HOSPITAL, DURBAN.

I, Mrs. Mercy I. King a registered student at the University of KwaZulu-Natal pursuing a Master degree in Nursing Management. My research study is titled: **Describing midwives' perception of maternal postnatal care role within a level one district hospital, in eThekwini KwaZulu-Natal.** I will be interviewing six midwives from St Mary's hospital Marianhill Durban. I have received full ethical approval from HSSREC UKZN (Protocol ref: HSS/0261/016M) (See attached).

I hereby request for your permission to conduct this qualitative study in St. Mary's Hospital, Mariamhill and interview ten midwives in the level one hospital, where I am currently working (St Mary's Hospital Marianhill Durban). Each interview will take no longer than one hour.

I am aware of my position in the setting and in order to gather the least contaminated data, I will be utilizing the services of an advanced psychiatric nurse. He will be conducting the interviews to ensure uncontaminated data that can best add value to St Mary's Hospital. I would like the data gatherer to interview ten midwives (possibly less depending on when saturation is reached) in the said hospital for the maximum of one hour per participant and then a further thirty minutes to verify information gathered Participants will each receive an information sheet and be requested to sign informed consent to establish their willingness in participating in the research.

I have attached the consent form, the information sheet, my proposal and HSSREC approval for your perusal.

Please do not hesitate to contact me if there is any more information you need. My contact details, my two supervisors, and the UKZN HSS research office are listed below. Thanking you in advance.

Regards,

Mercy I. Ojuri-King.

Cell – 0839674784

mercy4soji2002@yahoo.com

Supervisor's contact:

Supervisor: M A Jarvis: jarvism@ukzn.ac.za (031 2601135)

Co-supervisor: A. Smith smitha1@ukzn.ac.za (031 2602499)

HSSREC RESEARCH OFFICE

Full Name: Prem Mohun

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Govan Bheki Building

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Contact: 0312604557

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ANNEXURE 6: Informed consent to participate in interview (midwives)



PROJECT TITLE: Describing midwives' perceptions of maternal postnatal care role within a level one district hospital in eThekweni, KwaZulu-Natal.

RESEARCHER

Full Name: Mercy I. Ojuri-King
School: Nursing & Public Health
College: Health Sciences
Campus: Howard College
Proposed Qualification: Master of Nursing
St Mary's Hospital
Marianhill
Durban
Cell: 0839674784
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SUPERVISOR

Full Name of Supervisor: Mary Ann Jarvis
School: Nursing & Public Health
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Contact details: Mrs M. A. Jarvis (MN)
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CO-SUPERVISOR

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HSSREC RESEARCH OFFICE

Full Name: Prem Mohun
School: HSS Research Office
Govan Bheki Building
Westville Campus
Contact: 0312604557
Email: mohunp@ukzn.ac.za

I, Mrs. Mercy Itohan King a registered student at the University of KwaZulu-Natal pursuing a Master degree in Nursing Management. I am writing to invite you to participate in a 60 minutes' research interview titled: **Describing midwives' perception of maternal postnatal care role within a level one district hospital in eThekweni, KwaZulu-Natal.** I will be interviewing maximum ten midwives one-on-one for privacy and confidentiality. I hereby request for your permission as Midwives to be interviewed for 60 minutes and allow audio recording of sessions.

Kindly give your consent by signing below if you are willing to participate. I have attached the consent form and the information sheet for your perusal.

Please do not hesitate to contact me if there is any more information you need. My contact details, my two supervisors, and the UKZN HSSREC research office are listed below.

Thanking you in advance.

Regards,

Mercy I. Ojuri-King.

Cell – 0839674784

mercy4soji2002@yahoo.com

I declare that:	Yes	No
I have received detailed information about my voluntary participation in the research		
I have read and understand the contents of this letter and the nature of the research project has been clearly defined prior to participating in this research project.		
I have been assured of freedom to withdraw my consent to participate at any stage in this study without any sanction either physical or psychological.		
I willingly give my consent to participate in this study in off duty time and understand that transport will be provided for me home		
I am prepared to be audio recoded during the interview.		

Please do not include name, signature alone is required

Participant's signature: _____

Date and Time: _____

Researcher's signature: _____

Date and Time: _____

ANNEXURE 7: Online ethics certificates: researcher, research supervisor and co-supervisor



ANNEXURE 8: UKZN HSSREC ethical approval



30 March 2016

Mrs Mercy Itshan Qjuri-King 205504050
School of Nursing and Public Health
Howard College Campus

Dear Mrs Qjuri-King

Protocol reference number: HSS/0261/016M
Project Title: Describing Midwives' Perceptions of Maternal Postnatal care Role within a level one Districts Hospital in eThekweni, KwaZulu-Natal

Full Approval – Expedited Application

In response to your application received 14 March 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shanika Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc: Supervisor: Mary Ann Jarvis & Amanda Smith
Cc: Academic Leader Research: Professor M Mars
Cc: School Administrator: Ms Caroline Dhansa

Humanities & Social Sciences Research Ethics Committee

Dr Shanika Singh (Chair)

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Website: www.ukzn.ac.za



Fouring Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

ANNEXURE 9: Provincial Department of Health approval



Reference: 118/16
KZ_2016RP8_6

Date: 5 May 2016
Dear Mrs M. Cjun-King
Email: marcy4soj2002@yahoo.com

Approval of research

1. The research proposal titled 'Describing midwives' perceptions of maternal postnatal care role within a level one district hospital in eThekweni, KwaZulu-Natal' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby approved for research to be undertaken at St Mary's Hospital Maristhill.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to hikm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely



Dr E. Lutge

Chairperson, Health Research Committee

Date: 09/05/16

ANNEXURE 10: Transcription of recordings

INTERVIEW 1: PARTICIPANT 1 (P1)

on the 27/05/16

Interviewer: Here we go...so today is the 27th of the 5th month, 2016 and it is now 19.45, we doing interview 1 with Participant 1, (huh) she has read the consent form and she is willingly to taken part in the interview, so just a few questions that we need to ask before we go through the interview proper. (huh) One of the things about the recording is that you need to talk a little bit clearly, slower and clear so that we can hear what we say.

Participant: Ok

Interviewer: Ok, so first one is how old were you at your last birthday?

Participant: I was 38, (she laughs)

Interviewer: 38

Participant: I was 39

Interviewer: 39

Participant: Because next year I will be turning 40

Interviewer: Ok, and then they've got what is your highest nursing qualification? So they've got General nursing and midwife?

Participant: yes.

Interviewer: Is it General Nursing and Midwife?

Participant: Yes,

Interviewer: Is it diploma?

Participant: Yes.

Interviewer: Ok how many years of experience do you have as a midwife? Counting on your fingers? (She laughs)

Participant: Since 2006

Interviewer: ok

Participant: 2006 June (Counting on her fingers)

Interviewer: is now 10 years

Participant: is now 10 year yes.

Interviewer: (yah) and then how many years have you been worked in maternity unit of this hospital?

Participant: Since 2006 as I qualified.

Interviewer: So is 10 years, ok so what is your position in this hospital?

Participant: (ah,,) Midwife, Registered Midwife

Interviewer: So what do you think about postnatal maternal care within district hospital so we looking at district hospital and your opinion or your perception of what is the quality of postnatal maternal care?

Participant: ok should I answer according to what we do in our hospital or generally?

Interviewer: So this is very broad question, so basically asking here is if we are to look at districts hospital and you consider all the maternity postnatal care you guys are offering, what is your opinion? What do you think about that?

Participant: *So far, I don't see a problem, especially, after, I will start talking post normal vaginal delivery of the mothers but (hem...) According to DoH guidelines, postnatal, postnatal care is that if a mother deliver normally and there are no problem, she needs to be checked after 6 hours to see if she is fit to go home so, so far we've been adherent to that guideline (P1:1A) and we should, may we come across any problem during the checking, postnatal checking's, they get to be seen by the doctor, and nursed accordingly (P1:1A) and with regards to post caesarean mother they are kept up to 3 days, depending on their conditions as well, problem they came with, depending on what nursing management they would be giving, or interventions that would be done to them, or if they are ok, then they are discharged home by the doctor, they need to be checked by the*

doctor, checking the wound, checking the bleeding, checking the uterus contractions, and checking their babies then they are discharged home. (P1:1A).

Interviewer: Ok, so you covered NVD and c/sections,

Participant: yes

Interviewer: are there other categories of (huh) postnatal mother you might have in this hospital?

Participant: No just that the preterm mother that we call, the Kangaroo Mother.

Interviewer: Preterm?

Participant: Yes, they are kept here for longer, because they are waiting for their babies to gain weight. So they have a special place where they are kept, which is like warm part of the ward or sort of like educate them on the kangaroo care for their babies to grow faster so with those ones fall under post NVD, because most of them, they delivered normally.

Interviewer: Ok, so in generally you have a positive belief or positive impression about this.

Participant: So far, so far, (em..) yah so far is just that its differs with hospitals, am not too sure of other hospital how their practice is, because here when they are, since we are not a big hospital, so when they've you delivered, especially the NVD mothers, if may be let's just say the baby is got problem in Nursery for whatever reasons, after that 6 hours if they are ok, they have (em..) sort of like a lodge, sort of, which is down by the back of the ward, where they sleep (mothers) so for them to try and create space for other mothers because you know with the process of mothers coming here to deliver, it becomes a sort of something that is endless, so **sometimes we end up not having enough space for those mothers to sleep especially the new ones.(P1: 5A).** So those ones who are stable, they go to the flats, we call it mothers 'lodge. They are there, they only come to feed their babies in nursery or they come here may be if they have any other problems to report to us (midwives).

Interviewer: Ok, alright, so then just to go a little bit deeper, so we've looked at hospitals, districts hospital in generally, your hospital, you say, you are not sure about other hospital but as far as this hospital is concerned, you think they are doing well.

Participant: Yes.

Interviewer: is doing very well, so if you look at the activities (huh) that you actually conduct in postnatal maternal care, what are some of the activities that you would say this here belong to postnatal maternity care, in postnatal maternity this is what we do.

Participant: (Eh..) basically for Midwives, it is the checking of the mothers, we have to make sure that we know how they are (em..) recovering post-delivery be it normally or by caesarean section, we check their vaginal bleeding

Interviewer: (huh huh)

Participant: to see if its normal, if it not normal or if it is not normal or if there is anything that is deviating from what we are used to or is normal, then we report those mothers to the doctor, then they are nursed accordingly, for example, if may be, let's just say the patient deliver 9am in the morning, and you are a midwife working in postnatal ward, you have to, when you are checking those mothers, is not like we only check them after 6 hours that is stipulated for us to check the mothers but there is always like, the midwife and may be a junior category, who is there all the time to look, to see if they are any problem, doing the blood pressure, doing the temperatures, and all of that, and also checking them whether they are able to breastfeed their babies, especially for those who opted for breast feeding, so your duty as a midwife, (ya..) if you are allocated there, you have to look at all of that, whoever need help may be with the breast feeding or maybe she is struggling to latch the baby on the breast, you assist accordingly, you give education as well because most of the time we come across young mothers who are not even exposed to or may be received any sort of education as to how to care for their babies.

Interviewer: huh huh

Participant: As young as they are themselves, so we teach those mothers and most of them like nowadays, we, we received like young, young adults, younger like 12 year, 13, 14years so those ones, they are sorts of a high risks that we take into considerations, and we have such like how we sort of precautions as to how we treat those compare to the way we treat the older ones, (ya.)

Interviewer: Just a couple of things, you are talking about your routine, is that you got to check within 6 hours.

Participant: Yes.

Interviewer: But you saying actually that is out limit, but you check more regularly.

Participant: yes, it is regularly we do have to check because anything can happen within that 6 hours if you have to wait for that stipulated 6 hours, so that is why the there is always nurses especially allocated in postnatal, for example, like in postnatal cubicle in labour ward there is midwife, and there is a Staff Nurse and there is Enrolled Nursing Assistance who is helping mothers with basic things like bathing, you know because sometimes they feel weak post-delivery

Interviewer: huh huh

Participant: and if there is no one who is there to see that they are ok when they are going to the showers and all of that, then it means we might have some problem so with us, we have those people that are allocated there, who are there 24/7 on day duty as well as for night and they also assist in changing baby napkins, because mothers they are not all, you know as I also say we receive the small ones, so they help with napkin changing educating on breast as I said, and even education like when they are talking about breast engorgement, to those young ones, breast engorgement is like some things they don't even understand, so we have to explain basic things to them.

Interviewer: Ok, so the 6 hourly is outer limit, is the guideline, but you saying clinical setting there is always somebody.

Participant: There is always somebody yes, yes.

Interviewer: Now you also mentioned something about how they are recovery, you mentioned about vaginal bleeding, about any abnormality to report to the doctor

Participant: yes

Interviewer: besides vaginal bleeding, are there any other duties activities that you as a Midwives are required to do? As part of postnatal.

Participant: that goes together with checking their uterus, you know if it is contracted the way it should be and if especially those who have delivered normally, we also check their perineum to see if because during delivery they are localised with lignocaine which means they are muscle to be a little swollen, so when we are checking afterwards, we want to see and to make sure that everything is ok, there is nothing looking funny at all or if there is a problem of such you saw the things when you are checking those mothers and when you are checking the uterus, you make sure you palpate to see if the uterus is going down the way it should be, if it is not, then it means there is something that is still retaining inside, if there is something you act or whatever you also check if the general appearance of the mother, you check the pallor, like the whole general appearance, you check if the mother is not pale too much, because normally what we do in our baseline haemoglobin levels before they deliver, so we (wanna) know afterwards, when you are checking everything like pallor you just want to make sure that may be she didn't bleed too much, if you suspect anything, you act accordingly like even if before you tell the doctor, we are told as to what signs are for anaemia so you will see and may be you do your ward Hb, if it comes back and shows may be, it is abnormal, then you report accordingly, you also check the blood pressure because we also receive those mothers who are having high BP during pregnancy, so we want to see if it is going down after the delivery or if may be she will need treatment that she will have to take home and when she has to take some treatments, we have to make sure that we educate her as to how to take the treatments, which will be a little different from the treatments that she was taking during delivery, I mean pregnancy. (Ya) so we basically, you check like everything, like you were checking during admission, when you are checking from head to toe, you do the same when before they go home.

Interviewer: Ok.

Participant: Yeah.

Interviewer: alright so you are checking baseline blood for examples, you checking the ward Hb, checking the blood pressure and then if there is any challenges, any problem you find.

