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COLLABORATIVE MATERNITY CARE:

THE RELATIONSHIP BETWEEN INDEPENDENT MIDWIVES AND INTERPROFESSIONAL CARE PROVIDERS IN JOHANNESBURG, SOUTH AFRICA

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Science in Nursing

Johannesburg, 2023.

DECLARATION

I, Jeanell du Plessis, declare that this Research Report is my own, unaided work. It is being submitted for the Degree of Master of Science in Nursing at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

Jeanell du Plessis

12 June 2023

DEDICATION

This research report is dedicated to every health care professional within the maternity care environment who is passionate about providing high quality maternity care.

Don't burn out…Serve the Lord with a heart full of devotion….be joyful in hope, don't quit in hard times…. persist in prayer (Romans 12:11-13)

ABSTRACT

This research study explored the relationships among independent midwives, obstetricians, and referral facilities in the government health care sector and how these relationships influence the quality of maternity care provided within a multi-disciplinary team.

Interprofessional collaboration aims to improve communication, ensure improved, efficient, quality of patient care, provide increased access to care and assist with providing financial relief by lowering health care expenses. It is vital in maternity care environments.

An exploratory, descriptive qualitative design was followed. The participants consisted of eleven independent midwives practicing in Johannesburg, two obstetricians who offer back-up to independent midwives and two labour complex managers in public tertiary hospitals. Interviews were conducted with all participants. All interviews were audiotaped and transcribed verbatim. Data was analysed using thematic analysis. Study findings are discussed and supported from literature.

The current relationships between the participants are described and defined.

Requirements for effective collaboration that were identified in this study include trust, respect, clear role clarification and safe practices. Interprofessional collaboration is a process that was found to develop over time.

Barriers to effective collaborations that were identified include ineffective knowledge of each other's role, lack of formal policies and guidelines, reputational damage, and in-effective communication. Other barriers identified include negative attitudes and perceptions towards the independent midwives and their clients, challenges in the public sector and malpractice, unsafe and unethical behaviour.

The support of management, effective communication, standardised documentation, collaborative education, and promoting mutual understanding were identified as strategies to improve collaboration.

The limitations of the study were identified and recommendations for practice, nursing education and research are made.

Key words: Interprofessional collaboration, independent midwife, and maternity care providers

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Each and every client, midwife, obstetrician, doula, educator and health care provider whose path has crossed mine and who has helped to shape my course in this part of my life's journey.

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LIST OF ABBREVIATIONS:

CHC	Community Health Care Centre
DOH	Department of Health
ICM	International Confederation of Midwives
FIGO	International Federation of Gynaecology and Obstetrics
MDT	Multi-Disciplinary Team
MOU	Midwifery Obstetrics Unit
PPMA	Private Practicing Midwives Alliance
SANC	South African Nursing Council
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Chapter 1: Overview of the Study

1.1 Introduction

An introduction and background as well as the rationale for the research is given in this chapter. The operational definitions, problem statement, research question and aim of the study are also described. Further aspects such the research methodology and applicable ethical considerations are considered.

1.2 Background for the Research: An introduction to Collaborative Midwifery Care

The birthing environment in South Africa has seen many developments and changes over the last few of years. This warrants a closer look at the current situation within this vitally important area within the health care system.

The global focus on midwifery care emphasises the provision of services to pregnant clients that are safe, evidence based, effective, efficient, timely, equitable and patient-centred (The Royal College of Midwives, 2014), that function within a collaborative and integrated manner and which should include the patient as the key player in the health-care team (Shamian, 2014).

Although the fifth Millennium Development Goal, which aimed at improving maternal health globally, was not met, substantial progress was made in relation to maternal and child health. The Sustainable Developmental Goals, which followed the Millennium Development Goals, continue the focus on improving maternal health care in countries worldwide (UN Sustainable Developmental Goals 2020, 2020).

The World Health Organization (WHO), Save the Children Fund and International Confederation of Midwives (ICM) acknowledge the role of a skilled and competent midwifery workforce within a supportive health system in providing assistance throughout pregnancy and childbirth, and saving the lives of mothers and babies (UNFPA, International Confederation of Midwives, & WHO, 2014).

“Every year, more governments, professional associations and other partners are acting on the evidence that midwifery can dramatically accelerate progress on sexual, reproductive, maternal and newborn health and universal health coverage.” (UNFPA, International Confederation of Midwives, & WHO, 2014). Midwives who are educated and regulated by international standards can provide 87% of the essential care needed for women and their newborns (UNFPA, International Confederation of Midwives, & WHO, 2014).

Midwifery services form a core part of a country's health services. WHO encourages countries to deliver integrated care throughout the ante-, intra- and postpartum periods. According to WHO, the training of midwives is recognised as playing a key role in the reduction of maternal mortality (WHO, 2020).

Midwives, however, do not work in silos, but rather in collaboration with various care providers within the multi-disciplinary team. Interprofessional collaboration is required to ensure that effective maternity care is rendered (Warmerlink , Wiegers, de Cock, Klomp, & Hutton, 2017). Collaborative maternity care offers women the opportunity of having more choices, and ensuring high standards of quality care, leading to more favourable outcomes, improved communication, and lower health care costs (Morgan et al. 2014; Shamian, 2014; King, 2015).

James et al. (2012) investigated the options in care woman have in the South African private sector. They concluded that collaborative care and the formation of partnerships between the public and private health care sector as well as between expert midwives and obstetricians was needed to aid the provision of safe maternity care (James, Wibbelink, & Muthige, 2012).

To date, there has been limited exploration of collaborative practices between independent midwives and other interprofessional care providers and little is known about the effectiveness or otherwise of the collaboration between independent midwives and other interprofessional care providers within the South African context. If we are to encourage interprofessional collaborative practice, we need to understand the concepts and principles of collaboration among midwives, obstetricians and other care providers and understand how to achieve it successfully (Smith, 2014).

Through taking a closer in-depth look at collaboration in the maternity care environment in South Africa we may understand the multifaceted concept of collaborative care more clearly. This may lead us to understand and identify interprofessional threats and opportunities and aid in creating an efficient maternity care, which will lead to better patient outcomes (Van der Lee, Driessen, & Scheele, 2016).

In-depth knowledge and understanding of collaborative practices in the maternity care environment may also provide guidance in policy making at various levels, both in the private as well as in the public sectors, as well as in other areas such as interprofessional education, licencing of private practitioners, payment structures and regulation of health care providers (Smith, 2015).

1.3 Problem Statement

Collaboration among health professionals influences the quality of care, particularly in private midwifery practice, where the midwife cares holistically for patients but is obliged to

hand over care or work to other health professionals should the mother or the baby experience complications. An added difficulty is that patients of a midwife who are unable to afford further care in the private sector, need to be referred to public facilities when complications arise, and the transfer is usually urgent. Currently little is known about the collaboration between the independent midwives, other health professionals and institutions providing maternal care.

Factors limiting or contributing to collaborative care between independent midwives, obstetricians and the referral system in Johannesburg have not been identified and strategies to improve the care have not been developed. This study aimed to identify these factors with a view, at a later stage, to developing an intervention to strengthen collaboration and so improve the quality of care.

1.4 Research Question

How does the current relationship between independent midwives in Johannesburg and backup obstetricians as well as the referral facilities in the government sector influence the quality of collaborative maternity care?

1.5 Aim of the Study

To describe the current relationships among independent midwives, obstetricians and referral facilities in the government health care sector and determine how these interprofessional relationships influence the quality of maternity care provided within a multi-disciplinary team (MDT).

1.6 Significance of the Study

In an ever-changing health care system, where numerous health care professionals and care providers play a part in providing maternal and newborn care, it is important to investigate and explore the relationships among these parties to understand the roles of each and foster and encourage collaboration among all involved.

Findings in this study may assist in the development of policies and guidelines for maternal care providers to facilitate collaborative care. These findings may also aid nurse educators to identify the importance of introducing the topic of interprofessional collaboration within a South African context into current training programmes.

Not only low-risk women, but also midwives and obstetricians, medical aid insurance companies and the public need wider access to evidence regarding accessing and utilising safe, collaborative maternal care services.

1.7 Operational Definitions

1.7.1 Interprofessional Collaboration:

Interprofessional collaboration in the context of maternity care is defined as professionals within this sector, who are working together towards a common and shared goal of a healthy outcome for both the mother as well as the baby (Heatley & Kruske, 2011).

According to Smith (2016) Interprofessional collaborations between midwives and obstetricians leads to safe and high-quality maternity care. Smith (2016) further states that effective communication, trust, and respect between providers are needed for successful collaboration between care providers.

In this study, interprofessional collaboration or collaborative maternity carte refers to collaboration between independent midwives, obstetricians, and other care providers as well the collaboration between independent midwives and the two tertiary government facilities, in Johannesburg, utilised by the independent midwives as referral hospitals.

1.7.2 Interprofessional Care Providers

The multi-disciplinary team within obstetrics are made up of obstetrician, midwives and nurses who work together to provide obstetric care to clients (Romign, Teunissen, de Bruijne, Wagner, & de Groot, 2017)

In the context of this study, interprofessional care providers refer to the different care providers in the multi-disciplinary obstetric team, specifically obstetricians and midwives (in the private and public sector).

1.7.3 Midwife:

The International Confederation of Midwives define a midwife as: “a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery” (International Confederation of Midwives, 2018). According to the ICM (2018), midwives may practice in any settling including homes, communities, hospitals, clinics, or health units.

In the context of this study, a midwife is a health care provider, with the necessary qualification (stipulated by the South African Nursing Council in South Africa), who provides care to clients in the ante-, intra- and postpartum period. Midwives are skilled to manage healthy pregnant clients and refer clients to obstetricians or state facilities when complications are diagnosed.

1.7.4 Independent Midwife:

A self-employed, enrolled midwife, who provides midwifery services in private hospital settings, health care units or at the home of a client.

1.7.5 Labour Complex Manager:

The manager of the labour complex, which consists of maternity, admissions, labour ward, caesarean theatre, transitional newborn unit (where applicable) and obstetric high care. Each of these units has a Unit Manager.

1.7.6 Obstetrician:

An obstetrician is a physician who specialises in obstetrics. According to the American Board of Obstetrics and Gynaecology, obstetricians possess special knowledge, skills, and professional capability in the medical and surgical care of women related to pregnancy and disorders of the female reproductive system (American Board of Obstetrics and Gynecology, 2014). An obstetrician is therefore a skilled health care provider that is trained in managing medical disorders in pregnancy and birth, otherwise, high risk pregnancies and births.

1.7.7 “Back-up” Obstetrician:

An obstetrician that has entered into an agreement with an independent midwife to provided obstetric services to her clients when needed.

1.8 Methodology

This study follows an explorative, descriptive qualitative design in which contextual research approaches are applied. This design enables the researcher to describe the current collaboration and relationship between independent midwives and interprofessional care providers in Johannesburg and how these relationships influence the quality of collaborative maternity care.

The population consist of independent midwives practicing in Johannesburg, the obstetricians who supply back-up to them in the private sector as well as the labour complex managers of two referral hospitals.

Data collection is done in the form of semi-structured individual and group interviews.

1.9 Outline of Chapters

Chapter 1:

An introduction of and background to the research is given in chapter 1. The problem statement, research question, aim of the study and operational definitions, are described within this chapter. An outline of chapters is also described.

Chapter 2:

Chapter 2 consists of a review of available literature regarding maternity care in South Africa. The different providers of maternity care are defined and the setting in which these care providers practice is explored. Collaborative care among care providers within different settings is looked at extensively.

Chapter 3:

A description of the research design and the methodology applied within the research is looked at in chapter 3. The data collection process is described. Other aspects such the research methodology and applicable ethical considerations are also described.

Chapter 4:

Description and discussion of findings are given in chapter 4.

Chapter 5:

Chapter 5 consists of a summary of the research, including the main findings, conclusions and limitations are identified. Future recommendations are considered.

1.10 Conclusion

This chapter introduced the research. The rationale for the research was given. The operational definitions, problem statement, research question and aim of the study were described. Aspects such as the research methodology and applicable ethical considerations were considered. The chapter concluded with an outline of all the chapters. A review of available literature applicable to the research is presented in the next chapter.

Chapter 2: Literature Review

2.1 Introduction

This chapter consists of a review of the available literature regarding maternity care in South Africa that is pertinent to this study. The different providers of maternity care are defined and the setting in which these care providers practice is described. Collaborative care between care providers within the maternal care setting is examined. Educational preparation for interprofessional collaboration is also explored.

2.2 Maternity Care Options within the Health Care System of South Africa

Women in South Africa have the option to seek maternity care in government facilities or in the private sector. The choice (or lack thereof) of care providers is dependent on their circumstances, the availability of resources as well as their knowledge of their options.

The Department of Health governs health care in South Africa, which is organised in a two-tier health care system: a large subsidised public sector and a smaller private sector. On average, 80% of the South African population make use of public health care, with the wealthier 20% opting for private health care (Buswell, 2022).

Both the public sector and private sector are fraught with challenges in providing adequate, high standard midwifery care to the population of South Africa.

2.3 Provision of Maternity Services in the Government Sector

Should a woman birth in the public sector, she may have a vaginal delivery in a labour ward with a midwife (either within a hospital or midwife obstetric unit (MOU)) if low risk, or with an obstetrician (intermediate to high risk) with midwives attending. If she requires a caesarean section, this is performed by an obstetrician.

Health care within the government sector in South Africa is regionalised with specific referral systems (National Department of Health, Republic of South Africa, 2015). Health care facilities are categorised according to different levels of care. Clinics, community health centres, district, regional, tertiary, and central hospitals provide maternity services where care is escalated from one to the next according to predefined referral routes (National Department of Health, Republic of South Africa, 2015).

Health care facilities aim to staff the facility with a multidisciplinary team as described in the Maternity Guideline of South Africa (National Department of Health, Republic of South Africa, 2015).

Low and intermediate antenatal care and post-natal follow ups are provided at clinics. These clinics are staffed by professional nurses and midwives, enrolled nurses, nursing assistants, community health workers and a visiting medical officer.

The next level of maternity care consists of Community health centres (CHC) that have an obstetric unit run by midwives or a standalone midwife obstetric unit (MOU) (National Department of Health, Republic of South Africa, 2015).

Births under the care of a midwife and in the absence of a medical practitioner are the norm in community health centres and MOUs. A woman birthing at these centres have been screened and identified as low-risk clients. Care in these facilities is rendered by a multi-disciplinary team consisting of advanced midwives, midwives, enrolled nurses, nursing assistants, community health workers and a visiting or resident medical officer (National Department of Health, Republic of South Africa, 2015).

Intermediate and high-risk pregnant women are referred for specialised care in district, regional or tertiary hospitals. A multi-disciplinary team within a district hospital consists of advanced midwives, midwives, enrolled nurses, nursing assistants, social workers, dieticians, full time medical officers and visiting specialists. Full time specialist obstetricians form part of the team within regional hospitals and sub-speciality skills are offered at tertiary level (National Department of Health, Republic of South Africa, 2015).

Primary and secondary care levels provide most of the maternal health care in South Africa. Most babies in the government sector are therefore birthed by midwives, as this is an affordable, sustainable, low-intervention model of health care for healthy, low risk birthing mothers. The midwives working in the government sector are employed by the government sector.

One of the pillars of safe motherhood in South Africa is maternal health care services (National Department of Health, Republic of South Africa, 2015). Maternity care in the government facilities is seen an integral component of primary health care and given free of charge since July 1997 as indicated in the Maternity Guideline of South Africa (2015).