Participant: yes then you report to the doctors, and if may be it needs, may be like, 2nd level hospital, the doctors do arrange for such.

Interviewer: Ok, so in all of this stuff that you mentioned, now this is particularly, especially the Midwife.

Participant: yes.

Interviewer: ok if you are to look (hah) beyond the Midwife, who are the other players, who the other people that are involved in postnatal? And may be, then look at, for those group of people that are in postnatal, what are the other activities they do specifically for nurses, there might be something for example, the doctors that you mentioned, they might be doing.

Participant: (huh) Basically for the doctors in this hospital, the way we work is we are in contacts with patients all the time, like 24/7 unlike them, they only come for rounds at that time or because they are not there all the time, they are busy you know with other duties that they do them, they only come for rounds and because they are not there all the time with other duties that they do, so I would say yes the doctors do come when there is a need, the do come for their rounds,

Interviewer: huh huh

Participant: when they come for rounds, they do that like in during the day, in the morning, when they take the whole ward rounds, checking on who is fit to go home and who is not fit to go home. And if there is a problem, and what is the intervention that need to be done. (ah) other people, that I can mention other than nurses and midwife, (huh) **if there is like may be a social problem, we do involve social worker as well, we work with them a lot because if they are social problem,**

we have to refer those cases to the social workers for assistance or for whatever interventions that need to be done to those cases. (P1:3A).

Interviewer: ok

Participant: so other than that, (yah) because pharmacist is not direct to the patients, it is us (midwives) liaise with them, whatever medication we need for patients.

Interviewer: Alright so you mentioned, Nurses, Social-Workers, Doctors, Pharmacists, are not really directly involved.

Participant: No.

Interviewer: Are there any other people you see that might be involved in postnatal?

Participant: (aah..) ok. Ultrasound people, they can only be involved if we have may be like retained products of conception or retained placenta, then that is the only time that, that particular patient will be seen or go to X-ray departments for ultrasound. So other than that, (huh) the counsellors will be with them alone. I nearly missed that one, they work with them a lot because most of the time, like nowadays we all know we work with the HIV prevalence, so they get checked like all the time, we check the file before they deliver to make sure that we are in line with everybody to promote the PMTCT but the Counsellors are the ones who are counselling those patients like they sit one on one with those patients and they do the counselling. So that they explain everything to them, and our duty is to take, you know, blood, whatever that are involved for us to do, then we continue from there.

Interviewer: Ok, so initially we described the specific activities of the midwives,

Participant: yes

Interviewer: then we look at all the different categories, other people that might be involved in postnatal. Ok, if you are to compare any of the other categories. Is there anything that the nurses/midwives is actually involved in, may be (hah) if you look at the category ok, and say we doing it but we doing it but then we referred to, are doing this or not.

Participant: It will be...

Interviewer: Specifically, for that category, ultra-sound or ...

Participant: Whatever pertain to patients unfortunately it has to run through the midwives, regardless of what it is, for example, with the counsellor, the counsellor might not even pick up that there is a patient that need to be seen but if I since the patient, started with me, to be seen by me, then I am the one to notify the counsellor that I have someone that I will want you to see, or to help with whatever, so basically it's like if you a midwife, you have to be, you know to be sort of vigilant with whatever you are doing with the patients, because if the patient need a social worker, you are the one to liaise with the social worker to say that I have a case that I feel that you need to see and the doctor that you see even on admission or when the patient is about to go home, you are the one to report to the doctor, that I am not happy about this one, because 1234 then, the doctor will come and see the patient. If the patient is for ultrasound, you are the one to say (Ehe...), when I was checking my patient, the uterus was not ok or may be when I expelled I found something, so it looks like this patient is got a problem, then you will call a doctor to come and check the patient. And if he confirms whatever were your suspicion, they will send the patient for ultrasound and before the patient is booked for ultrasound, you are the one to notify ultrasound to say that am having a case that need to come to you what time and all of that, and then if may be you need may be like a nursing assistance, you are the one (midwife) to ask the nursing assistance that I have a case, that I need you to accompany to ultrasound, so basically is like, you have to be like yes..

Interviewer: So what you saying is that as a nurse you need to know your patient, to be able to refer to the appropriate person

Participant: yes

Interviewer: but you don't necessary do those functions.

Participant: No not really, not everything, not everything, you can (yah) you can refer for other activities, e.g. you cannot be the one who is wheeling the patient to ultrasound but you can always appoints someone, to say that please take this one to ultrasound but when that person is coming from ultrasound, you need to

know that the patient is back and what happened, and you suppose to notify the doctor, not that you have to be like doing everything on your own, no.

Interviewer: ok alright, so we looked (huh) at your specific functions as midwife, we looked at other functions, (huh) that other people within the system are doing postnatal were actually involved with.

Participant: Huh

Interviewer: (aah) is there anything that makes your work easier? Or is there anything that makes your work difficult? If you look at it that way'.

Participant: As I was explaining all the activities,

Interviewer: huh

Participant: I do not see much that can make a midwives job easy honestly, to be honest because when, when, when is just that you are not working alone that is the only thing, other than that, I don't see what that can make it easy, because I am not too sure about other hospital, we use to hear our colleagues from other hospital saying that they are working with doctors, like you know they are in the ward all the time, with us here, we are the ones who are in the ward most of the time, and we only call the doctor, especially now after hours, like its night now, we not gonna have may be like doctors walking around, checking whatever problem, unless if we call the doctors to say we have this one, like you saw the blood by that time, so we are the ones to see things even then, with whatever results like blood results we are the ones to say oh this blood result are ok, because we have normal range, and then we notify the doctor, and then the doctor will come by that time. I think at night because it's only (huh huh) on-call doctors,

Interviewer: ok

Participant: but during the day, it's like if they are done with their ward rounds, afterwards whatever happens afterwards you have to be sure that you know everything so that you will be able to record whatever that you need to record.

Interviewer: ok so in your opinion, nursing in postnatal is a lot of work and there is nothing that can make it easier.

Participant: easier (yaa,), it is a lot of work, it need you to be.., you know, up to standard, you need to be sure of what you are doing, may be the best part or may be the what...I don't know how to put it, but may be if it could be like it because it seems like no one can take the midwife activities as such. May be if we can get allocated like, many midwives, not like scanty, you know,

Interviewer: Ok.

Participant: Ya.

Interviewer: So you actually talking here now specifically about staff-ratio example.

Participant: staff yes, yes but to care for plus or minus twenty (20) patients you can't be the only midwife on the floor, at least may be like four (4) you know, so that the other 2 will do something, and the other 2 will do something. In the meantime, in between, you are able to see other things, so may be by that way it could be a little bit better, but with the responsibilities. I don't see the relieved in anyway or shared with anyone in anyway.

Interviewer: Ok, so besides staffing, (huh) is there anything else that you, if you look at your own practice now currently, is there anything you can say this is a good practice, this is a good activities, this is good whatever, that helps me do what it is am doing.

Participant: (ah) There are good things, there are good things, is not like the even workload is too much, but there are good things, for example like, ok let's just say during the night, we are like am working on night duty, and I will be referring to night, most of the time, if may be the routine was too much, when we come at night we have, (huh) sort of like, may be a stand-by doctor who will be coming to check on patients everything, I mean every patient to see if there are any problem, if there are no problem, if there is no problem then it is fine.

Interviewer: Ok.

Participant: Other than waiting for or relying on one on-call doctor, for you know for the...

Interviewer: So you do have, you do have this doc that she does the rounds.

Participant: We do not have currently,

Interviewer: But you saying it will be nice to have

Participant: it will be nice to have, it will be nice to have a person like that, not only relying on on-call, sometime you find that you wish to have a doctor now, and may be because, he is the only one who is on-call for the wards, he is stuck may be in theatre, maybe he is doing a caesarean section, so by that time, yes you are, we are free to call them, whoever take the phone may be he is cutting (operating) can relate the message to the doctor, but it's not the same as coming to see the patients at that point or may be having this responsibilities of going around you know, may be like a regular

Interviewer: huh huh

Participant: intervals.

Interviewer: Ok, alright, so we talked about what makes the work easier, we talked about a little bit about some of your challenges, Are there any other challenges that you think, (huh) that might be making your job a little more difficult, so we know that staffing is one of them.

Participant: Yaeh, staffing is one of them, and too much overcrowding of patients, or may be because we are under staff as well.

Interviewer: So with under staffing it will be, we don't have enough of nurses, and overcrowding is we have more patients than we should have in the ward, so which of these would you say is challenging for you?

Participant: I wouldn't say, that is why am saying it brings me back if I say overcrowding, it will bring me back to under staffing because the ward are still the same, is not like they are renovated to be big, they are still the same standard you know (em...), the wards with these beds is just that we are, it seems that we are not enough, you know to look after those patients.

Interviewer: alright

Participant: yah

Interviewer: ok so the last thing I want to look at, is when your patient has delivers that is now postnatal right?

Participant: Yes.

Interviewer: ok so take me through the process or the steps that you see (huh) from postnatal if she is just delivered and how she will come to your ward, and to the last, which is now everything is fine and she is going home.

Participant: Ok.

Interviewer: Tell me may be specifically so let's look at first what are those steps, may be you want to look at the one you as a midwife actually involved with.

Participant: (Excuse me hem..) post-delivery ok, she is just giving birth, and she is coming to our ward, (em..) the well-being of the patient, vital signs, (huh) vaginal bleeding that we check (em..), general appearance, or the condition of the patient, the baby, if the baby is ok, (em,,) everything

Interviewer: ok

Participant like I was trying..., I don't know if I get the question correctly.

Interviewer: Let me rephrase it, so we know the mom is delivered.

Participant: Ya.

Interviewer: You got 2 patients, you got the mom and you got the baby.

Participant: Yes.

Interviewer: ok when they come to your unit,

Participant: yes

Interviewer: what are your responsibilities? Are you the one that receive the patient or somebody else received the patient?

Participant: Ok, no it is the midwives; firstly, what happens is that we get a call to be given report that a patient is coming to us,

Interviewer: ok

Participant: ok over the phone, then the general condition of the patient is stated, then the patient will come with Enrol Nursing Assistance, who will be accompanying the patient with the baby, then she will come with the file and the patient and she will give us the report, this is the patient, so, and so, and this is the problem, or this is the condition of the patient and so we receive her.

Interviewer: She will hand her over to you?

Participant: Yes, then I will take the patient and put the patient in bed and assisted her by my junior colleague. Put the patient in bed and then check the patient with vital signs and I can assign someone to do that, the vital signs like BP, which I know is not the problem, but am the one to check the general condition of the patient, to write the report after checking everything which is towards the bleeding and all, and all. And then, check the baby if the baby is fine and if there are any problem with the baby. And then I will write my full reports, of receiving the patient now from labour ward, they are stable and this is my checking and this is what.

Interviewer: ok so with the observation of the mom, you will be able to get somebody else to do the observations

Participant: yes

Interviewer: and for the baby do you also do the same?

Participant: and for the baby normally the baby goes to nursery, so I am the one, as a midwife to take the baby to nursery to present the baby

Interviewer: ok

Participant: but in our hospital the way, it happen like for us the postnatal unit, if the mother is got a problem, then it means that, the mother is coming to me and the baby there is no need for the baby to go to nursery, unless the mother, may be the baby we need to sort of like take the baby as a border baby, he will be in nursery if the condition of the mother is that bad.

Interviewer: that bad?

Participant: Yes, but other than that if the baby is fine and everything is ok, the mother is coming to me for whatever problems, I will take the baby to the nursery and give the report, that mother is having this problem and am asking them to keep the baby for me, the baby will go to the mother for feeding and what not, while we (midwives) are taking care of the mother.

Interviewer: ok so once this is done, you will now nurse the mom, if this is done, you will now nursed the mom, if there is any challenges, we know you said it will be referred to

Participant: refer to the doctor

Interviewer: the appropriate doctor or ultrasound, so whatever it might be, at some point, the, (huh) the mom is now ready to go home, so take me through that process, what happens?

Participant: ok what happens is...

Interviewer: How do you decide that mom is ready to now go home?

Participant: What happen is that, ok (huh) then the doctor will comes, and then do the rounds in the ward like, she will be in the ward like 2-3 days always with the mom, for whatever problem that she is here for, be normal vaginal delivery baby like after or after she was a retained placenta or what, why she is continued been nursed or managed in the ward, until we see the progress, we are writing the report, we are checking the vital signs, doing everything and if treatments is involved, we give the treatments, then the doctor will see and decide when she is coming for her rounds, to say that from all the checking and observations, Hb everything is fine and the mothers condition is ok and the mother can go home, so when that happens it will be the doctor to write in the patient file that patient is fit to go home.

Interviewer: Ok

Participants: But as a midwife I have to make sure that the mother is ok to go home, like in the sense that there is someone who is coming to fetch the mother

Interviewer: ok

Participant: and the mode of transport I have asked from the mother if she sort of like arranged mode of transport and if she is fit but (em....) other than that, it's that, and before they go home they are checked by the doctor, we (midwife) also check to make sure that the mother is still fine because most of the time, when they get discharged, during the morning hours, like 9am, 10am in the morning so before they go there is a process of like before they go home, they need to be immunized all of that and the time that they leave, may be 12, or something like that, is not like they discharge one patient at a time, so we check the mothers, to see if they are ok to go home, at that point in time, and if everything is ok, their name tag is in line with their babies name tag before they go out of the gate, they are no problems.

Interviewer: Ok.

Participant: Yah.

Interviewer: Who will tell the mom, everything is been sorted out, mom is ready to go now, who will actually be the one to take the mom out.

Participant: Normally if the mother is discharged home, then that mother is fit to go home, she can walk out by herself with her baby, (eem.), if there is a relative, we will see the relatives and handover the mother to the relatives to take her home.

Interviewer: Ok, then, once the mom is discharged do you have any kind of interaction with her after that or how does it work?

Participant: Unless if there is something from mothers who are having like high risk baby, like preterm baby or abnormal babies where they have to go to our clinic, St. Anne's, the those mothers, they leave their contacts numbers, we have a book in nursery where we record those mothers to be able to remind them of the dates for review for those babies, other than that, we don't keep any sort of follow-up information because they get discharged with a discharged summary to instruct them to go to the nearest clinic for (eem) check-ups.

Interviewer: Ok, so that's basically covers everything that I want to ask. Is there anything you want to tell me? May be that I haven't focused on, as far as postnatal is concerned, so maybe there is something that is happening, or something

exciting that you want to tell, something you concerned about, that you know we need to look at, so any other thing that I haven't touched that you might want to talk about?