According to Stats SA, an increase in the use of maternal health care services during ante-, intra- and postpartum periods has been identified (Stats SA, 2020). The majority of women in South Africa seek maternity care in the public sector (Stats SA, 2020). A staggering 96.3% of births are within the poorest to poorer economic status populations (Stats SA, 2020).

This is a huge number of births that need to be conducted in an already overburdened health care system (AfricaCheck, 2019). A system where many problems such as negative attitudes by health workers, poor quality care, administrative and financial management inefficiencies, and lack of accountability for health system failures are rampant (Human Rights Watch, 2011).

2.4 Provision of Maternity Services in the Private Sector

In the private sector, a pregnant woman can opt to have a hospital birth in a labour ward, where the obstetrician is the main care provider supported by midwives employed by the facility, or she may choose or need a caesarean section which is performed by an obstetrician (James, Wibbelink, & Muthige, 2012). The private sector is very much doctor dominated – with clients in the private sector commonly opting to see an obstetrician rather than a midwife (James, Wibbelink, & Muthige, 2012).

Pregnant women may also choose to have a normal vaginal delivery at a home or in a birth unit under the care of a midwife. Birthing at home, however, is not actively encouraged by the National Department of Health (National Department of Health, Republic of South Africa, 2015, p. 17). Alternatively, a pregnant woman has the option to deliver in a private hospital or at private MOU with an independent midwife.

A woman seeking health care in the private sector needs to pay the provider for the services rendered, either privately or as a member of a medical aid (Du Plessis & Roets, 2014).

The private sector has its own challenges. Rising health care costs are causing more clients to seek care in the already overburdened public sector due to being unable to afford the care in the private sector (Abraham & Elliott, 2017) resulting in lower patient numbers. The rising costs associated with private maternity care with an obstetrician as the primary care provider do however make midwifery-led births a more viable option for low-risk clients (Du Plessis & Roets, 2014).

Private facilities are not readily available in all provinces in South Africa. Three hospital groups, namely Netcare, Mediclinic and Life Healthcare, dominate the market and make it very challenging for newcomers to establish themselves (Writer, 2019).

High caesarean section rates are prevalent in the private sector. According to Stats SA, six (6) out ten (10) neonates delivered in the private sector are via caesarean section (Stats SA, 2020).

According to a study by Du Plessis et al, (2014) hospital managers of private institutions are reluctant to grant independent midwives “birthing rights” (consent from a specific facility to practice/provide health care within that facility) because of perceived risks (Du Plessis & Roets, 2014).

2.4.1 Obstetricians

In the context of South African private health care, most women contributing to a medical aid choose a medical practitioner (Obstetrician and Gynaecologist) as their primary care

giver (Du Plessis & Roets, 2014), and birth in the private hospital where their chosen service provider has admission and birthing rights (James, Wibbelink, & Muthige, 2012).

Obstetricians see their clients, in most cases, for all antenatal visits. A small number of obstetricians do employ midwives to assist with consultations with some of their low-risk clients for certain of the antenatal and postnatal check-ups, although most obstetricians work independently and refer to other care providers as needed.

Midwives employed by a private facility where an obstetrician has birthing rights may assist with the midwifery care if a client is admitted to the facility. The obstetrician, as the primary care provider, will conduct the delivery with the midwives assisting (Wibbelink & James, 2015).

2.4.2 Midwives and Independent Midwives

According to the International Confederation of Midwives (ICM), a midwife is defined as: "a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licenced to practice midwifery and who demonstrates competency in the practice of midwifery" (International Confederation of Midwives, 2018).

The International Confederation of Midwives (ICM) recognises the midwife as a health care professional who is responsible and accountable and who works in collaboration with women to give needed support, care and advice during pregnancy, labour, and the post-partum period. The scope of practice of the midwife, according to the ICM, includes "preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures" (International Confederation of Midwives, 2018).

In South Africa midwives are defined as trained care providers who are experts in managing low risk, healthy pregnant women throughout the journey of pregnancy and birth with the goal to achieve and maintain optimal health. They support and assist the mother-baby-dyad during the puerperium period (SANC, 2005) and are skilled to identify complications and risks, manage obstetric emergencies and to refer care to an obstetrician (SANC, 1990).

Understanding the role that an independent midwife plays in providing maternity care in South Africa is pivotal within this study to ensure clarity.

An independent midwife refers to a professional nurse and midwife, registered with the South African Nursing Council (according to the Nursing Act, 2005) and the Board of Healthcare Funders. Independent midwives practise independently in a private, midwife led practice and obtain payment from their clients.

A nurse may practice as a private practitioner “provided that she practices within her scope of practice and does not contravene the rules setting out as the acts and omissions which could lead to disciplinary action by the Council” (SANC). Her nursing practice is governed by the Nursing Act, 2005 (Act no. 33 of 2005).

The rising costs of medical aids, the high number of caesarean sections, accessibility of evidence-based information with regards to pregnancy and care and a growing demand for less technological medicalised births have resulted in an increased demand for services provided by independent midwives (Du Plessis & Roets. 2014).

Despite the World Health Organization’s acknowledgment of the need for an increase in skilled midwives (WHO); maternity care under the care of independent midwives in the private health care system is largely not advocated for because of perceived risks (Du Plessis & Roets. 2014).

There is currently no formal register within the South African Nursing Council (SANC) to indicate the number of midwives that are practicing independent midwifery care in South Africa. The membership numbers of certain organisations such as the Society of Midwives of South Africa (SOMSA), Sensitive Midwifery and the publications of the Expectant Mother’s Guide provide an indication of these practitioners, however this number does not include independent midwives not associated with these organisations.

The membership numbers do however indicate that the largest population of independent midwives in South Africa is based in Johannesburg, Gauteng (SOMSA, 2022; Sensitive Midwifery, 2022; Expectant Mothers Guide, 2022) .

The number of independent midwives does seem to be a very small population in comparison to other health care personnel in South Africa (Africa Health Exhibition, 2020).

Of the midwives practicing independently, many have acquired “birthing rights” at certain private facilities (Du Plessis & Roets, 2014). A number of independent midwives also provide “home births” or births at privately owned “birthing units”. Independent midwives have not been issued with “birthing rights” in the public sector.

Women who choose an independent midwife as a primary care provider, are required to be seen by an obstetrician at certain times during the pregnancy (Nursing Act, R2488). This obstetrician is referred to as the “back-up” obstetrician and they take over the care of clients who develop complications during the pregnancy and birth.

If the complication is managed and the client is again deemed as being low risk, care may again revert to the independent midwife. The back-up obstetrician will perform a caesarean section should the need arise. In the event of a complication arising during a home delivery or at a birthing unit where theatre facilities are not available and the client cannot afford private sector care, the client is transferred to a public hospital for further management (National Health Act 61 of 2003).

The collaboration among midwives, obstetricians and the referral health care facility is vital to ensure quality collaborative care is rendered (World Health Organization, 2010).

2.5 Interprofessional Collaboration

2.5.1 Defining Interprofessional Collaboration in Maternal Health care

Pregnancy, labour, and the postpartum period in a woman's life revolves around much more than just the physical changes and the growth and development of the neonate. Holistic care is needed in the physical, emotional, psychosocial, and spiritual spheres. According to a recent study about collaborative practice in maternity care, collaboration between care providers within a multidisciplinary team is critical to ensure that quality maternal care is rendered (Chodzaza, Mbiza, Gadama, & Kafulafula, 2020).

Smith (2015) defined midwife-obstetric collaboration as:" A process in which midwives and physicians work together towards a common purpose: to provide safe, effective patient-centred care for women and their families, guided by shared rules and structures, both formal and informal, which govern a mutually beneficial relationship, a relationship which seeks to optimise the context in which the collaboration is convened." (Smith, 2015)

2.5.2 Goals, Benefits and Requirements of Interprofessional Collaboration

Interprofessional collaboration aims to improve communication, ensure improved, efficient, quality in patient care, provide increased access to care and assist with providing financial relief by lowering health care expenses (American College of Nurse-Midwives, 2015; Smith, 2015). Maternal and neonatal outcomes as well as clinician's satisfaction have been shown to improve where there is effective collaboration (Oluwatosin, Morelli, Illuzzi, & Marney, 2021).

Commitment, interpersonal skills, and teamwork are required to ensure that interprofessional collaboration between different types of maternity care providers succeed (Waldman, Kennedy, & Kendig, 2012). Other essential elements include a commitment to excellence in patient care, communication, and interdisciplinary education, solid mutual respect, and clarity on each of each team members' role and responsibilities (Pecci, Motti-Santiago, Culpepper, et al., (2012); Munro, Kornelsen, &Grzybowski, (2013).

Increased access to care, a decrease in cost of care and improved efficiency could potentially all be attained within collaborative practice models (Smith, 2015). Wibbelink and James (2015) found that midwives and obstetricians in the private sector in the Eastern Cape, South Africa identified that interprofessional collaboration would positively add to the care provided within the maternity environment (Wibbelink & James, 2015).

2.5.3 Challenges of and Barriers to Interprofessional Collaboration

Midwives and obstetricians have different philosophies of care and different scopes of practice, which act as a barrier to collaboration and is partly the reason why there is poor integration of midwives in certain medical facilities (Behruzi, Klam, Dehertog, Jimenez, & Hatem, 2017; Munro, Kornelsen, & Grzybowski, 2013).

Other factors that Munro et al. (2013) identified as barriers are: doctors' and midwives' negative perceptions of independent midwifery practices and homebirth, unfairness in payments between doctors and midwives, as well as inadequate formal policies and structures.

A more recent systematic review done by Macdonald, Snelgrove-Clarke, Campbell-Yeo, Aston, & Baker (2015) supports these findings. The review found that barriers to collaborative midwifery care are affected by a lack of trust, no clear roles and unprofessional behaviour.

According to Waldman et al (2012) many doctors are concerned about the liability risk since they are seen as supervisors who can be held liable for the actions of their associates. They do however state that this concern can be mitigated when there is an official agreement between the parties involved and all parties work and act within their scope of practice, referring patients promptly to the next level of care when needed (Waldman, Kennedy, & Kendig, 2012).

2.5.4 Interprofessional Collaboration within the Global Community

The World Health Organization recognises the importance of and need for interprofessional collaboration within the maternal and child health care environment, where health care providers draw on the key strengths of each member of a multi-disciplinary team to ensure safe maternity care and to decrease preventable incidents (World Health Organization, 2010).

The international Mother Baby Childbirth Organization (IMBCO) and the International Federation of Gynaecology and Obstetrics (FIGO) have joined forces to develop a single global initiative to provide guidance and support safe and respectful maternity care. They launched "The International Childbirth Initiative (ICI): 12 Steps to Safe and Respectful Mother Baby-Family Maternity Care" in 2018. In these steps, collaboration and communication between care providers is encouraged to ensure health and wellness as well as appropriate emergency care to pregnant, labouring, and post-partum women (International Childbirth Initiative, 2022).

In the United States, health care provided by a multi-disciplinary team is becoming more prevalent and interprofessional collaboration between midwives and physicians has been

identified as a factor than can increase safe, high quality midwifery care (Smith, 2016). Collaboration within a multi-disciplinary team has been identified as an essential component in the midwifery care rendered in the United States (King, 2015).

Interprofessional collaboration within maternity care has been identified as an important component to ensure that women receive appropriate and timely care in Australia. A collaborative approach is promoted within their training institutions such as the Australian College of Midwives as well as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (Australian Government National Health and Medical Research Council Department of Health and Ageing, 2010).

A review of maternity in Australia in 2009 suggested that maternity care is provided in "collaborative partnerships", where midwives, obstetricians, general practitioners and rural doctors are encouraged to use their different but complementary skills and knowledge to work together as professional equals (Watkins, Nagle, Kent, & Hutchinson, 2017).

In a Canadian study to better understand the factors affecting collaboration between midwives and other health care professionals in a birth centre and its affiliated hospital certain barriers, such as a conflict in scope of midwifery practice, myth about midwifery care, pre-judgment, and lack of effective communication skills between health care providers, were identified. It was further found that midwives were not integrated into the hospital due to several factors including the culture of the organisation. The study concluded that although collaborative maternity care is the optimal, it is at times hard to achieve (Behruzi, Klam, Dehertog, Jimenez, & Hatem, 2017).

2.5.5 Interprofessional Collaboration within the Maternal Health Environment: The South African Context

A hierarchical system in maternity services, with the obstetricians at the top followed by the midwives and the patients respectively has been the most accepted practice in maternity care in the past, however a change in this practice was brought on with the introduction of midwifery obstetric units in South Africa (James, Wibbelink, & Muthige, 2012).

Independent midwives work in collaboration with a multi-disciplinary team, where an independent midwife acts as the primary care giver for her clients. An independent midwife will refer clients to other health care providers, such as physiotherapists, chiropractors, sonographers, and breastfeeding consultants, when needed. Independent midwives also engage with other service providers such as doulas.

Independent midwives are not part of the workforce in the government sector. They also do not have practicing or birthing rights at these facilities (National Department of Health, Republic of South Africa, 2015).

The collaboration between health professionals influences the quality of care (Morgan et al 2014), particularly in independent midwifery practice where the midwife cares holistically for patients but is obliged to hand over care of the client to other health professionals should the mother or the baby experience complications (SANC, 2005).

2.6 Educational Preparation for Interprofessional Collaboration

There has been a noticeable increase in interprofessional courses in education programmes in America (American College of Nurse-Midwives, 2015). The United States has seen a marked increase in interprofessional courses in education programmes as well as interprofessional collaboration amongst their professional associations (King, 2015). King (2015) further states that this expansion of interprofessional collaboration within educational systems is a necessity to ensure successful collaboration within health care systems.

In a recent study about interprofessional collaboration in a specialised teaching hospital in West Ethiopia it was recommended that to promote interprofessional collaboration between nurses, midwives and physicians, ongoing training, seminars, and workshops should be held about this issue. They further suggested that team training programmes should be encouraged to promote interactions between medical students and nursing and midwifery students (Melkamu, Woldemariam, & Haftu, 2020).

Health care teams are increasingly becoming the norm within health care systems, hence the need to train clinicians and nurses in effective communication and collaboration skills instead of in individual silos has become very apparent (King, 2015).

The university of California, San Francisco, implemented childbirth simulation as well as obstetric emergency simulations for different students such as nurse-midwifery students, residents in obstetrics, paediatrics, medical students, and advanced practice nurse students in paediatrics amongst others. The goal of the training was to assist these students to develop their competencies interprofessionally. Both faculty members and students benefitted and more grounded interprofessional relationships were developed (Shaw-Battista, Belew, Anderson, & van Schaik, 2015).

Shaw-Battista, Belew ,Anderson, and van Schaik (2015) found that in order for such a programme to succeed, the co-ordinators, administrators and clinical facilitators needed to be advocates of interprofessional education as the process is at times complicated, time consuming and requires extensive planning and curriculum development (Shaw-Battista, Belew, Anderson, & van Schaik, 2015).

In the framework for action on interprofessional education, WHO requests all policymakers, decision-makers, educators, health care workers, community leaders and global health

advocates to embrace and implement interprofessional education and collaborative practice to strengthen health systems and improve global health outcomes (World Health Organization, 2010).

A South African study about undergraduate interprofessional education found that it aids in improving comprehensive patient evaluation and ensures better holistic management of patients. Further, the study found that the graduates involved who embraced interprofessional health care had improved confidence in their management of clients and felt less overwhelmed when tasked to provide health care to clients in under resourced settings (Muller & Cooper, 2021).