Participant: I think we spoken about everything.

Interviewer: alright, thank you very much, and that's the end of the interview.

Participant: alright thank you.

INTERVIEW 2 PARTICIPANTS 2 (P2)

Interviewer: Ok so today is the 25th of the 6th, 2016, is now 19.30 and this is interview 2 participant 2nd this is her first interview, so just to warm up and (em..) settle down a bit, just some easy questions, alright so how old were you in your last birthday?

Participant: 39.

Interviewer: Ok, and what is your highest nursing qualification, so they gave us some choices, general nurse and midwife and diploma, general nurse and midwife degree, general nurse and advanced midwife and maters in midwifery?

Participant: General Nurse and diploma in midwifery.

Interviewer: How many years' experience do you have as a midwife?

Participant: Three years.

Interviewer: And how many years have you worked in maternity unit of this hospital?

Participant: Two and half years.

Interviewer: What is your position in this hospital?

Participant: I'm a registered midwife.

Interviewer: okay just some questions just to try and get a feel for what it is that you are doing in this facility, so you have to think about maternal care in South Africa, ok we are looking specifically at postnatal maternal care in South Africa. If you have to look at the standard of care, or the quality of care, what would be your opinion about that kind of care in South Africa in general?

Participant: I can say it is good, the general nursing we are doing is very good because we usually (eem) we treating mothers and the baby, they always go home healthy, unless there was a (eh...) problem before but during the management the management I can say is good in South Africa.

Interviewer: Alright and then if you had to compare this hospital so you saying that South Africa care is good and you can compare this hospital in comparison to the

general South Africa would it be the same level, how would you describe the quality of care, the standard of care.

Participant: I can say it can be, it's all the same, it is also good, it has also gets complement after given care to our patients.

Interviewer: Ok, that's nice.

Participant: Because usually the family, they phone, they comments on about, (um) about ur care.

Interviewer: Ok, so if you look at the activities that involved in postnatal maternal care and this is not only about nurses, it can be any other category of staff, so we looking at the over view of your activities in postnatal maternal care, what would those activities be is there a list of activities that you would say that these are only the activities of postnatal care.

Participants: Yes, because when the patient is coming from theatre, the nurse, we admit patient and kept nil per os, during that time, the patient is been observed, if they are not vomiting, to exclude or paralyses, in the, in the abdomen, so you let the patient, (em...) they don't eat for six hours, they don't eat, that is done by midwives.

Interviewer: Ok.

Participant: They also check the intakes and outputs, because they got urinary catheters, so we need to exclude that there was not trauma during surgery, they check the colour, we check the outputs, we need to exclude our, our kidney failures like that, then we also push fluids, a lot of fluids because the patients are nil per os, then we record intakes and outputs even the ward must be clean, then we supervise (ama) general nursing assistants, the ward must be clean because the patients have got wounds, open wounds, they don't need infection, we also encourage staff to wash hands in between patients, not to cross infection, the midwife also check the bleeding, they expel clots, because we need to see the bleeding, because the patient was done caesarean section, because we are dealing with caesarean section in our, in our postnatal ward. It is very rear to

find a patient, may be they are no beds in other ward, the patient was done laparotomy, the patient is also sent to us.

Interviewer: uhum.

Participant: We also monitor bleeding, intakes and outputs, we record everything, and then we also monitor the patient when they are eating, they are not vomiting because we need to see, we also monitor the, the blood loss, we check (ama) baby, we check how was the blood loss during delivery if there was, which is maybe there is a low Hb, we transfused patient before they go home, we also covered, the patient who come from theatre covered with antibiotics, we also give antibiotics to exclude infection, and we also manage pain, they are in pain, so we have to manage pain as they ordered by doctor, (um...) we do as many things as possible, but all in all, we need to treat patient holistically because the baby too they also born with the mothers, so the nursery staff will come and check the baby with the mothers, to see if they are suckling well, they are bonding well with the, the mothers.

Interviewer: Ok, it's quite a lot of stuff, you've mentioned.

Participant: yes.

Interviewer: I noticed you say we, we, and I assumed as you say we, you talking about the...

Participant: Nurses.

Interviewer: The Midwives.

Participant: The Midwives, yes.

Interviewer: You mentioned general assistant for example that are cleaning staff.

Participant: **Yes, we also supervise staff nurses when they are checking the wounds, (P2:2A) they are staff nurses, they are used to checking the wound, the bleeding, the staff nurse they open the wound so that the doctor will see, they also, also work hand in hand with us as midwives, staff nurses changing drips, giving analgesia to patient and IMI, but we as midwives, we give IVI meds to patients. (P2:2B)**

Interviewer: Alright, so you are saying in this ward, the staff nurses will do the oral stuff, oral meds?

Participant: Yes.

Interviewer: and you will do the IV meds?

Participant: Yes, at the same time I will be supervising staff, whether they are doing the job well.

Interviewer: Ok, alright, you also mentioned the nursery staff to come and check for latching babies and tetras.

Participant: Yes.

Interviewer: The nursery staffs are they also midwife so is that?

Participant: They are midwives and

Interviewer: They are midwives.

Participant: Yes, they come and check, **there is some time, the student midwives, because we've got student here, they come as sister, they are sister, I orientate them on what to do when we are bringing the baby to the mother, like checking the ID bands. (P2: 2A)**

Interviewer: Uhum.

Participant: **before you give the mother, if the mother corresponds with the mother, so that you don't give the wrong baby to the wrong mothers. So it is also done by midwives, and student midwives supervised by the midwives. (P2:2A).**

Interviewer: Ok, so quite a lot of work there.

Participant: Quite a lot of work.

Interviewer: Okay that was actually the second part which was asked, which is from all the responsibility that you see as part of postnatal maternal care.

Participant: Hum.

Interviewer: Which one specifically (haaa) midwives' responsibilities; you sort of cover some of them, ok.

Participant: Oh, yes.

Interviewer: Are they any other duties that you see ok, we doing, the maternal postnatal maternity care but this is not specifically nurse's duty, so the general assistant cleaning for example is not their duty.

Participant: Yes, yes.

Interviewer: (ahaa) during the oral medication, you supervised?

Participant: Yes.

Interviewer: That is not really your duty, is the staff nurse duty.

Participant: Yes.

Interviewer: Are there anything else like that that you might say that this is actually not the midwives duty, they might supervise but we don't specifically this is not my duty it is someone else's duty. Are there any other things like that?

Participant: Like changing of bandages, as I mentioned is also done by the staff nurses, then we supervise them, the feeding of the babies is also done by the enrolled nursing assistance, and then we supervise them.

Interviewer: Ok.

Participant: The Sister in postnatal ward supervise the nursery staff, Enrolled Nursing Assistant come and feed the baby on (e..em) formula, is fed by the nurses when they are still fresh ceasers, for the mothers.

Interviewer: Ok, so tell me what about, what makes it easy or difficult to provide care to postnatal mothers, so what makes your job easy or difficult as a midwife?

Participant: **What makes it easy is that we are working as a team. If you are working as a team, you don't leave un, don't leave things unattended, because as you are delegating, you are also supervising as a midwife, you are also working, so the job become very easy, if you've got that team spirit. (P2:4A).**

Interviewer: Uhum

Participant: Then if the staff you've got is also responsible, there are no hazards in wards, (eem).

Interviewer: Ok, so if we had to look at your job (eem) we looking specifically postnatal maternity care.

Participant: Yes,

Interviewer: when would your duties start as far as the patient is concerned so where does it start and where does it actually end? Is there a clear starting point, and is there a clear ending point.

Participant: Yes

Interviewer: Where is the starting point and when is the ending point?

Participant: It starts when receiving the patient from theatre.

Interviewer: Uhum.

Participant: Then, vital signs, checking the contraction of the uterus checking the bleeding.

Interviewer: Ok.

Participant: And then it continues during nursing care and it must end when the patient is leaving the hospital.

Interviewer: Ok.

Participant: Uhum.

Interviewer: Ok, so just before the mother is discharged, before she leaves the hospital.

Participants: Hum.

Interviewer: Are there any specific health education that you need to give to the mother, before they leave.

Participant: Usually, usually, it starts from (eem) ante-natal clinic, they are teaching them what to bring when they are coming to the hospital, because we encourage them

to bring bags packed with clothes for the baby, nappies and everything that is gonna be needed by the mother, then when the patient is admitted in postnatal we also check whether she provide everything that she gonna needs like pads, and nappies for the baby then we also check the mother, that ok, (eem) physically and spiritually because they are sometime have postnatal blues, something like that so we treat the patient.... So what is the question?

Interviewer: So you know where your job starts and where it ends, I am saying at the ending part.

Participant: Hum

Interviewer: When the mother is discharged, what education, health education you need to actually give to this mother, before she...

Participant: Health education.

Interviewer: So you tell me about the staff of ante-natal, the stuff that she need to bring but now, concentrate on just before she is discharged, what is the information that you need to give her.

Participant: We also encourage them to register the baby for birth.

Interviewer: Ok.

Participant: Home affairs, we got home affairs in this hospital but is not working during holidays and weekends, so when they go out usually, they get birth certificate for the baby from the police, then we talk about care, their personal hygiene at home.

Interviewer: Ok.

Participant: Then we also teach them how to wake up on the bed, because they've got fresh scar, when they go out, they already know how to wake up, just to wake up, just to lie on the side first, and then stand up, not vigorously.(P2: 2A)

Interviewer: Ok.

Participant: So we teach them all of that, then we go to the taking of medication, the importance of taking medication, because usually we discharge them with oral antibiotics just to treat infection and pain killer (P2: 2A). We encourage them to eat, before taking medication, if the medication is taken, is taken before we also explain the medication to them, we also tell them how to take care of the baby, to keep baby warm, to keep baby away from the hot, to make sure that they clean the umbilical cord for the for the baby personal, just personal hygiene, changing of nappies.

Interviewer: Ahaa.

Participant: So we teach everything before they go we tell the mother the feeding, we encourage them to feed the baby.

Interviewer: Alright.

Participant: Yes.

Interviewer: Ok thank you very much. And that's as easy as that

Participant: We done.

INTERVIEW 3 PARTICIPANTS 3 (P3)

Interviewer: So today is the 25/06/2016 is now 19.50 and is interview 3 and participant 3 is just an introductory question, just to relax a bit.

Participant: Ok.

Interviewer: So how old were you at your last birthday?

Participant: My last (she laughs)

Interviewer: Your last birthday not this birthday, your last birthday.

Participant: (she laughs) I was 36.

Interviewer: 36 years old ok.

Participant: Uhum.

Interviewer: What is your highest nursing qualification; you have some choices here, General Nurse and Midwife diploma? General Nurse and Midwife degree? Or General Nurse Advanced Midwife? And Masters in Midwifery?

Participant: General Nurse and Midwife diploma.

Interviewer: Diploma, How many years of experience do you have as a midwife?

Participant: one

Interviewer: And how many years have worked in maternity unit of this hospital?

Participant: (uum) maternity only or not labour ward?

Interviewer: Well these are maternity unit of this hospital, so am not sure what does it mean.

Participant: Other hospital they include, they, they, labour ward is in maternity, so sometime they are two.

Interviewer: Ok.

Participant: 8 months.

Interviewer: 8 months, 8 months, (aah) what is your position in this hospital?

Participant: I am a Midwife.

Interviewer: Midwife, Registered Midwife

Participant: Yes. But locum I am not permanent.

Interviewer: Ok, so these are question to ask (eem) what do you consider maternal or postnatal maternal care in South Africa in general, what would you say is the standard or quality of care in South Africa.

Participant: The standard of postnatal care.

Interviewer: Postnatal maternal care.

Participant: What do you mean by standard?

Interviewer: The quality (eem) is a way of measuring quality.

Participant: Oh ok, (uum) I think we are trying if you compare last time or the past year to this year

Interviewer: Ok.

Participant: I think it is getting better.

Interviewer: Ok.

Participant: It is getting better, most mothers are attending ANC, and then they getting full is what is expected of them in postnatal.

Interviewer: Ok, so if you think about postnatal care in this hospital (aah) compared to what it is in South Africa, how would you think, how would you compare the quality and standard of care here as to compare to South Africa.

Participant: I think we're good.

Interviewer: Good

Participant: Good

Interviewer: alright then if we have to look at the activities of postnatal maternal care and I'm not looking only at what nurses are doing, so it's everyone that is involved in maternal care or what are some of the activities you think that would be that this would be classified as postnatal maternal care?

Participant: (u..hum) activities.

Interviewer: Yeah. Remember there is no right or wrong answers, so you can start anywhere, there is no order.

Participant: Which I think it belongs to postnatal?

Interviewer: Yes. So irrespective of the category or staff or this is for this, if you had to look at this activity, you would say this activity is part of postnatal.

Participant: I don't get your question.

Interviewer: Ok so let's say for example, when a mom comes to your unit, this postnatal maternal unit, so what are some of the things that will be done for this mother, the activities that will be done for this mother?

Participant: Ok, (eem) so the mother needs to be helped to initiate the breast feeding first, I think that is the most important thing because if the mother is comfortable with the baby everything gets easier.

Interviewer: Ok

Participant: (eem) the health education to the mother, especially the new mothers, (eem) what else. May be the, the, when we refer the mother to the other clinics that is the most important part, because others if they are discharged, they just go home and just sit there, they not go for follow ups (uuh) things like that. (eem) what else? I think is that?

Interviewer: So this activities that you described now, were those activities specifically the activities that the midwives perform or is the other people 'activities.

Participant: Others can perform them.

Interviewer: Ok so.

Participant: Because we use to have, am not sure if we still have those people of those people, they were ladies that were trained to help the mothers with breastfeeding.

Interviewer: Ok.

Participant: like the mothers that are in ceaser ward because is not easy for them to initiate breastfeeding,

Interviewer: Ok.

Participant they go there and help them, the ENA they also do that, they help the mothers to, to, to lash properly the babies (eem) **we have the counsellors they also go to the mothers and help them, then they do the CD4 counts if the mothers are HIV positives and they do follow ups. (P3:3A)**

Interviewer: Ok so is the counsellor you talking about, who are they?

Participant: The counsellors, they, they are HIV counsellors.

Interviewer: Ok

Participant: Yah they are also part of it.

Interviewer: Ok so with those activities that you described that the counsellors are doing, ENA are doing, will there be specific activities midwives are doing or is there something that this is not what the midwives do, midwives do this activities and these other activates belong to ENA or to staff nurses or anything like that.

Participant: Some of them, the midwives can do.

Interviewer: Which one specifically would you say that this one the only the midwives can do?

Participant: (uuh) especially the health education that is the midwives part and (um...) examination of the mother post-delivery, are midwives' activities, (eem) what else, yeah I think.

Interviewer: I told you that there is no right or wrong answers, just relax

Participant: (she laughs)

Interviewer: So if you look at your job, tell me what makes it easy or difficult to provide care to postnatal mothers?

Participant: (uuh) I think is because we are short staffed.

Interviewer: Yeah.

Participant: **We are short staffed sometimes we don't do everything we are supposed to do because we have a lot to do so we end up rushing of other things. (P3:5A)**

Interviewer: Ok, so staff shortages are the problem, any other challenges that make it difficult or anything that makes it easy to do your work?

Participant: **What makes it easy is, I think most of the time (um...) the clients that come here, the patients are Zulu speaking patients so it is easy to explain and to educate them. (P3:4A)**

Interviewer: So language makes it easy.

Participant: Yes it's easy.

Interviewer: Alright.

Participant: what else?

Interviewer: Alright so, if you have to look at your job, your functions as a midwife right, where does your responsibility start and end in regarding to postnatal maternal care? Ok is there clear start and end point? As far as the care in postnatal maternal care?

Participant: Postnatal?

Interviewer: Uum.

Participant: (she laughs) it starts after the delivery of the baby.

Interviewer: Ok.

Participant: But I think it doesn't end, it doesn't because if the mother is discharged they still come back with problem and we have to attend to them. (P3: 2B)

Interviewer: Ok so, when you say we, are you talking you or midwives generally.

Participant: The Midwives.

Interviewer: Ok, the midwives are to take care of moms after they are discharged and have problem and come back, is there a specific place when they come here to this hospital, is there another unit that they go to?

Participant: There is another unit.

Interviewer: Ok.

Participant: They go to St. Anne's'.

Interviewer: And it is also covered for by Midwives.

Participant: Yes.

Interviewer: So what are the health educations you need to give to moms before they are discharged?

Participant: (eem) we encourage them to mobilised, because that helps with the healing, and we encourage them to eat proper diets, because it helps with the healing and (uh...) production of milk. (P3: 2B).

Interviewer: Ok.

Participant: hygiene, (uuh) what else (she laughs) maternal health, it is important to go to clinic because when we discharge them we tell them to go to clinic after 3 days, so they have to go for check-up for the mother and the baby, (P3: 2B)

Interviewer: Ok alright

Participant: (uum) what else? (She laughs)

Interviewer: thank you very much and that is the end of this interview it is 10 minutes,20 seconds, thank you very much.

INTERVIEW 4: PARTICIPANT 4 (P4)

Interviewer: Ok so today is the 12th of the 7th, 2016. It is now 19.38 and this is interview 4, and to participant 4 so is going to take about 15 minutes, (uhm..) there is no right or wrong answers, ok so you can relax.

Participant: Yeah she told us is something that we doing in the ward (she laughs)

Interviewer: Yes.is just some easy questions first. First one is so how old were you at your last birthday?

Participant: (uum) 43.

Interviewer: Ok, and what is your highest nursing qualification, they've given us four choices here, General Nurse and Midwife Diploma, General Nurse and Midwife Degree, General Nurse and Midwife Advance or Masters in Midwifery.

Participant: The first one, General Nurse and Midwife Diploma.

Interviewer: How many years of experience do you have as a midwife?

Participant: 19.

Interviewer: Wow Ok 19, how many years have you worked in the maternity unit of this hospital?

Participant: Wow can I really count it; I have been on and off resigning on and off

Interviewer: So

Participant: Umm.

Interviewer: Approximate number maybe.

Participant: May be about 15 or let's just say 10.

Interviewer: Ok and what is your position in this hospital?

Participant: (Um) just a Nurse, Professional Nurse.

Interviewer: Professional Nurse, ok you function as a midwife right?

Participant: Yes.

Participant: ok so couple of questions, so if we look at postnatal maternal care, so we looking at postnatal maternal care in South Africa itself what would you say is your impression about the standard or quality of care in South Africa?

Participant: (Uum) good in general.

Interviewer: ok so you say good and general but it seem you want to say something else after that.

Participant: Yeah but I feel that we sometimes, when back in the days some things have change, I know that change is good but I feel that sometime it slips back to the... **they've introduce a lot of things, a lot of paper work, which is taking us away from the patients most of the time and seemingly we are concentrating more on paper work rather than the patient, so the patient get neglected sometimes (P4: 1B).** Come back to the old days when it is just simple.

Interviewer: Ok so in general you saying the status, or the quality of postnatal maternal care in South Africa is good, but there is some challenges

Participant: yes.

Interviewer: so if you compare this hospital to South Africa hospital in general, you say South Africa good, how is this hospital compared to that standard?

Participant: good but I feel that we may be discharging awkward ceaser patient too early and then they end up complicating and sometimes they end up coming back.

Interviewer: Ok

Participant: It's because of space

Interviewer: Ok so there is a challenge of space

Participant: Yes

Interviewer: So the first one was paper work, and now also say space is also a challenge, so if you had to look at your activities as a midwife (huh) in postnatal maternal care, there is a specific duty you as a midwife will do but there is also that if you were to look at postnatal maternal care it will be much broader than just

what the nurse does, so let's first look at quite the broad list of things that will happen in postnatal maternal care, is there a list of activities that may think ok this is what we do in maternal care, postnatal maternal care.

Participant: (em..) We admit the patient, we give health education,

Interviewer: Yeah.

Participant: (eem) we make sure that (eem..) Patient is comfortable, make sure that we because since are baby-friendly hospital we promote the principle that go along with baby friendly hospital (eem) what else? We try to prevent as complication as much as possible and attend to them as early as possible

Interviewer: Ok, so in all of these that you listed, is there a specific one that relate only to nurses, only to midwives, or do you see yourself doing all of these (eem).

Participant: We do all because we are short staff first of all

Interviewer: Ok

Participant: so you find yourself doing a lot of things, so you are not stalk like, you put up bloods, when the patient needs to be done bloods

Interviewer: Ok

Participant: you put up the line if the drip has infiltrated which is something other hospital the doctor or intern they attend to that,

Interviewer: Ok

Participant: but here you are the one who is this one, you are the one that supposed to do that (eeh)

Interviewer: Ok

Participant: what else? (hummm) I think its overlapping because you are the one, even if something like minor, your patient is complicating

Interviewer: huh huh

Participant: you are the first person that need to act before you call the doctor and sometimes to be honest with you, our doctors here, they compared to other hospital they are a bit lazy.

Interviewer: Ok

Participant: so you find that you will call the doctor. The doesn't come it takes two hours before the doctors comes

Interviewer: Uhummm

Participant: so you have to be sharp and know what you are doing and act by the time the doctor come, you most of the time you have to know the treatment you are giving around here and you have to know the doses so that you can start the treatment before hand, if he is not coming or most especially at night because is only two doctors that are around so if he is stocked in theatre you can't do, she can do anything

Interviewer: Ok

Participant: so you are there with the patient so you know, you have to know what you are doing

Participant: Yes, yes. (All night)

Interviewer: Ok, so that is because of there are challenges regarding doctor's irregularities.

Participant: Yes, shortage too, there is shortage too.

Interviewer: Ok, alright so now if you have to look at, in spite all of those shortages are there specific things that you will say these are the list of things midwives must do in postnatal maternal care? Are there clear list, is there clear ideas of that? What would you include in that list?

Participant: You do admissions, you do discharges, you do observations, you do... look at the babies as well, assist the babies not only about the mothers, you do, you give treatments, and then you do admissions, discharges, you do your discharges

Interviewer: Yes

Participant: And then you have to be doing simple stuff like (eem) as a midwife you end up doing even (eem) bed-making sometimes.

Interviewer: (Uhum) Ok, so again I want us look at your definition of postnatal, so where would you say would postnatal starts and where would postnatal end as far as maternal care, is it clear starting is clear start and end for that?

Participant: It starts as soon as the patient walk into the ward and then it ends when you are discharging the patient, and you've giving them advice and health education and stuff and you are pretty much secure that you've discharged one patient.

Interviewer: Ok (eem) so you talked about health education, so maybe this methods is actually that you will improve in health education for the mothers before they get discharged

Participant: (e..hm) you talk about the especially in the post ceaser because now we don't due to shortage space, we don't keep the NVD's (Normal vaginal delivery) they get, they stays downstairs for 6 hours and then they get discharged, only if they complication then they come up, so maybe this side is only ceaser mothers, so you will give them advice on (eem) baby care, which will include the cord care, because we discharge 2 days since the cord is there, and we don't give them anything to clean the cord with.

Interviewer: Ok

Participant: Bath on care, breastfeeding, immunization that you've given the first BCG and Polio, and meant to go back to the clinic for next dose

Interviewer: Ok

Participant: you give them the first date,

Interviewer: Ok

Participant: for postnatal checking, the mother is still okay and the baby is still okay, we have our offices down here,

Interviewer: Ok

Participant: The Home Affairs offices and tell them when to go,

Interviewer: Ok

Participant: to home affairs and when to come back, because they do get charged, when it is free, they get charged if it is after 7, after 10 days I do believe, after 10 days, before that it becomes free,

Interviewer: Ok

Participant: so we give them advice and then we talk about when should they remove the stitches?

Interviewer: U...hum

Participant: 7 days, and then the 10th day, they will remove all of them

Interviewer: Ok

Participant: then we talk about coughing, that they must hold, and we talk about (eem) lifting of stuff, no heavy lifting of stuff, since they've been done a ceaser, we talk about (eem) no driving, for the next 6 weeks of puerperium, until they are stable, we talk about the next (eem) when they fall pregnant again that they must book early, and we talk about the possibility then, and then that is when we look at the indication of the ceaser, why was the ceaser done, if it was a fetal distress, then we give them an idea that most likely, with your second pregnancy there is something called like vaginal birth, we call it V-back, when you will be giving a trial of scar, it doesn't automatically mean that since that were done ceaser the next pregnant would be ceaser, so they should be aware, not unless it is CPD (cephalous pelvic disproportion) or something like that and the previous ceaser X 2, obviously,

Interviewer: Uhum

Participant: she needs to be (uhum) ceaser again. So we look at these options and we talk about family planning, we are (eem) catholic hospital, so we don't offer (she laughs) any family planning, so we tell them that, we ask them what would they like for family planning so that they have methods, then they can go to their nearest clinic so after that for follow ups.

Interviewer: right?

Participant: yes, and then we talk about (eem) the general stuff like hygiene, that they must be (eem) must make sure that they are clean, there nails are clean, about hand washing and then when it comes to the baby most of the time, I have mentioned the card, immunization,(ban-ban) then we talk about the danger signs of the baby.

Interviewer: Ok

Participant: that they should watch out for sunken fontanel, (ee..m) Sunken eyes, diarrhoea, vomiting, that there is something wrong with that baby, then that they should come to back to hospital sooner, yes.

Interviewer: that is quite comprehensive list.

Participant: **Yeah... (She laughs) you do talk about a lot of things. You talk about sometimes like thing like because some of them do ask so when should I have sex (she laughs) (P4: 2B).**

Interviewer: Is alright.

Participant: when should I have sex and do talk about that, you say, talk about you can have sex after the puerperium, after the 6 weeks is over you are free, but then you should starts family planning and you should use condoms, **if the mother is HIV positive, we tell them that we've done the PCR because we do the (buhm..) PCR at birth, (P4: 2B).**

Interviewer: alright.

Participant: and then we tell them at 6 weeks when that take the baby to the clinic, they should be performing a PCR again, and 18 months they should be asking for the result of that, we also emphasized the exclusive breastfeeding, or formula if they opted because we do get those who are opt, who opt for formula and when to introduce the liquid on the baby, and then since we give them NVP and then we tell them when they automatically it shouldn't because it 100ml but should something happen or drops or whatever, then they can go to their local clinic to get another dose again. (P4: 2B).

Interviewer: Ok

Participant: Yeah

Interviewer: alright good, so the last thing that I want to look at, what makes it easy or difficult to provide care to postnatal mothers so you mention shortage makes it difficult

Participant: Shortage of staff

Interviewer: Shortage of staff, is there anything else you want to add to that list? What makes it difficult or easy?

Participant: it will be nice if we had a in-house doctor (she laughs)

Interviewer: Ok

Participant: who is always there so that you don't worry yourself? Until you get to do things that are over, above and beyond your scope most of the time.

Interviewer: ehem

Participant: that they will tell you that since you are covered, it's a hospital policy, but its covered and you have to do them, but it would be nice if we have a doctor that is in-house we don't have to be calling a doctor out, or be sharing like we are sharing

Interviewer: (Huum) ok anything else you want to add

Participant: it will be nice to have a lot of space for the mothers as well, I know that it is not possible, because we also, since we are baby-friendly we also talk about roaming-in so we let the baby, when they come we do the KMC, skin to skin, and then we make sure that the baby is lashing, and then the baby stays with the mother, **sometime you find out that the mother is like sleeping in awkward position because they are trying to run away from this baby now, but if we have space where we can push in cots or crimps so that when the mother is sleeping, at least the baby is sleeping. (P4:5A).**

Interviewer: Ok so.

Participant: next to her or whatever, because she is sleeping, because rest is also important to her.

Interviewer: ok

Participant: so now you find out ok since there no space, they have to be sharing the bed.

Interviewer: Ok, well that's it for now, so thank you so much for your time

Participant: really.

Interviewer: easy as that.

Interview 4b – participant 4

Participant: It's like when they come here we do

Interviewer: So let me just say (heem) we gonna continue with interview 4 participant 4 because they might be a few additional things you want to talk about ok, so you talk about observation, and what else are you saying?

Participant: The..., the vital signs

Interviewer: vital signs

Participant: yeah..., for the first two hours, which makes it difficult again like they say because of shortage of staff for the first two hours when the patient just come back from the theatre you need to be doing quarter hourly vital signs, to see that everything is fine, and then put them on 8 hourly ringers lactate to keep them well hydrated.