2.7 Conclusion

In this chapter a closer look at available literature about maternity care in South Africa was done. The different providers of maternity care were defined as well as the setting in which these providers practice. Collaborative maternity care was looked at – with specific focus on collaboration between the independent midwives and members of the MDT. The educational preparation for interprofessional collaboration was also explored.

The research design and methodology will be discussed in the next chapter.

Chapter 3: Research Design and Methodology

A description of the research design and the methodology applied within the research is discussed in this chapter and the data collection process is described. The setting, population, sampling, and sampling procedures are discussed. Data collection methods are described along with data analysis techniques. The adherence to ethical conduct and standards in the research is discussed.

3.1 Methodology and Research Design

An explorative, descriptive qualitative design was followed in this study where contextual research approaches were applied. This design enabled the researcher to describe the current collaboration and relationship between independent midwives and interprofessional care providers in Johannesburg and how these relationships influence the quality of collaborative maternity care.

3.2 Setting

Participants from different but related settings were included in the research.

The practices of independent midwives and backup obstetricians are all situated in Johannesburg, Gauteng. Interviews were conducted virtually.

Both the independent midwives as well as the backup obstetricians all practiced in the private sector within their own independent practices. They consult patients in consulting rooms across Johannesburg and treat patients at a variety of health care facilities in Johannesburg. The Independent midwives refer clients to both the private as well as the government facilities in the research area.

The two government facilities, which are both tertiary and training hospitals was the setting for the labour complex managers. One interview was conducted virtually, and the other interview was conducted face-to-face within the hospital.

3.3 Population, Sampling and Sampling Procedures

3.3.1. Population

The population consisted of independent midwives practicing in Johannesburg, the obstetricians who supply back-up to them in the private sector as well as the labour complex managers of two referral hospitals.

The independent midwives and the back-up obstetricians were interviewed as independent health care providers who were all registered as independent practitioners at the Health Professions Council of South Africa (HPCSA) and the Board of Healthcare Funders (BHF) respectively.

3.3.2. Sampling

There is currently no official register for midwives working as independent practitioners in South Africa. Independent midwives were identified using social media sources, from the Expectant Mother's Guide, a publication by the Childbirth Educators Professional Forum and the members of organisations such as Sensitive Midwifery. All the independent midwives who were included in the study are currently practicing in Johannesburg.

A list of obstetricians who provide "backup" for the independent midwives in Johannesburg were made available to the researcher by the midwives. Obstetricians from this list were invited to participate in the study.

A purposive sample of the two tertiary government facilities, in Johannesburg, utilised by the independent midwives as referral hospitals, was done.

A total of thirty-eight independent midwives and six back-up obstetricians were contacted via electronic methods and invited to participate in the study. The labour complex managers of the two selected tertiary government facilities were also invited to participate in the study via e-mail.

3.3.3. Sample

The total number of independent midwives practicing in the research area was found to be less than fifty. The sample for this study was therefore limited to this number. In interview-based qualitative research, a small size sample (6-12 persons or however many are found) is recommended within the academic context (Mocanasu, 2020). Purposive sampling of participants ensured a diversity of perspectives within the realm of independent midwifery care.

The sample size for this research was therefore fifteen (n = 15) – a number that ensured saturation was reached. The health care professionals who participated in the study were aged between thirty-one (31) and seventy-two (72) years and consisted of eleven independent midwives, two back-up obstetricians and two labour complex managers in public tertiary hospitals. All participants have worked in the maternity care environment for over 10 years.

3.4 Data Collection

The following methods were employed:

3.4.1 Semi-structured Individual and Group Interviews

Due to the COViD-19 pandemic and restrictions at the time of data collection, most of the semi-structured individual and group interviews were held online via the MS-Teams application. One individual interview was conducted telephonically. Another individual interview was done face-to-face with the participant once COVID restrictions were lifted.

The two obstetricians and two labour complex managers were interviewed individually.

The researcher planned to conduct focus groups with the independent midwives with the objective of having 5-7 independent midwives attending each of the focus groups on-line. It was anticipated that 3 focus groups would need to be conducted to accommodate the majority of the independent midwives in the research area identified and to strive to reach a point of saturation. The aim of conducting focus groups was to gather in-depth information and insights regarding the research topic and to encourage the sharing of diverse perspectives.

This, however, did not prove possible due to factors such as availability of the participants at any given time as well as the number of participants who agreed to participate in the study. Six independent midwives were interviewed individually; five independent midwives were interviewed in small groups with two and three participants respectively.

3.5 Data Collection Process

Participants were contacted and informed regarding the purpose of the study (Annexure 1 and 2) and were requested to sign a consent form to participate in the study (Annexure 3 and 5) as well a consent form regarding the recording of the interviews since the interviews were recorded (Annexure 4 and 6). The researcher also made use of field notes and reflective journaling.

The interviews with the labour complex managers and back-up obstetricians incorporated questions as outlined in annexure 7 and 9 respectively. The guides included suggestions for "probes" designed to elicit more detailed information. Questions were open ended to give participants the opportunity to provide detailed information about the research topic.

Group and individual interviews of independent midwives were conducted as outlined in annexure 8. Interviews lasted between forty-five (45) and sixty (60) minutes.

Audio-recordings of the semi-structured interviews were transcribed verbatim by the researcher and a transcription service. The researcher also listened to some audio-recordings whilst simultaneously reading through the transcribed version in order to ensure accuracy of the transcription and to clean the data. The researcher used communication techniques such as paraphrasing, summarising and requesting participants to confirm that the researcher understands them correctly when conducting interviews as forms of member checking. All transcriptions were checked for accuracy by the researcher. Corrections were made before a final typed copy was approved.

3.6 Data Analysis

In an attempt to ensure that the research findings were a true reflection of the participants' views and contributions, without possible bias from the researcher, a detailed methodology was followed.

Braun and Clarke's method of data analysis (Braun & Clarke, 2006) was used to analyse the qualitative data. As the research is qualitative, this method was best identified to aid to identify, analyse and interpret the data to answer the research questions. Data collection during the semi-structured individual and group interviews is suited to this type of analysis.

Content analysis involved the following steps:

1. The researcher read through all the transcripts multiple times to identify themes and subthemes. All transcriptions were copied into 2 columns, with the script on the left and themes identified on the right. The participants were identified by means of a code, e.g., IM1 being independent midwife number 1, Dr 1 being backup obstetrician 1 and LCM 1 being Labour Complex Manager 1.
2. Similar ideas and concepts were colour coded to identify initial codes. For example, all content related to the theme of "communication between care providers" were colour coded green and the content relating to the theme of "Requirements for effective collaboration" were colour coded yellow.
3. Formulation of themes from the coded data was done consistently for each transcript.
4. A review of the formulated themes was completed and consistency and/or similarities and discrepant data identified.
5. Themes were named and defined along with possible sub themes.

6. The data from the coded interviews data was interpreted and written up in the research report. A sample of an analysed interview (Annexure 14) is added to the report as an example of the data analysis process that was followed.

Data from interviews and group interviews was analysed separately. Data and field notes were managed meticulously and verbatim transcripts in the research process were utilised. To reduce the elements of subjectivity and possible bias of the researcher and to ensure rigorous findings of the research, both the researcher and supervisors were involved in identifying codes and reached consensus about the codes and themes identified.

3.7 Trustworthiness

Methodologically sound research practices were employed during the research process. To establish trustworthiness, the principles of trustworthiness, namely credibility, authenticity, confirmability, transferability, and dependability as defined by Lincoln and Guba were applied (Lincoln & Guba, 1985).

Credibility was obtained in the research by applying strategies such as identifying and tapping into numerous sources during the process of data gathering, conducting extended interviews with participants, and verifying and validating content shared by the research participants by asking for clarification and summarising during the interviews. The researcher conducted all the interviews herself.

The implementation of interview guides, while conducting individual and group interviews, allowed the researcher the ability to extract similar and comparable data from similar participants thus further ensuring the credibility of the research. Data from each interview was analysed separately, data and field notes were managed meticulously and verbatim transcripts in the research process were utilised.

To attempt to ensure that the research findings were a true reflection of the participants' views and contributions without possible bias from the researcher, a detailed methodology was followed. This demonstrates conformability of the research. Multiple perspectives of all participants are included in the research report to ensure authenticity.

The researcher attempted to achieve the principle of dependability by conducting selective and purposive sampling of the different participants. Participants were selected according to the needs of the research as well as their extensive knowledge and involvement within the research environment. The research strove towards obtaining data saturation and not size.

Transferability was established by providing a thick description of data and detailed records of transcripts of the interviews with participants. Obtaining data saturation ensured

transferability. Adequate information about participants and the research process followed are provided to allow the reader to decide how the research and the findings may related to other similar settings.

The findings of the research were submitted to the researcher's supervisors, who ensured that the correct and acceptable processes and procedures were followed, hence ensuring trustworthiness.

3.8 Ethical Considerations

The researcher adhered to ethical principles and all appropriate ethical standards were followed to protect the dignity and rights of all the research participants.

Permission to conduct the study was obtained from the Postgraduate Committee and the Human Research Committee (Medical) of the University of Witwatersrand. Further permission was also obtained from the Department of Health on the National Health Research Database.

Written consent was sought and obtained from the Chief Executive Officers/Hospital Managers at the public maternity hospitals to which independent midwives refer clients.

An information sheet explaining the research and the purpose of the interviews was provided to all participants (Annexure 1 and 2). This information letter further explained that each participant's identity would remain confidential and that there were no consequences to participating or declining to participate in the study. Participants were informed that they could voluntarily withdraw from the research at any point.

Anonymity within the focus groups could not be guaranteed, due to the nature of a focus group, but the researcher took every precaution to maintain confidentiality of the data. The research report does not include any identifying information of participants. Participants consented to having disguised extracts of their comments quoted in the research report, conference presentations, published papers, etc.

The research was conducted over a period of two years. Being a health care professional within the obstetric care environment herself, the researcher was able to immerse herself in the research and build trust with the participants throughout the research period. Prolonged engagement was achieved.

Participants were further informed that they could request that the audio recording be paused at any time during the interviews. They were reassured that they may choose how much or how little they want to contribute during the interviews. Group participants were reminded to respect the privacy of all fellow participants and not to repeat what was said.

Participants were informed that the study may not benefit then directly, but that it will help us to understand and learn about collaboration in maternity care. No significant risks related to participation in this study were identified. No financial benefits were offered to participants; however, participants will have access to the findings of the study.

Consent to be interviewed was obtained from all interview participants (Annexure 3 and 5). Consent for audio-recording of the interviews was also obtained from each interview participant (Annexure 4 and 6).

Data collected is stored securely and safely in the Department of Nursing Education. Consent forms are stored separately from the recording and transcripts. Audio-recordings of the focus groups are kept on a password-protected computer. Only the researcher and the supervisors were able to listen to the recordings and read the typed version of the recordings.

3.9 Conclusion

The research design and methodology were discussed in this chapter. The findings and discussions of the research are discussed on the next chapter.

Chapter 4: Findings

4.1 Introduction

The findings of the study are presented and discussed in this chapter.

Five main themes were identified as shown in table 4.1. below. Sub-themes were derived from the data analysed and categorised under the main themes. These themes and sub-themes are discussed in this chapter.

The structure of this chapter is summary statements of the views of participants under the different sub-themes, followed by an analysis and discussion of each of the main themes at the end of the chapter.

Participants verbatim quotes have been written in italics to indicate to the reader how participants responded. The quote of the participant is followed by the code used to identify the participant (e.g., IM1) where the letter reflects the type of respondents (IM = Independent midwife; Dr = backup obstetrician and LCM = Labour Complex Manager) and the number reflects the specific participant in the study.

To ensure that no institutional names are included in this report, the researcher refers to institutions as public tertiary hospitals, private hospitals, and private MOUs where applicable. A number has been allocated to each institution where more than 1 of any specific institution was mentioned (e.g., public tertiary hospital 1).

It was interesting to note that midwives refer to backup obstetricians as gynaes, OBGYN's and obstetricians. In this report all these terms relate to the backup obstetricians. Another interesting observation was that a woman receiving midwifery care is referred to as a pregnant woman or an expecting mother or a client or a patient. These terms are used interchangeably in this report.

4.2 Findings

Table 4.1 Themes and Sub-Themes

Themes	**Sub-Themes**
4.2.1 Collaborative practices	4.2.1.1 The referral process of clients between care providers 4.2.1.2 Communication between care providers 4.2.1.3 Other collaborative relations

Themes	Sub-Themes
4.2.2 The engagement process: Setting up the relationship	4.2.2.1 Setting up the relationship between the independent midwives and the backup Obstetricians 4.2.2.2 Setting up the relationship between the independent midwives and the public sector
4.2.3 Requirements for effective collaboration	4.2.3.1 Trust and Respect 4.2.3.2 Time 4.2.3.3 Clarification of roles 4.2.3.4 Safe Practice
4.2.4 Barriers to effective collaboration	4.2.4.1 Insufficient knowledge of each other's role 4.2.4.2 Lack of formal contracts 4.2.4.3 Reputational damage 4.2.4.4 Ineffective communication 4.2.4.5 Negative attitudes and perceptions towards independent midwives 4.2.4.6 Challenges in public sector 4.2.4.7 Malpractice, unsafe and unethical behaviour
4.2.5 Strategies to improve collaboration	4.2.5.1 Buy in of Management 4.2.5.2 Effective communication 4.2.5.3 Standardised Documentation 4.2.5.4 Collaborative Education 4.2.5.5 Promoting mutual understanding

4.2.1 Theme 1: Collaborative Practices

This theme refers to the current relationship between independent midwives, their backup obstetricians and referral hospitals in the public sector and include the current relationships and practices of communication and referrals. Throughout this theme, the importance of collaborative relationships was highlighted by the participants.

The participants spoke mainly of current relationships with obstetricians and gynaecologists but also referred to their relationships with the health professionals in the public sector. It became clear that although the midwives in independent practice are referred to as such, their role is, in reality, an inter-dependent one.

One independent midwife participant (IM10) indicated that several obstetricians provide backup for independent midwives in the research setting. This does not always seem to be

the case in other areas where midwives are practicing independently. Said midwife expressed her wish that there could be similar backup for midwives in other areas.

> *So, in Joburg, I think we are incredibly blessed that we've got such a good hub. I've even for some of my home births, I've got a doctor in (name of hospital) that will help me with backups; I've got a doctor in (name of facility) that's pro-natural that would help us as a backup… And I've got a doctor in Benoni that will help…. So, we are very, very blessed in Johannesburg with the backup that we've got with the obstetricians, and I just wish it was like that everywhere.* (IM10)

Midwives are excited to build new relationships with obstetricians, but it seems to be challenging to find obstetric back-up at times according to another participating midwife (IM5).

> *So, the doctors that do support us, when we find them, we hold on to them and we foster those relationships and every time we meet a new gynae that says: "yes, vaginal birth, woo-hoo!" We're like: "yes please! I want your personal number. I want to come and meet you" because that's something personally that I've done before.... it's hard to find a new backup and it requires a lot of input.* (IM5)

Independent midwives recognise the need for this collaboration and acknowledge that they cannot perform their duties safely and according to the scope of practice if they are unable to refer to other health care providers and facilities.