Interviewer: uhum

Participant: we also monitor the urinary output, we also check the bleeding, and because of most of them will PPH, (postpartum haemorrhage)

Interviewer: Ok

Participant: afterwards, so we check frequently for that and check the wound site if is dry and clean, and if it is leaking or it need to be repacked or if the patient need to go back to theatre to know what is happening to bleeding and we have (eem) the routine where we have the PPH pack which is already prepared,

Interviewer: huh huh

Participant: so that you don't run around, and (eem) what is the other one? Eclampsia pack, which you just pick up and then you go to the patient for so that, everything is in there and then we have something which is make our work easy, is like on day and night staff,

Interviewer: yeah

Participant: me self am doing it, emergency trolley,

Interviewer: Ok

Participant: if we do have emergency, we know that everything is there, is working, it functioning, there would be no delays.

Interviewer: Ok, good So I think we've covered most of this thing, so you talk about emergency, vital signs, is it the midwife that does the vital signs or is it some else that actually help with those observations.

Participant: (aah,) sometimes you do it because sometimes it's only two people, and the bed is 20 that side, and we have 4 KMC beds, where its low birth weight,

Interviewer: Ok

Participant: So you find out sometime it's only the staff nurse and the midwife

Interviewer: Uhum

Participant: so you find out theatre is calling, another ceaser still need to be picked up, we don't have porters around, so one has to go, most likely is the staff nurse that goes down because you can't leave the ward, should something happens, so you have to be doing the vital signs if you see that the urine bag is full, you can't leave it, you have to empty it, if the vacolitre, like I said you do almost everything,

Interviewer: Ok, alright there is quite a lot of things that you do in there, your junior staff will have to do if they are available,

Participant: if they are available. If a lot of staffs are available, yes

Interviewer: Ok, alright anything else because you seem like you has quite a bit

Participant: (she laughs).

Interviewer: Anything else again

Participant: (she laughs) let's see, I mention staff, that we will like to get a lot of staff, I don't know if this interview for Mercy will help us getting staff or what.

Interviewer: I am not sure, am not promising anything.

Participant: (she laughs)

Interviewer: (he laughs) alright thank you so much.

Interview 4c – participant 4

Interviewer: Alright, so we continuing with

Participant: HUUU.. (Laughs and creaming) we continuing

Interviewer: interview 4, participant 4, the second time (hum) so you mentioning about TTO, so just saying about TTO's

Participant: (hum) when we discharged them because we found that (eem) when we usually, usually they only got treatment for 24 hours

Interviewer: Uhum

Participant: and then we out that a lot of patients are coming back to surgical ward with septic word and then it was changed now so we giving them treatment until they discharged, IV treatment.

Interviewer: Ok

Participant: then we discharge them and then the doctor will prescribe oral treatment, which Flupen, Flagyl and (ee. Hum) what is the other one, panado, and pregamal and Brufen for pain and then we give it to them as TTO. So we also give instruction to the mother how to take the treatments, how to stick to the full course of antibiotics so that it will be effective, and not to take the treatment with alcohol, to drink it with water, and (eem) we run..., the other part I forgot, is that we check the Hb afterwards, because a lot of them will bleed automatically since they are giving delivery, giving birth, so we check the Hb, and if the patient need to be

transfused, the doctor will order, then we transfused it and if the patient need to.. Let's just say it's not that bad so those with Hb's of 8, and 9, we don't give pregamal, we give pherosulphate and folic acid

Interviewer: Ok

Participant: Hb of 10 and above we gives pregamal

Interviewer: Ok,

Participant: yes

Interviewer: Alright, so that is about the medication and, and

Participant: the medication yes, and the pain, we never talk about the pain.

Interviewer: we can talk about the pain, so what is it about the pain you want to mention.

Participant: (Hum) when they come back from theatre, there will be in pains, so as a midwife you will make sure that you (eem) give the prescribed medications that is given, and if it is not effective you inform the doctor, but also you should check

Interviewer: Ok

Participant: what is causing the pain? Because sometime we do, not sometime, it might not be pain from the head, because we do spinal

Interviewer: Ok

Participant: so they do get a lot of spinal afterwards, so we give up extra fluid (eem) at one point we have this doctor, working there now (she laughs) a neonate nurse, we had this doctor who was advocating for caffeine free coffee,

Interviewer: Ok

Participant: said it out, prescribe it,

Interviewer: then if the patient is having it said is headache, severe headache, we tell them to lie down and then we give the fluid, and then we give the coffee,

Interviewer: Ok

Participant: and then we take hope, for the pain after ceaser then is automatically to be checked if the pain is from there, is not a headache pain not a after pain which are normal for the person who has just given birth or it is not leg pain, because they will get DVT,

Interviewer: Ok

Participant: Yeah so that is an emergency as well,

Interviewer: Ok

Participant: the DVT and then we also encourage our mothers for early ambulation. (P4: CB)

Interviewer: Ok

Participant: they need to be moving around

Interviewer: alright,

Participant: afterwards,

Interviewer: so before I put it off again,

Participant: (she laughs)

Interviewer: (he laughs) there is no rush, say anything else more, anything that you would, may want to talk

Participant: (hum..) what else? (ha..am) there was this thing that we wanted to, that (hum) they wanted to try out they have read in the internet

Interviewer: Unum

Participant: we, most of the time we starved the patient after 12 (excuse me) and then goes to ceaser and then comes back, and then what we use to do is to starve them again for the whole day, but the first day and then they can start with a light diet, the liquid and the light and then they go on the soft, but we, sister our matron, deputy matron was here that time, wanted to implement something that he read on the internet.

Interviewer: Uhum

Participant: that is better for patient to start eating as early as possible, but still not happening,

Interviewer: Ok

Participant: yes,

Interviewer: so is that one of the challenges, best practice but not yet implementing

Participant: yes, which is still not happening? Is like people are now telling them that you know that they've been starved, they are tasty we tried sometime we has crushed ice, which was not crushed, now am lying this not private, (she laughs) but we had ice in the fridge, because they've been tasty

Interviewer: Ok

Participant: and then we give them ice cube, just to relief that tasty.

Interviewer: alright

Participant: but now we no longer have that.

Interviewer: Ok, so what are challenges you are facing around (eem) starting with eating as early as possible?

Participant: it's Nurses who don't want to change, who are reluctant and sometime people will tell that ok have it down in writing even if you are saying is best for the patient, but have it down in writing but there no body that is willing to put it down in writing.

Interviewer: Ok

Participant: so that's the delay and sometime people will tell you that no, no, am not starting anything until the patient is day one, completed all the 24 hours whatever, then I can start as you say, but the research has been done, says that the sooner, the better to start the fluid after 12 hours the patient can start drinking, and then you move on to other stuff, but is wasn't so

Interviewer: Ok

Participant: it faded away (she laughs)

Interviewer: So one of the challenges is to get (eem) best practices as part of your standard of operating.

Participant: she laughs (hum).

Interviewer: so we looking at all the challenges, best practices is part of written standard of operating procedures in hospital

Participant: yes and I feel that we have done, another thing we've done, we've done away with a lot of good practices

Interviewer: Uhum

Participant: when I just qualified, we used to ambulate after 6 hours, we will take the patient out of bed, you let them go and sit and then we can take them back into the bed, and that's it of which was enough, now they lie on bed for 24 hours, which is, they become more prone to the DVT because they are just lying there, doing nothing which is like early ambulation is not a crime, which is good for the patient, is good for the circulation, it will be good for the wound, but is...

Interviewer: something you don't do

Participant: something that doesn't happen

Interviewer: Ok

Participant: like before, something I think was the best practice that we had, because patient recovered much earlier, now the next day (aha) wake up, it's had for the patient because is been lying for 24 hours and not doing anything,

Interviewer: Ok

Participant: Yeah, and I will like, may be have (hum) more junior staff, because (ha) we give Pethidine and it's a sedative and the mother will fall asleep, and then the mother has to change the nappies, because its two of us, we can't be doing all of that and sometimes you find out babies are not changed, they are filthy because the mother is still under sedation, he is still in pains, can't move so if there is a lot of staff, then they will be taken care of.

Interviewer: Ok, thank you so much am gonna ends it there, and then I will ask (eem) if we need spread on credible we get back to you.

Participant: Ok

INTERVIEW 5: PARTICIPANT 5 (P5)

Interviewer: Alright today is the 12th of the 7, 2016, its 20:10 now, we doing interview 5, participant 5. (hum) there no right or wrong answers, is just giving an expression of your opinion and your experience.

Participant: Ok

Interviewer: Just some easy questions first, how old were you at your last birthday?

Participant: I was 30

Interviewer: 30

Participant: yes

Interviewer: (hum), what is your highest nursing qualification? They've given us four choices here. General Nurse and midwife diploma, general nurse and midwife degree, general nurse and advanced midwife and Masters in midwifery?

Participant: the first one, general nurse and midwife diploma

Interviewer: ok, how many years of experience do you have as a midwife?

Participant: I have 2

Interviewer: 2

Participant: yes

Interviewer: how many years have you worked in the maternity unit of this hospital?

Participant: 2

Interviewer: What is your position in this hospital?

Participant: I am a registered midwife on a contract.

Interviewer: Oh like a cushion,

Participant: so the first question am ready to ask you, if you look at South Africa in general, if you look at the quality of the standard of postnatal maternal care what would you say is that standard, how would you rate that standard

Participant: (haa) I will say it's satisfactory

Interviewer: satisfactory ok, and if you had to compare this hospital to the hospital in South Africa in general so you said, South Africa satisfactory, if we look at this hospital what would be the standard of care, postnatal maternal care? What would you say here?

Participant: I would say standard of care is nice

Interviewer: Ok, what do you think are the activities so, in postnatal maternal care, there is range of activities right, what are the activities that you think would include postnatal maternal care that would be done in postnatal maternal care, it doesn't have to be only the nursing staff, it might be a whole range of other people, to do, who contribute to this (eem) activities in postnatal maternal care, so you have how that list might include.

Participant: the list of activities?

Interviewer: Yeah

Participant: What I really understand by activities is it what we perform, like for postnatal mothers?

Interviewer: yes

Participant: By checking how was the (aha) uterine contraction

Interviewer: Uhum

Participant: the uterus has contracted, checking the postpartum haemorrhages, the general condition of the mother,

Interviewer: Ok

Participant: Check if they are breastfeeding, if the milk are secreting, (hum) the lashing of the baby, if he is lashing well onto the breast, and we check (hum) vital signs, the blood pressure, pulse, temperature and we check those mothers who are, if I can tell this, RVD positive to check those viral load is (hum) if the viral load is less than a thousand, to repeat or if it was done 3 months ago, it has to be repeated, and then ok education, educating mothers, (hum) recently (hum, hum,

(hum) a mother has recently given birth and now to breast and now to prepare breast milk or if they are not breastfeeding, then formula how to prepare it, we emphasised on hygiene, emphasised on breastfeeding on demand, then what else? (hum) look at big countless, if a mother is a non-clinic case, then the counsellors will come and do the, HIV and AIDS, HCT, HIV counselling and testing, and then what else we do? Wide range of things are to be done, we need everything that is...

Interviewer: so may be if you can remember anything else, you add to the list if you want to, if you've exhausted it, is fine, anything else you want to add to the list?

Participant: Yeah I would

Interviewer: Ok, from the list you've given now so you mentioned things that the counsellors are doing HCT etc., this list is comprehensive of what you do in postnatal maternal care; ok from that list are there specific things you will say ok this from here is what midwives do in postnatal maternal care?

Participant: Yes (hum) like checking postpartum haemorrhage that is midwives' duty, uterine contractions so to prevent postpartum haemorrhage, checking and then epis if the patient has episiotomy performed, that is cutting of the perineum,

Interviewer: Yeah

Participant: then checking if is not oozing, and then if it was performed well, so we checking the sign of infection, that is midwives' duty, and we check milk secretion that is midwives' duty and lashing of the baby, if he is lashing well and suckling and suckling reflexes from the baby if the baby is suckling well from the breast, if the baby for sign of jaundice, if the baby has jaundice and then you check your (hum) what else? Again postpartum haemorrhage cases, full blood count, ward Hb., it depends on the condition if there is severity of postpartum haemorrhage (hum) last, the general condition of the patients is still the midwives' duty, before we discharge, the doses, previous caesars of mothers, may be you have caesar scar a year before or two years back year, so we check if caesar scar is not (hum) is not oozing or still in good condition, (hum) I think yeah that is it.

Interviewer: ok alright, so if you had to postnatal maternal care is there a clear point where your duty starts, and where it ends, so if you are looking at the whole process, of all coming together, can you say as soon as she come in, at this point this where it starts postnatal and this is where it end postnatal? Is there a clear idea for you or is just everything?

Participant: for me I will say is everything, like what we do its everything because even with counselling it is still us if the counsellors are not there, but luckily for us the counsellors is always there, so i will say because I also worked labour ward and labour ward postnatal ward, so I would say it is clear even though it is so much to do, that is why we need other staff nurses, and all what not, I will say it is clear to some extent, I will say it's clear what is other things.

Interviewer: so you saying it's clear postnatal, it's clear where its starts and where its ends, is that what are saying or is it.

Participant: I thought you are talking about the duties, of nurses and midwives' duties starts

Interviewer: so the midwives' duties start even before postnatal, before delivery, am looking specifically postnatal is there clear place where midwives' postnatal duty starts and this is the time it's actually ends.

Participant: is not clear

Interviewer: not clear, ok and (hum) you mentioned something like health education, what are some other things you will actually cover in health education

Participant: Ok I did mentioned breastfeeding

Interviewer: Uhum

Participant: breastfeeding on demand, then baby has to, you don't have to wait for the baby to wake up for her to breastfeed and (hum) educate about preparing of feeds,

Interviewer: Uhum

Participant: when and how (hum) changing of nappies, checking of the colour of the stool, what colour it should be (hum) then how often does the baby or infant passes, that would tell you whether baby is well fed or not, then the cry of baby, the cry

can tell you something that if baby is crying it could be wet nappies, or baby is no been breastfed well, or baby is not generally in good condition and then (hum) is that, education, educate that mother has to come back after, 72 hours, post-delivery for follow-up, it start in her local clinic.

Interviewer: ok

Participant: to check episiotomy if there is episiotomy performed, or ceasers usually we give 4 –to 6 days to ceaser patients, to check the scar if they are still intact, is not oozing, (hum) the general condition of the mother as well as the baby, there is no jaundice, is feeding well, is gaining weight well, (hum) is good passing of stool, and any by sight, that will indicate that the baby is fed well, and then if the baby is growing well, and that looking at the head circumference, the height and the weight (hum) education, gave education desired, I will say for relief RVD positive and any mother who has been given treatment to take home, like antibiotics, that is because they got episiotomy, they are sore, or bleeding, infection started to be septic, and they are given antibiotics so they are advised to take antibiotics, as advised or educated as per manufacturer guideline and as prescribed by the doctor and look at those that have investigation done, and then to come back to the hospital or local clinic for results, then those who are birth asphyxia, they are given date to come back to the clinic, so they will be educated to adhere to those dates, and they will be made to understand that if they don't come back on the dates they are supposed to come, they will be educated about the consequences, and if they are formula feeding, there are method occur, I did say preparing

Interviewer: Uhum

Participant: and how to store the existing formula,

Interviewer: Ok

Participant: even if you are breastfeeding, but if you want to go back to work after a week or sometime a month, you can still continue but you have express milk and then you store in cool dry place if not in refrigerator (yeah) what else? Yeah I think everything I have said.

Interviewer: quite a large list as well, ok last question is, what is it that actually make it easy or difficult to provide care to postnatal mothers? So from your experience, are there things that make it easy or makes it difficult? To provide postnatal maternal care.

Participant: in my experience I will say (hem) that, I won't talk about our postnatal care, so I work in labour ward so there postnatal is like a room, it's very small so sometimes you find out that it is stuffy it is not conducive for postnatal mothers to be kept there, and sometime its too many for a day, **the staff is not enough for us to provide quality care, or to give a proper care, and education because we want to push, to push in other for them to go, (P5:5A)**, sometime the visitors will come and then push us, **making it difficult I think is paper work, paper work unfortunately it has to be done ,but paper works sometimes make us not to be able to give quality or proper patient care, (P5:1B)**, and what much makes it easier is that we've got counsellors, sometimes the nurses are meant to be counsellors too, to do head counting, do the CD4 counts, HIV and viral loads, so they deal with that stuff, we then got Enrol Nurse who is to help with immunisation, who help in doing blood pressure, pulse and respiration, for the postnatal patients, without them we won't be liable to do all those things because immunisation is there (hum) doing of vital signs, PPH patients are quarter hourly observation

Interviewer: Uhum

Participant: sometimes what makes it difficult is language, language sometimes is the problem, because we find that (hum) clients are coming from outside of S/A

Interviewer: Uhum

Participant: then they don't speak English at all,

Interviewer: Uhum

Participant: so it's kind of difficult to communicate, so if communication is difficult is not easy to render quality care and then sometime like I have said, you can push, they need to go they just ask for fetch the mother and go home sometimes there is nothing you can do but I will say communication from clients that are coming

from outside the borders of S/A, which makes it difficult but (hum) I will say it's more of difficult than anything easy, easy is because we've got like En's and Counsellors, yeah and so forth, otherwise most of the time is difficult to work in those conditions.

Interviewer: Ok alright thank you so much, is there anything you want to add?

Participant: (he laughs)

Interviewer: that's the end

INTERVIEW 6: PARTICIPANT 6 (P6)

Interviewer: Ok so today is the 4th of the 8, 2016 its now 20.45

Participant: Is 19.45

Interviewer: (hem) yes it's 19.45, not 20.45, 19.45. Interview 6 with participant 6 and then we going to make some brief introduction just sort of ease into it.

Participant: Alright

Interviewer: (huh) how old were you at your last birthday?

Participant: (huh) 29

Interviewer: Ok what is your highest nursing qualification?

Participant: Degree in Nursing

Interviewer: (huh) so you've got (huh) general nursing and midwife, degree?

Participant: Yes

Interviewer: Ok how many years of experience do you have as a midwife?

Participant: (ah) 6 years now

Interviewer: And how many years have you worked in the maternity unit of this hospital?

Participant: of this hospital, this is my first year, I just completed one year now.

Interviewer: Ok, and what is your position in this hospital?

Participant: Am a Midwife Accoucher Registered Nurse

Interviewer: Ok so we talking about postnatal maternal care

Participant: Ok

Interviewer: What do you think about postnatal maternal care within hospital in South Africa in general? So if you think about South Africa and think about postnatal maternal care what is the quality of care, what is the standard of care as far as you are concern.

Participant: I wouldn't comments on other hospital s but to the ones I have been through,

Interviewer: Hum hum

Participant: I don't know if I have to mention this.

Interviewer: You don't have to mention the names, but think about it and say what you have to say.

Participant: to the one I have been through and here, I think the government hospitals I think the postnatal is like, is requiring for you to be like open minded it's toughen actually, there is that sub patient coming through and the staff is a bit, is short staff, we are short staffed but at the end we still manage to get through, to get the job done.

Interviewer: Ok

Participant: So the quality of the standard

Interviewer: hum

Participant: yeah at the end of the day that is what you need to give the patients. Not to complain about that, whether you are short staffed or not because they patients are here for help, so we just here to offer help for the patient.

Interviewer: Ok so again if you look at the quality what would you say generally in South Africa?

Participant: the quality is of high standard

Interviewer: high standard

Participant: yes

Interviewer: and then if you have to compare this hospital to that higher standard that you are talking about the general hospital, how would you rate this hospital?

Participant: ok the previous hospitals I have been through are like secondary hospital and

Interviewer: primary

Participant: this one is like primary but I think I will rate this one a bit higher than those one, because here is like midwives who are hands-on unlike in secondary where they have doctors all over the place

Interviewer: ok

Participant: so here there are midwives who are making decision and who are, who will look after the patients most of the time.

Interviewer: ok alright (hum) when we look at the activities in postnatal maternal care (huh) there is a lot of different activities from a lot of different people

Participant: yeah

Interviewer: so if I may ask you what are the activities that is involved in postnatal maternal care, no matter whose client, is there a list of things you can think of ok these are the things that are involved in postnatal maternal care?

Participant: like the things we do?

Interviewer: yeah

Participant: like patient care

Interviewer: Ok so patient care alright

Participant: Hum

Interviewer: and patient care might be broken down into a lot of different places

Participant: yeah that is what I am thinking

Interviewer: so you could do that as well

Participant: I can break it down as well, ok like patient care are like someone can call postnatal right ceaser or NVD (normal vaginal delivery) doesn't matter?

Interviewer: ok yeah

Participant: alright so soon as the patient they come from theatre you as a midwife, whoever is getting the patient like may be your junior staff nurses, they have to, soon as they get the patient from theatre; they have to see that the patient is in stable

condition after the ceaser obviously, so they need to know they taking a stable patient and once the patient is here, you as a midwife you have to look after the patient, the patient has just been cut so anything might happen, the patient might PPH (postpartum haemorrhage) a lot, a lot of...

Interviewer: sorry what is PPH again?

Participant: Sorry?

Interviewer: PPH I just want to make sure that we...

Participant: Postpartum haemorrhage

Interviewer: alright yes

Participant: yes, patient might PPH, there a lot of adverse effects because the patient just delivers, because the homeostasis is not yet achieved, so the circulation is still trying like to come into place

Interviewer: ok

Participant: so that patient needs to be looked after, check them hourly, you see patient with BP's you need to check them hourly, the BP's are not going up, the BP would be, which means they wound

Interviewer: Uhum

Participant: and yeah the bleeding, the wound, look where they cut the patient is not bleeding, is not oozing, and PV because yeah and the patients are not dehydrated, there is drip put there, there output again is fine, you have to monitor all of those because if one of those is not like going correctly, then you have to attend to that, that means there is a problem, so you need to attend there and then.

Interviewer: Ok, so this stuff that you told me now, this list that you have given me

Participant: yeah

Interviewer: would that be things you as a midwife do?

Participant: yeah

Interviewer: is there anything else you can add to this list, may be like other people in your postnatal ward also be in all this?

Participant: the junior nurses, they will do the vital signs

Interviewer: Aha

Participant: yeah and the measuring of the output

Interviewer: Hum

Participant: yeah and what else? Oh yeah like patient bath care, yeah

Interviewer: ok so

Participant: with the medication they do give some of it but the schedule is given by you as a midwife

Interviewer: ok

Participant: yeah

Interviewer: so alright that list that we had initially (huh) is specifically for your responsibility as an Accoucher Midwife?

Participant: yeah

Interviewer: alright, (huh) what makes it easy or difficult to provide care to postnatal mothers?

Participant: I think what makes it easy is because we work as a team, we work as a team likes for instance, if it's like packed that side, like here in nursery or on the ANC side, they will come help, helping each other with work, otherwise I don't think it will be easy to cope, unless if we are having small number of patients but if the ward is like come full.

Interviewer: huh

Participant: yeah we just work hand in hand, that is how we get through the day, (huh) I think that is the most difficult part of it, is like when we getting a lot of patients

Interviewer: huh

Participant: yeah

Interviewer: alright so team work makes it easy but having a large number of...

Participant: if, if the other wards, this other wards are busy they cannot help, then that is when it becomes difficult.

Interviewer: yeah so team work helps to make it easy but is a large number of patients, if the other wards are busy?

Participant: yeah then it's difficult because short staffed

Interviewer: ok

Participant: somehow.

Interviewer: ok so that pretty goes back to the short staffed, ok anything else you can think of makes it easy or difficult to provide postnatal mom?

Participant: (huh) I think is also been committed to what you doing, it makes it easy as well, because when the pressure comes, when you like, when you know your work

Interviewer: Uhum

Participant: even when you're pressured, you know when you doing your work, you try to break it down the best way you could, because like if you say ok this is what I have to do in such time so am gonna do this now, now, now in just kind of break it down so you don't think, I think that helps to ease the situation as well.

Interviewer: ok

Participant: yeah

Interviewer: and then if we looking at postnatal care is there a way to say clearly this I where postnatal care starts and this is where postnatal care ends, is there a clear start and end points? As far as you can say?

Participant: yeah I think there is, (huh) soon as the patient delivers, that is when they become postnatal right, and it ends when they are going home.

Interviewer: ok

Participant: with review ones they go home, they go to local clinic so they don't come back to us, unless if they encounter a problem at home, like secondary PPH or something

Interviewer: ok

Participant: which is not, it doesn't usually happens

Interviewer: alright

Participant: yeah

Interviewer: so if you can truly identify a start and an end point as far as postnatal maternal is concern care, where does your responsibilities as a midwife start and ends.

Participant: it starts when the patient delivers and ends when a discharging the patient,

Interviewer: ok, and then part of discharge (huh) processes, what does that involved, what is involved in it?

Participant: when am discharging the patient, ok I need to check or I need to see in order for me to discharge the patient, I need to see patient, I need to be convinced that the patient is fit to go home, she is fit for discharged, everything is normal, she is no longer bleeding, everything, the vital signs are normal, the bleeding, no bleeding or there is minor bleeding because yeah they will bleed still but we need to make sure there is minor bleeding

Interviewer: yeah

Participant: if it is ceaser, the wound is intact, uterus is well contracted, PV bleeding is normal, no signs of anaemia, or anything, the patient is just stable, then there the baby as well, you need to check the baby as well again, if the baby is ok, is breastfeeding well, everything, yeah then I guess you will be like ok am good, I can let it go home, they can review her at the local clinic.

Interviewer: ok (huh) do you provide any kind of health education as part of your discharge planning.

Participant: yes we do provide health education for those patients, for every patient, for every patient, that is discharged,

Interviewer: ok

Participant: yeah do you want me to go on...

Interviewer: let me just mention some of those points...

Participant: ok like, ok it depends, alright all those like some patients are HIV positive, start with that, you can like give them health education to benefit their health like diet wise, sexually you need protection and all, adhere to their medications, and the mode of feeding, if they are breastfeeding or formula feeding to stick whatever they choose, and if its formula to stick in formula and make sure whenever they preparing the milk, its clean all the time

Interviewer: ok

Participant: and again with breastfeeding, when they breastfeeding, they stick on breastfeeding, ok not to mix and again with the pressure at home or from their in-laws you kind like high-light it to them, not to be like influenced by those kind of ideas, because they end up changing and mixed feeding, because there are pressures from in-laws,

Interviewer: ok

Participant: yeah so you kind like, counsel on those, counsel on protection, counsel on family planning again, like whenever they are ready, ok like we not saying they should have baby right, but we saying to them, whenever they feel like having babies, they should consult like a health care worker first, and see that, and get an advise, especially about their health at that time, because is kind like they are been immune compromised some of them, so kind of that advise them on their health, on what to do next even those who are not HIV positive, everyone need to give them family planning,

Interviewer: Uhuh

Participant: like health education family planning, give them all the types of family planning, we have because this hospital doesn't offer any, we don't offer family planning here, what we do is just give you ideas, we just give you all

the types, injectable, tablets, IUCD, all the type of family planning, then what we do is we refer you to your local clinic. (P6:2B)

Interviewer: ok

Participant: yeah for it, so we just we discuss it, so you know it's a major issue, we just break it down for you to do this, do this,

Interviewer: ok

Participant: especially those young children, you know all those 15 years, 16 years old,

Interviewer: yeah

Participant: because they still need to complete school all that, you teach them on condoms, family planning and yeah you refer them to a local clinic from there.

Interviewer: alright so you mentioned, diets, you mentioned family planning issues,

Participant: yeah

Interviewer: Uhuh anything else? As far as your health education that you want to give?

Participant: I think (Huh) ok with the baby as well like cord care,

Interviewer: Uhuh

Participant: cord care yeah, monitor the baby's feeding, if the baby is feeding well for jaundice sign, and yeah monitor the baby for may be diarrhoea if your baby having diarrhoea you can also send the patient to the hospital. All those dangerous signs for the baby and for her as well if she is having any bleeding at home because they normally go for review like 3 days after you've discharged them,

Interviewer: Ok

Participant: so yeah but we do tell them even if, you don't have to wait for 3 days if you encounter problem within even if now, you can come back.

Interviewer: Ok

Participant: yeah if you can't go to your local clinic, whatever is nearer to you, but you don't have to wait for the 3rd day to go for it.

Interviewer: so if there was an issue now, so you discharge them, they just driving out somewhere, and few hours later they supposed to come back here?

Participant: it depends where they want to go, they can come back straight here, but it depends, some of them because it's minor issue by people, but may be if they are at home, then the clinic is nearer, they will rather go to the clinic, then they can be transferred back here with an ambulance,

Interviewer: ok

Participant: so it's much easier that way, and when they come back to your ward, yeah if it is same day, they come straight back to our ward, if is 24 hour pass, they will be seen at our out-patient department.

Interviewer: Ok

Participant: yeah

Interviewer: alright so and just to close up, anything else? Do you think you want to add to what you've been talking about postnatal maternal care?