> *A relationship a midwife has as an independent with her obstetrician; is the greatest gift. It is her main treasure. I certainly am so grateful to the obstetricians that I work with, and that I have worked with in the past, because that relationship is everything to a midwife. It enables me to work the way that I do.* (IM11)

According to a midwife participant (IM10), collaborative care is needed to ensure that the care provided is holistic and comprehensive. The obstetricians have certain skills that the midwives do not have and that are needed to screen a patient and to identify risks. The midwife went on to say that she wants to work in collaboration with obstetricians and not in opposition to them.

> *They* (the patients) *have to been with a gynae…. I can tell you how big the baby is. I can tell her the position. I can tell her everything about the baby. I need them to tell me about the placenta, which I cannot see. And I need them to tell me that the liquor volume is fine and everything else is fine for a natural birth…. We want to work together with obstetricians. We don't want to work against them.* (IM10)

One midwife (IM11) described her way of working as one of always working in collaboration with the obstetricians and not only contacting the obstetricians in the event of an emergency. The relationship therefor is a collegial one.

It's my method to work in conjunction always with the obstetrician. So, I don't only use an obstetrician for emergencies or now I'm in the meconium and …but that we work hand in hand. (IM11)

The independent midwives inform their clients that they work within a team and collaboratively with other health care providers such as back-up obstetricians. These back-up obstetricians take over the care should a pregnancy or birth complicate, and the client is no longer a low-risk patient.

When we start seeing these clients, we always told them we don't work alone, we have to have some backup gynaes in the event of anything changing but also, we need them (the gynaes) to know that indeed, she is a low risk we can carry on. (IM6)

Collaboration between the independent midwives and the public sector is a requirement according to our South African guidelines as indicated by a midwife participant (IM5).

It's actually in our very guidelines that we all use, that there should be collaboration between the private sector and the public sector. (IM5)

The independent midwives recognise the need for collaboration between themselves and the public sector to work effectively since many of their clients may need to be referred to the public sector if they become a high-risk patient or in the case of a complication occurring. The midwives are unsure of how to approach and establish the relationship so that it works. It seems to be a daunting task that one of the midwife participants did not want to manage single handed (IM2).

So, the majority of our clients unfortunately are going to be referred to government if there is a problem. So yes, we are going to have to sort it out somehow. I don't know, I've in the past felt maybe, I don't know but you see this is something that I don't want to do on my own. I want somebody to go with me. (IM2)

The need for collaboration between independent midwives and the public sector was also identified as being necessary according to a participating labour ward complex manger (LCM1). Benefits of collaboration listed by this participant included improved patient care and better outcomes. She further indicated that the hospital management would need to be involved in this process.

And also, for statistical purposes and for improved patient care and better working relationships. It is better to rather, you know, just have a relationship with them (independent midwives). So, we are not anti it at all, but obviously if there is going to be that type of thing then we need to have a discussion in our EXCO. (LCM1)

Due to economic challenges and not having the financial means to afford private medical care, many clients of independent midwives are sent to the public sector if the need arises, as explained by an independent midwife participant (IM2).

> *Most of the clients that we serve are patients that are going to be using the government as their referral. They don't have medical aids, they can't go to the private and as soon as you explain to them that if there's an emergency and you have to go to the private hospital, you're going to need to fork out R60 000 right there and then. They're all like:" okay no sorry, we can't do that*". (IM2)

During the interviews it became clear that some independent midwives have good working relationships with certain public referral hospitals. One midwife (IM9) went as far as to explain that she calls on the assistance of former colleagues who are working in the public sector when she refers a client to a specific public hospital. Like the previous participant, this midwife also refers clients to the public sector if they have financial constraints.

> *Yes, I do refer patients to the public sector. And again, I'm very fortunate because I know people like, for instance, in public hospital 6. Umm, that is actually great midwives, because I worked with them. So, if I see that this client is really cash strapped and we're gonna kill her to get everything she wants, look I make them understand and try and guide them to get in touch with somebody at that specific hospital.* (IM9)

Other midwives do not seem to have the same sort of relationship with the public sector as stated by another participating midwife.

> *I cannot talk about public sector. I have no idea how they work and what they do.* (IM8)

One of the labour ward complex managers confirmed that a relationship exists between some, but not all, independent midwives and the public hospitals and referral hospitals. (LCM1).

> *We do have a relationship. Not with all the midwives but with a few of them that have practices in our catchment area.* (LCM1)

Another labour complex manager of a public referral hospital explained that previously there was good collaboration with independent midwives, including good communication, but that these relationships had for some, or other reason deteriorated resulting in clients being sent to the hospital that do not meet hospital admission criteria (LCM2).

> *So, in the past when I started in 2009, actually we had a great relationship with the midwives. There would be constant communication if they need to refer, if they needed advice, and to that extent that they would call actually to look for the doctor, the receiving doctors instead of just sending patients, but then recently when I started in 2020 in labour ward; I do not know if COVID had an impact on that but I just noticed a few patients that actually walk in with a note from private midwives or from private midwives saying that "just walk straight to public tertiary hospital 2" and then when you actually get to peruse the record you find that there is not even a*

reason for the patient to be here, it is quite a few of them hence I think it is significant. (LCM2)

4.2.1.1 The referral process of clients between care providers

This sub theme looks at the referral process for clients. The participants indicated who refers to whom, how the referral is done and what documentation accompanies the patient when care is transferred from one care provider to another care provider, such as an obstetrician or a public referral hospital.

At times, due to complications arising in a client's pregnancy journey, an independent midwife needs to refer a client to either a back-up obstetrician or a government facility. These referral processes have several challenges – more so when referring a client to the public sector as stated by an independent midwife participant (IM5).

> *I'm someone who sits in a position where probably ninety percent of my practice are actually private (paying) clients who do not have medical aid and who at some point in their pregnancy will access public health care and I think for me the referral process of the private sector is very well established and there's good lines of communication with your select doctors. There are the occasional hiccup where mommies go to doctors that we're not affiliated with and then some conflict may arise but that's fairly minimal. I have more challenge referring moms back to the public sector even though they are private (paying) clients*. (IM5)

An obstetrician who provides backup to independent midwives indicated that s/he would refer clients to an independent midwife should the client request a midwife supported labour and birth (DR1).

> *And then I think it's a great thing for me to be able to call the midwife, right and say: "listen, I have seen this patient. She wants a private midwife. Can you help me out?"* (DR1)

When referring a client to either an obstetrician or the public sector, one of the midwife participants indicated that she sends the client with a letter stating all the information about the client's history, present condition, and the problems that she has identified (IM7).

> *How I work… I now have …compiled a sort of letter. In which I will state what the current problem is, her medical history… her entire history quickly summarised in one sentence… Then my findings… …the palpations…the documents that I include and the problems…and that document … really works well.* (IM7)

Another midwife participant indicated that she also sends her clients to the public facilities with a referral letter which has resulted in the clients being attended to more quickly than in the past (IM3).

> *So, they're* (the public sector) *kind of now I think putting more weight into my referral letter and what I'm suggesting the issue might be of why the labour's not progressing or whatever the case may be and kind of dealing with it a little bit quicker than they used to in the beginning.* (IM3)

The public sector has its own referral system. The public facilities accept clients from various care providers including midwives and obstetricians. Clients are transferred to a selected facility according to their risk profile. These referral routes do not seem to be well understood or well complied with by the independent midwives according to a labour complex manager (LCM2).

> *And when you inquire further some patients will say my midwife advised that I go to public tertiary hospital 2 because the care is better compared to other places of which that should not be the case, it should be in terms of the referral system and the risk involved….Remember we take referrals from; we are a referral hospital, as long as it is a patient that is deemed to be at public tertiary hospital 2, I do not think people even consider that it is a midwife or an obstetrician from outside*. (LCM2)

The fact that independent midwives do not understand the public referral system was again highlighted in an example given by a labour complex manager. She stated that having to turn patients away due to them not meeting admission criteria causes unnecessary conflict (LCM2).