Participant: yeah I think I have covered everything, most of it yeah,

Interviewer: ok

Participant: yeah I think I have covered most of it

Interviewer: alright thank you very much

Participant: alright

Interviewer: and that's we are done.

INTERVIEW 7: PARTICIPANT 7 (P7)

Interviewer: Today is the 4th of the 8, 2016, then we starting now at 20.07, this interview 7, participant 7, what we have to do is to ask you some basic introduction questions just to ease, ok

Participant: Ok

Interviewer: How old were you at your last birthday?

Participant: at my last birthday I was 42

Interviewer: ok and what is your highest nursing qualification, so they've given us some choices here

Participant: huh

Interviewer: they said general nursing and midwife diploma, general nurse and midwife degree, general nurse and advanced midwife, Masters in midwifery

Participant: general nursing and diploma

Interviewer: ok how many years of experience do you have as a midwife?

Participant: 2 years, am two years today

Interviewer: ok (he laughs) huh, how many years have you worked in the maternity unit of this hospital?

Participant: 2 years

Interviewer: and what is your position in this hospital?

Participant: I am a midwife, who works in ANC ward

Interviewer: as a midwife?

Participant: huh-huh.

Interviewer: in ANC ok so if you had to look at, we looking in generally about postnatal maternal care.

Participant: huh huh

Interviewer: if you had to look at the hospital in general in South Africa, postnatal maternal care how you would rate the service, how would you rate the quality of the standard as far as you are concerned, as you can see.

Participant: As far as I am concerned about the postnatal ward, I can say that the nurse is the one who do total patient care, **but sometimes we finding it difficult because the nurses are not enough, the quality of patient-nurse ratio is not enough, because in postnatal ward, there is a lot of things that we do, so it need a lot of people like, (P7:5A)**, if you give an example of here in St. Mary's (hah) you can find there is one nurse, like one registered midwife and two staff nurses and those people they are there just do a vital signs, and the these registered midwives we doing valve swapping, checking there op site, giving IV's, IMI, but we are trying our best to give total patient care.

Interviewer: huh ok, so if you had to rate the service in South Africa postnatal care?

Participant: (huh), I think you mean can I rate into percentage?

Interviewer: percentage or however

Participant: I think we are trying about 70 percent

Interviewer: 70 percent ok and then if you compare this hospital and other hospital in South Africa what would the percentage would you give.

Participant: ok like me I can compare this because I normally go and work with eThekwini hospital as well, so as am seeing this hospital because of patient-ratio I can compare this hospital to eThekwini maternity home, eThekwini there a lot, is above us, is about 80 percent, as am saying even shifa, I normally go to Shifa again am saying that there is different 20 percentage or 30 percent due to nurse-patient ratio.

Interviewer: ok

Participant: (huh huh) but we are trying, we can't say that patient are not been taking care of, they are not getting total patient.

Interviewer: ok so you still getting good patient care here

Participant: yes

Interviewer: but not as good as some other hospital

Participant: yes

Interviewer: ok then if you are to look at the activities that forms part of postnatal maternal care

Participant: (huh)

Interviewer: what would those activities include, so it doesn't have to be only for the nurse?

Participant: huh

Interviewer: it's any of the activities you that you would consider this is all part of postnatal maternal care.

Participant: ok

Interviewer: is there a list you can think of

Participant: yeah the activities that there in the postnatal ward is between the nurse and patients

Interviewer: huh

Participant: the patient also needs to take care of herself if she is got a problem, she need to tell the sister what the problem she has, because you can't know, because other people they've got other things which we cannot see physically, even if you take our vital signs you cannot find it.

Interviewer: huh

Participants: so other patient they've got other issues which need to be solved for them, to be well.

Interviewer: alright

Participant: which need mentally?

Interviewer: ok

Participant: like you know postnatal that is where people have this blues, because of the previous during the pregnancy, which need the patient nurse to talk so that they come out with a solution for the patient to be well, because giving medication alone, never let the patients go home.

Interviewer: huh huh

Participant: (huh) because other patient, may be starting from the scratch we can be doing vulva swabbing, checking everything for the patient but the patients is got other issues which can let her not to decide to go home or when she is going home, she will end up having other problems like tachycardia, what is going on with this patient, you are not bleeding, you not having this, what is this, but if you solve that problem behind, it will quickly let the patient go home.

Interviewer: huh huh

Participant: huh

Interviewer: so that is all like the psychiatric issue around

Participant: yes, psychiatric issues, social problems, (huh...) financial problems

Interviewer: huh huh

Participant: huh huh

Interviewer: so this are the things you actually deal with, as part of your care here in hospital

Participant: yes, yeah we do, because we need to know about those things, because other patient may be she is here, she is still a teenager we are delivering a patient which are 13, 14 years, maybe she was chased away from home, she was staying with another auntie, she doesn't even have a nappy to give to the patient, we need to observed those things and go deeper so we can help this patient before she goes home.

Interviewer: ok

Participant: huh huh

Interviewer: alright you also mentioned so those were the psychiatric, social, financial issues.

Participant: huh huh

Interviewer: then you mentioned for example, vaginal swabbing, managing bleeding, you talked about personal issues.

Participant: yes

Interviewer: Any other things that you think are part of postnatal maternal care?

Participant: ok in the postnatal those are the just checking care but there is other thing which we do also, we do family planning

Interviewer: alright

Participant: though we don't have it here but we give them advice where to go and get it at the clinic, you need to decide, we tell them the advantage and the disadvantage of different type of family planning methods which they can take and the patient has to decide before she goes to the clinic. Because maybe the person she will find there may not able to find the time to, because you know clinic has got a lot of client,

Interviewer: yeah

Participant: so we teach them prior.

Interviewer: alright

Participant: before they go, to choose, so that they can choose

Interviewer: ok

Participant: and we teach them also about (huh) immunization of the baby,

Interviewer: alright

Participant: immunization of the baby, how they will go about and why are they doing certain injection and what are they preventing,

Interviewer: huh huh

Participant: and also we teach them another thing, we should teach before deciding, teach them about the wound care,

Interviewer: ok

Participant: we teach them about the gap between if is a first child or second child, what are the danger if is the third gap child

Interviewer: huh huh

Participant: so that they know prior before they went home, others the third baby is a caesarean section and they can think of coming here because they don't have the knowledge, we teach them the dangers,

Interviewer: huh huh

Participant: and if she is a first child we tell her the in between so that the wound can heal

Interviewer: alright

Participant: because if we don't teach them prior they will come back with fresh stitches, she was having caeser in July and next year July she is having, so we are preventing those things,

Interviewer: ok

Participant: huh huh

Interviewer: alright so you mentioned a few things, you talk about medication, counselling,

Participant: huh huh

Interviewer: financial, social, psychiatry issues,

Participant: huh huh

Interviewer: valve swabs, managing bleeding, the health education issues (hah...) are there anything else that would be part of postnatal maternal care? That may be beside midwives others also do?

Participant: beside midwives?

Interviewer: yeah

Participant: other things which other people do (huh...) for even, we don't do..., "those one are done by those people who does Physio, if you find out that the patient is got a problem which doesn't need medication, but she needs physio, we need to call a physio therapy to come and exercise the patient and so that the patient can go a little, because some time you give antibiotics is not going away is a not or nil problem, she need exercise that would be done, we call those physio people to come and do that to the patient". (P7:3A).

Interviewer: ok and is there any other (huh) people that are involved in

Participant: in taking care? Another people which are..., social workers,

Interviewer: ok

Participant: we involve social worker if the patient is got a problem where to stay, financial problem,

Interviewer: ok they were also done here

Participant: yes, they will also do here in postnatal.

Interviewer: ok

Participant: and also other people, like other people got a problem like what we are saying psychic problem, those ones sometime we need to involve the spiritual people, here we've got spiritual people, who come and pray with the person or she can decide herself to bring her own pastors or whatever she believes (she laughs)

Interviewer: Ok

Participant: to come because some of the problem you can think is like a nurse if I call (eem) Christian, maybe she doesn't believe so you need to talk to the patient and see how we can solve this problem.

Interviewer: ok so if we looking at all of that stuff that actually outside of

Participant: Nurses

Interviewer: outside of nurses, there is quite a bit

Participant: yeah there is quite a bit which is involved (huh hun)

Interviewer: (huh) and then the ones that are specific to nurses, you will think is what? Like medications?

Participant: oh the ones that are specific in postnatal, we give medications,

Interviewer: yeah

Participant: we check their, we do vulva swabbing, we check the bleeding, how is the bleeding, is it moderate, is it not (huh) normal one so that we can call the doctor to come and see if it is PPH or whatever, we involved the doctor there, and also another thing which we check is the wound site, (P7:2B).

Interviewer: huh huh

Participant: because sometime if you don't check, maybe is gapping, maybe is bleeding inside, we need to check those things, because it delayed the patient to be discharged,

Interviewer: ok

Participant: and another thing also which we do, sometime the patient, the medication which is maybe she day 2 but they can weaned them those patient on antibiotics, but you because you are talking to the patient, you see that she is still having this, you can re-advised also the doctor to please prescribe for the patient,

Interviewer: ok

Participant: huh huh

Interviewer: alright, ok so there are specific things that you mentioned that are midwives' responsibilities.

Participant: (huh huh) and to check sepsis also because sepsis can start, especially from day one.

Interviewer: huh

Participant: because other patient they've got other infection which you don't know, because is not about only bleeding, we can check also for sepsis because when you are checking you check the type, of course on day 1, we check lochia, rubia, we checking lochia, it differential until the patients is gone.

Interviewer: alright

Participant: so they have different type of smell, texture so that you know if there is a problem.

Interviewer: ok alright

Participant: even too the baby also, we check the babies

Interviewer: alright

Participant: on daily we check the baby, the weight, the skin colour, the abdomen, how the baby is breathing, check if the baby is also having any tinge of jaundice, because in postnatal there is a lot, you see, we are dealing with mother and the baby

Interviewer: and the baby ok,

Participant: we still continue mother and the baby,

Interviewer: alright

Participant: huh huh

Interviewer: (huh) alright, so if you looking at postnatal care,

Participant: huh huh

Interviewer: is there anything that makes it easy or difficult to provide care to the postnatal care mom?

Participant: (ha...) here at this hospital, am not seeing any difficult, only as I told you that if there are more caesars, only the problem is when there is no enough of us to provide.

Interviewer: staffing is a problem

Participant: staffing is a problem, but we try, we don't want to lie, but we try because what we need is for the patient to get what she came here for

Interviewer: alright, ok so how do you make sure she get what she came here for?

Participant: we just go extra mile (she laughs)

Interviewer: ok

Participant: we go extra mile, if they are many we increase also speed, we work together, sometime it doesn't mean if that sister is allocated, she is the one, when they are many we go as a team, to help. (P7:4A).

Interviewer: ok, team ok alright.

Participant: yeah we use team work,

Interviewer: yeah

Participant: so that our patients get what they are supposed to get,

Interviewer: alright, so staffing will make. Under-staffing will actually a difficult as a team work is appropriate

Participant: team work it will, at the end team work will improve the total patient care,

Interviewer: ok anything else you wanna had to that, that makes it difficult or easy,

Participant: for a difficult, when there is less, but when the other wards are easy we use team work

Interviewer: ok

Participant: starting from, everyone we are involved in one, even if there is a problem you know like in postnatal we can have cases like PPH, Fits, she can't do it alone, we have to do it as a team work.

Interviewer: ok,

Participant: huh huh

Interviewer: alright, ok so two more questions

Participant: huh huh

Interviewer: (huh) if you had to look at postnatal maternal care, is there a clear starting and an ending point? Where would postnatal starts, where would postnatal ends?

Participant: postnatal starts when the day when the patient is operated or delivered. Whether normally or whether is caeser,

Interviewer: right

Participant: that's where it starts when you are checking, the wound site or the bleeding or the uterus is it contracted, we check everything, that is where it starts until (eem..) 6 months.

Interviewer: Ok

Participant: we will be checking, because there is after,

Interviewer: alright

Participant: after which will find sepsis that you see the patient they can come, after two months

Interviewer: ok so would your definition of the end of postnatal be up to six months or two months

Participant: (hah) is three months

Interviewer: three months

Participant: three months

Interviewer: ok and would that include the patient coming back to in this hospital or

Participant: they can come to our OPD, but they are still our patient, they come to OPD because we've got a clinic,

Interviewer: alright

Participant: here they come again to ANC if they've got a problem

Interviewer: right

Participant: yeah

Interviewer: ok

Participant: so if you don't solve it here, we have many like the wound, if you don't check if they are having sepsis or gapping, the patient end up going to MFS, so that ward is just for a small ward for a few people, so if you don't take care of the postnatal, it quickly flair that small

Interviewer: sorry what is MFS again?

Participant: MFS is male surgical ward where they go after they've delivered, when they got operation, or they've got sepsis on the stitches, so we need to check thoroughly before the patient goes. That is there any infection, is there anything?

Interviewer: ok

Participant: to avoid that,

Interviewer: ok alright, so if they are discharged from you here today

Participant: huh

Interviewer: and if they have issue around up to 2, 3, 4, 5, 6 months, they can still come back to this hospital?

Participant: up to 3 months

Interviewer: up to 3 months to this hospital?

Participant: they go to the clinic,

Interviewer: and then they go to the clinic but they won't necessarily come back to this ward

Participant: no they don't come back to this ward,

Interviewer: ok and then (uuh..)

Participant: and the other thing which we check also in postnatal, we check also Hb, before she goes, from day 1, we check, before she goes home we check also because they are bleeding after delivery,

Interviewer: alright, ok

Participant: so we need to check that because send the patient, will go there is this break down of white blood cells or whatever, the patient can end up collapsed, we've got one patient incident which happened last, patient was discharged with a low Hb, she went home, she came OPD collapsed and passed on.

Interviewer: ok

Participant: so we avoid those cases, because it's a critical issue

Interviewer: yeah, yeah

Participant: huh huh

Interviewer: alright so let me just recap, so your postnatal would start when the mom is delivered?

Participant: huh huh

Interviewer: whether is normal vaginal or caesarean?

Participant: huh huh

Interviewer: and you say up to 3 months?

Participant: huh huh, after 3 months yes postnatal,

Interviewer: as far as this ward is concerned, and your duties are concerned

Participant: huh huh

Interviewer: where do you see your postnatal duty starts and where does it end?

Participant: ok ours starts from (huh) for us it starts when the patient delivers, normally or as per vaginal until the patient is day 3 she goes home,

Interviewer: ok so yours is limited to 3 days?

Participant: (huh) to 3 days (hem) but when the problem comes, its comes back because they have to verify who was the sister then?

Interviewer: alright

Participant: yeah, although it doesn't, the patient card doesn't come but the problem comes back to you

Interviewer: how does it come back to you?

Participant: like there is an incident that a patient was checked, the person who did the ceaser didn't check that the patient was HIV, but the baby was not given, he was discharged, they didn't see on the space it was not written that the patient is HIV, the baby was not given a nevarapine,

Interviewer: yeah

Participant: and the patient was not even given advice on how to do it,

Interviewer: right

Participant: the patient was in clinic, it has to come back again, who discharged, what happened, who went to theatre with this patient?

Interviewer: ok so..,

Participant: it came back again,

Interviewer: so it does come back inform of the query

Participant: yes you write incident report

Interviewer: ok alright, and then you mentioned quite a few things about health education, but may be the list goes but summarize those

Participant: summarize it

Interviewer: what is the health education you would give to mom before they are discharged?

Participant: before they are discharged

Interviewer: so you mentioned family planning,

Participant: huh huh

Interviewer: immunization, wound care,

Participant: huh huh

Interviewer: anything else that you want to add?

Participant: us also we talk about if they are HIV, how the will continue with the baby, been giving, to go and check PCR and themselves to continue with medication also

Interviewer: ok

Participant: huh

Interviewer: and some of the, let's say those ones who are Rh negative, will tell them also to keep on checking, so that they get the medication for next pregnancy,

Interviewer: ok

Participant: Hun hun

Interviewer: alright and then Rh rhesus,

Participant: yeah rhesus

Interviewer: ok (huh) alright your family planning, immunization, wound care, HIV patients, rhesus negative patients, any other health educations you give to mom before they get discharged?

Participant: they get discharged? The other things which we talk is to teach them, like the other things you see when you are talking to this patients, sometime you that some of the things are laziness, they need to also to find things to do like hand on, so that they can provide for themselves because even if they wait for mean only, they end up not given enough for the baby, like we don't, when you are giving health education we talk about also breastfeeding, formula feeding,

Interviewer: Huh huh

Participant: it depends what the mother choose but we normally encourage them to do breastfeeding,

Interviewer: ok

Participant: but they are cases that the patient will say no I need formula feeding, you must teach her how to do the formula feeding, and try to tell her to how to make money, that money too, and to..., because you can talk of formula, but she doesn't have the money, she end up giving water

Interviewer: alright

Participant: and the baby comes back with kwashiorkor, malnutrition,

Interviewer: ok

Participant: huh huh

Interviewer: alright so, before she is done, just to add to the last one, is there anything else you want to add to anything we've discussed around postnatal maternal care, maybe something you want to add to it,

Participant: huh..., what can I say? On the postnatal we need to keep on teaching our mothers that when they come for this postnatal is not only or the nurses to take care for themselves, but for them also they must contribute because others they hide what they have, and also this thing that the others they are too young, we need to keep on re-advising them, especially those ones with HIV, that they must not be issue of stigma, people will see me at home with this nevarapine, what would they say, they see me not breastfeeding, so we must remove that fear from them because is their child, is their life, is not about the mother, is not about the uncle,

Interviewer: alright

Participant: huh hun

Interviewer: ok

Participant: hun

Interviewer: thank you very much, and that's it

INTERVIEW 8: PARTICIPANT 8 (P8)

Interviewer: ok so today is the 4th of the 8, 2016 is now 20.30 am doing interview 8, participant 8, I just wanna talk on some easy question right, just the easiest for interview, alright so how old were you at your last birthday?

Participant: I was 34

Interviewer: 34, ok what is your highest nursing qualification, there are four choices here, general nursing and midwife diploma, general nursing and midwife degree, general nursing advanced midwife, Masters in Midwifery.

Participant: general nursing and midwife diploma

Interviewer: ok, how many years of experience do you have as a midwife?

Participant: just a year, only one year.

Interviewer: and how many years have you worked in the maternity unit of this hospital?

Participant: one year

Interviewer: ok, what is your position in this hospital? So your qualification or your progress?

Participant: (huh) as a registered midwife,

Interviewer: as a midwife

Participant: yes

Interviewer: ok alright, so in general if you get to look at all the hospital in South Africa, and you are to rate the postnatal care,

Participant: (huh)

Interviewer: what would you say about the standard or the quality of care in postnatal maternal care?

Participant: (huh) it's very good according to, because we are guided by the Department of Health in everything that we are doing, we are maintaining the standard as a

national, yes on what we are practicing on postnatal department or on our postnatal patients,

Interviewer: ok

Participant: yeah

Interviewer: and then if you had to compare this hospital to, so you said generally hospital in South Africa very good?

Participant: (huh)

Interviewer: they meeting standard etc., if you had to compare this hospital to that standard what would you say this hospital is? As far as the standard is concerned in quality?

Participant: are we talking about the percentage or

Interviewer: well you can give me in percentage if you want, but you gave me, you said very good for all the hospital, we guided by DoH, we maintaining the standard etc., so if you had to look at this hospital specifically and compare that to the general hospital, all over South Africa is it the same, is it less, how would you rate it? Would you give it the same....?

Participant: I will say is the same?

Interviewer: ok

Participant: yeah, because the things are, most of the cases that we attend they never come back with problem, because since we know that postnatal is those who are having caesars most of the time, they never come back with septic wound, so I will say we are maintaining, actually at the moment we are the best,

Interviewer: is you guys different?

Participant: (she laughs)

Interviewer: (he laughs) so from very good now, you saying is the best ok,

Participant: ok

Interviewer: is alright is not a problem (he laughs) alright I don't have something back, alright so if you had to look at postnatal maternal care, there is lots of different people involved in it

Participant: huh huh

Interviewer: and there is a lot of different activities

Participant: huh huh

Interviewer: if you had to look at it, what are all the activities, it doesn't matter who is providing the activities or whatever? If you have to think about the list of activities, you would say this here belong to postnatal maternal care,

Participant: so..., like can you repeat your question, you want specific things that we are doing in postnatal,

Interviewer: postnatal, who ever does it, whether it's you or somebody else

Participant: huh huh

Interviewer: things, activities you do in postnatal

Participant: ok (huh) firstly, you attend to the mother; make sure that she is free from pain,

Interviewer: huh huh

Participant: she is comfortable, because since they bleed after delivery, so the sister must be very alert and check pad now and again, like every 2 to 3 hours,

Interviewer: huh huh

Participant: yeah, others they bleed a lot, so on those who are bleeding a lot we attend to them differ from those having normal bleeding,

Interviewer: yeah

Participant: yes, then (huh) you make sure that she is comfortable, then another thing that we do is vital signs, because if they are high or they are low, that is another complication that we need to attend as a sister, then we attend to the babies, because most of the time they are with their babies, we don't separate the

mothers from the babies unless their condition doesn't allow, that is when we separate, but if both of them they are okay, we promote bonding 24/7.

Interviewer: alright

Participant: huh huh, then you ensure that (huh) while they are bonding may the mother to be able to feed the baby, though is not easy for them because they are still having those pains but you control the pain first, then assist her on feeding the baby,

Interviewer: huh huh

Participant: ehm, we also encourage them to mobilize; we don't allow them to sit in bed for a long time, because we trying to prevent some complication as well,

Interviewer: ok

Participant: then we give them antibiotics, that were ordered by the doctor, to control infection (huh) yeah we encourage meals, they must drink, eat so that they can have energy

Interviewer: huh huh

Participant: yeah

Interviewer: alright so, you mentioned something about keeping them pain free, comfortable, sorting out bleeding, doing the vital signs, ensuring there is bonding

Participant: between her and the baby,

Interviewer: are these things specific to the midwives or does it involved other people as well?

Participant: it does involved other people as well,

Interviewer: ok so give me some example of who else might be involved?

Participant: (huh) the staff nurses, but most of the time they deal with oral medication, but IV's are the sisters who are attending to the IV's (huh) the vital signs they can do then they report if there are abnormalities to the sister,

Interviewer: ok

Participant: then you act, then even the doctor as well, if as a sister I see that am failing here, I inform the doctor immediately so that he comes because our doctors they are not with us like 24/7, they are busy somewhere else,

Interviewer: ok

Participant: yes

Interviewer: alright so we sort of cover the second part here which is, which of this is the midwives' responsibilities, so just to recap

Participant: ok

Interviewer: the things that are part of the midwives' responsibilities we talked about taking care of the mother and the baby, (eem) make sure the mom is pain free, and comfortable, sort out bleeding, vital signs, and as far as the baby is concerned, mom and baby are encouraged to be together, encouraged feeding and then you will take care of mom's as far as mobilizing, antibiotics,

Participant: antibiotics and that's fine

Interviewer: alright if you had to look at your practice what is it that makes it easy or difficult to provide care to postnatal moms?

Participant: that makes it difficult is when you are short staffed,

Interviewer: huh huh

Participant: yeah, when you are short staffed, (huh) and when you find out that the ward is full, because they are those busy days that you can't predict really it just happened, you find out that you are having a busy day, it's very difficult to render the proper care to them because they are many, and you are short staffed, but you always managed to work as a team,

Interviewer: huh huh

Participant: others they move from other department just to assist to give you hands so that you work smoothly by the end of the day,

Interviewer: ok so you say other department

Participant: what am saying pardon?

Interviewer: yeah carry on

Participant: what as saying when I say other department, you see we are one unit but we are like separated, its nursery, its ANC ward that side, so you find out, other sister they would move from ANC department to come and assist you on your postnatal department,

Interviewer: ok so they would still be midwives

Participant: yes those are still midwives

Interviewer: alright (huh..) alright so those are the things that would make it

Participant: make it easy

Interviewer: are team works

Participant: yeah team work

Interviewer: ok anything else that you want to had to that? Huh ok, (eem..) if you have to look at postnatal maternal care is there a clear start point and a end point?

Participant: (huh) a clear start point

Interviewer: a clear start point ok, so what would be that clear start point? When did that starts?

Participant: (huh) I don't know if am following your question

Interviewer: alright so let me try again, so if you looking at postnatal maternal care

Participant: huh huh

Interviewer: is there a clear point where you can say this is where postnatal starts and this the place where postnatal ends?

Participant: are you talking about the routine wise or just a department side?

Interviewer: (huh) it would be including both actually, the routine that you do, in this side, look at your unit here,

Participant: huh huh

Interviewer: looking at postnatal now, when will you say this person here belong to postnatal.

Participant: oh ok (eem..) we are talking about the people who delivers immediately like yeah those are the postnatal cases

Interviewer: so patients who deliver are the postnatal, that is the starting

Participant: yes, that is when it starts

Interviewer: ok when will it ends

Participant: it ends when we..., is not like we ending totally, but like when we discharged them, like others after two days it depends, they are differs, others after two days, others after three days, we discharged them, but we usually refer them to the local clinic,

Interviewer: alright

Participant: yes, for continuation of the care

Interviewer: so you would discharge the patient, if after three days they have complication, they can come back to you, is that what you saying?

Participant: they do come back to you

Interviewer: they do come back to you

Participant: yeah, they can come back to us

Interviewer: but in most cases you will try and refer them to the local clinic

Participant: we refer them to the local clinic yes,

Interviewer: up to three days will still come back to you

Participant: yes

Interviewer: and would that be, would that be the ending point of discharge in general for postnatal maternal care or is it specifically for this unit after three days that it how it ends

Participant: specifically, for this unit

Interviewer: ok

Participant: yes

Interviewer: alright so three days for this unit and would there still be a period after this three days to considered postnatal?

Participant: yeah we still considered them as postnatal (huh) because ok as long as postnatal start immediately after delivery, then six weeks post after delivery

Interviewer: alright

Participant: so but with us we keep them like as I said two to three days,

Interviewer: ok

Participant: yes, it continues in postnatal though most of the time they are not with us, as I said we refer them to local clinic but they are postnatal, its end up to six weeks after delivery.

Interviewer: ok so the start point is clear

Participant: huh huh

Interviewer: till the patient delivers

Participant: huh huh

Interviewer: the postnatal in general is up to six weeks but for this unit, you saying is three days

Participant: is three days yes,

Interviewer: alright and then my last one here, is about health education, so before you discharge is there any particular or specific health education that you provide to the moms?

Participant: yeah, yes (huh) we emphasized about the personal hygiene, firstly we emphasized about looking after the baby at home, because you find out they don't breastfeed the baby as they used to because here with us you keep on

reminding them to feed the baby, because the baby will develop jaundice so we running away from all those things

Interviewer: yeah, yeah

Participant: so at home they turned, most of the time our baby they sleep, so even when they sleep, they don't wake up the baby so as while they are here, we encourage them, we wake up the baby so that we feed the baby to prevent jaundice, so we emphasized on those things, then we encourage them as well to, they continue with antibiotics because we discharge them with medication, they mustn't drink alcohol while breastfeeding, and then while taking medication, and they must make sure they finish the course of antibiotics,

Interviewer: huh huh

Participant: (huh) then we will educate them as well about family planning

Interviewer: ok

Participant: yeah (huh) though we don't initiate it because we are catholic hospital, but we usually just tell them about the plan and the method of family planning, then they will decide, we encourage them you go to the local clinic if you want or you can go to private doctors, on those who are affording, so choice of method we don't intervene, we just tell them about the importance of family planning, yes.

Interviewer: ok

Participant: (huh) what else?

Interviewer: So you give me about personal hygiene, you talked about take care of the baby, breastfeeding,

Participant: huh hun

Interviewer: about the medication, completing the course, (ah) family planning,

Participant: yes

Interviewer: anything else you want to add?

Participant: oh they must continue with (huh) taking the baby to the clinic for immunization

Interviewer: ok

Participant: yeah

Interviewer: so immunization?

Participant: immunization to the local clinics,

Interviewer: alright

Participant: huh huh

Interviewer: anything else you would like to add? So am done, is there anything else you want to add about?

Participant: (she laughs)

Interviewer: postnatal maternal care?

Participant: (huh) ah.., the only thing that are left, encourage them while here they must allow the fathers to look after the baby, that helps to promote bonding as well

Interviewer: so would that be part of the health education?

Participant: yes

Interviewer: ok

Participant: yes

Interviewer: to encourage the father?

Participant: you know the Zulu guys, they belief that if..

Interviewer: (he laughs)

Participant: you get what I am saying (she laughs) yeah so they need to bond with their babies

Interviewer: ok alright that's it, thank you very much.