> *When it is just a normal case maybe a 23-year-old that has her second pregnancy, never had issues in her pregnancy, she is 38 weeks, she is told to come through to a tertiary institution that is where you actually see that people get upset because now, they feel when the patient is here it is difficult to tell someone that you do not belong here. When the person that have built trust with said that is the right place, it is that one. So, to explain and reverse the whole thing to say actually you are a normal case based on 1, 2, 3 and then you need to go to somewhere else and you would find that some of the patients when they get told to come to public tertiary hospital 2 that actually come and check out the place, just to check out the place, and then to go tell her that the place that she checked out and got comfortable with is not the right place then it becomes a problem*. (LCM2)

A labour complex manager was happy to admit clients referred from independent midwives if the patient meets the admission criteria (LCM2).

> *We are more than happy to receive patients from private midwives as long as it is patients that belong in the tertiary institution. LCM2)*

When transferring care of a client to the public sector, some midwives have adopted the practice of completing the maternity case record that the public sector uses. In doing this, they found that the transfer goes easier, as stated by a midwife participant (IM6):

It's better that they (clients) have that maternity case record, because it makes it much, much easier because at least then you've got it and as long as you've documented everything at least there's no problem. (IM6)

The challenge with using the maternity case records seems to be that independent midwives do not have access to these records in the booklet form and can only download the records. They then print these downloaded records and complete them by hand. Because the documents are not in the original booklet form, it is at times frowned upon in the public sector.

People can download the maternity case record but obviously we are not all open minded. If someone sees a hardcopy, they'll be more receptive but if they see a printed copy, they will raise their eyebrows. (IM6)

Another practice that independent midwives have adopted to facilitate the process of admission of a client in a government facility is to encourage the client to book with their nearest government clinic. An "antenatal card" is then issued to the client at the government facility. This facilitates the process should the client be admitted, less questions are asked, and she is admitted more readily seeing that she is viewed as an "already existing client" of the facility.

Because they do not have a medical aid, we get them to the government hospitals, we tell them that they have got to go and book in at the hospital. To get a card, and that type of thing…. So, what it does is basically they sidestep casualty, and go straight through to labour ward…. Otherwise, if they are not booked at the government hospitals, then they have to go through casualty first. (IM4)

In the beginning I had a lot of flak. Like I mean, they would have these green cards with a maternity booklet, they would have a proper referral letter from me, and the patient would still be shouted at…. But now the last couple of clients that I've had to refer, the feedback that I've gotten from them is that they were receive much, in a much more positive way. (IM1)

The importance of a completed antenatal card was confirmed by one of the labour complex managers. She indicated that a completed antenatal card would suffice as documentation when transferring a patient to her public hospital (LCM2).

Okay from the private midwives: an antenatal card is everything. They are actually allowed to write everything on the card including the reason for referral, you do not need to write an additional letter like hospitals who do write the patients file and write the referral, there is no need. You check the card you have everything; we will actually check your history and your follow ups and check the referral date and the reason for referral, which is then easier because as long as we have the card, they can actually write there is no specific stationary that is needed for a patient being

referred here. Even public clinics or public midwives are using antenatal card for referral. (LCM2)

Another labour ward complex manager indicated that proper referral documents are required for admission in her hospital and that independent midwives were sending patients without these documents (LCM1).

Because some of them (independent midwives) were sending their patients and weren't really sending them with any relevant information, proper referrals…. Blood results weren't attached to anything of the sort. (LCM1)

This challenge was addressed by the hospital by having a meeting with some of the independent midwives.

So, we spoke to a few of them and arranged a meeting with them. And they came in and we discussed referral routes. Antenatally. What our expectations are regarding what we would like on the referral letter. (LCM1)

4.2.1.2 Communication between care providers

This sub theme describes the communication between care providers. The importance of effective communication is highlighted. The different methods that care providers use to communicate with each other are identified.

Both the independent midwives and the obstetricians who participated in this study agreed that communication is key to a successful, collaborative relationship.

What I also found works really well is your communication with your doctor…. And when those lines of communication remain open between you and your doctor, then you work together peacefully… (IM5)

Communication lanes should be open both ways. (DR1)

A benefit of good communication between the backup obstetrician and the midwives is that it ensures that clients receive the necessary care when needed as stated by a participating midwife (IM5).

You know, where your midwife scope ends; your doctor's scope starts. And if you have things that you feel uncomfortable with, then you can always call your doctor and say: "Hi doctor, I have the patient, this is the problem, I don't feel comfortable dealing with it myself. What is your input? Or please take over the patient because I think this patient is going to be safer with you." (IM5)

One of the backup obstetricians indicated that she uses various methods of communication when informing the independent midwives about clients or when she gives certain instructions with regards to care needed. The mode of communication is dependent on the

urgency of the matter as explained by the backup obstetrician. The doctor went on to state that the midwives can also send messages if needed (DR1).

> *Whenever I see a patient... and they are a midwife patient, so I will send a letter to the midwife to say: "I've seen your patient. OK. This is what I think: she's eligible, she's low risk so she can have a Private MOU1 birth, or I don't suggest you birth at Private MOU1 for 1,2,3." So basically ….that's the sort of communication from my side, but also if it's an urgent thing, like it's happened a couple of times where I'll be seeing a patient at 36 weeks for instance and there is growth restriction, there is abnormal dopplers, but then I'm able to pick up the phone and call the midwife and say listen 1,2,3, I don't [think] this patient should, is a midwife patient…I think we need to deliver and, I think she needs to Caesar for 1,2,3. So, I mean the midwives also know…. I mean they can call me at any time. They can send me messages… if they need to.* (DR1)

Not all communications are done in the same way with the obstetricians as they seem to have different preferences. One midwife stated that she uses different modes of communication depending on what the preference of the back-up obstetrician is. She has identified the importance of good communication and realises that the obstetricians appreciate being kept well informed (IM2).

> *I do write a letter when I send my clients to them, and I give them an update and then I SMS them when or WhatsApp them when the moms are in labour. I WhatsApp them after the moms have given birth. I generally do everything in documentation. They seem to like that because they are kept in the loop and updated on what's happening*. (IM2)

This midwife participant indicated that she also sends photos to her backup obstetrician as another way of communication (IM2).

> *A lot of times that I would send a photo of a CTG with maybe a baseline of 110. I know it's fine, but I want them to tell me that it's also fine with them*. (IM2)

One independent midwife indicated that the communication between her and her backup obstetrician is mostly telephonic. She highlighted that the downside of this communication is the fact that there is no record of what transpired (IM4).

> *Most of it is telephonic. Which in a way is a little bit difficult because he can say one thing over the phone, and say he never said that.* (IM4)

One midwife admitted to not being too concerned about informing her backup obstetricians about the outcome of a birth. She calls them if their services are needed; no news is good news (IM10).

> *I'm terrible with letting them know what the outcome of the delivery is, except that they've done it, but I don't send that form… so many hours into labour…. They just know if I call then they need a caesar, If I don't call them, they know that the mom is delivered.* (IM10)

The backup obstetricians all practice differently and prefer different ways and times of how the midwives communicate with them. It is up to the midwife to establish how and when to communicate with her backup obstetrician most effectively as stated by a participating independent midwife (IM3).

> *Some gynaes, a specific gynae would want us to inform them in the middle of the night, if the patient goes into labour, whereas another gynae only want us, if it's in the middle of the night, to let us know if there's emergency…. I ask them specifically. When I see them, I ask them: "what are your preferences on this? Would you like me to let you know in the middle of the night, if a patient is in labour and everything's going well or?" you know and some of them do, and some don't.* (IM3)

One midwife highlighted that she is grateful that her relationship with her backup obstetrician is such that if she calls them telephonically, they answer without fail (IM11).

> *And I think too that one of the things that I'm very grateful for with my obstetric backup is that because of how I work, and I know that my obstetrician, whoever it is, will answer the phone immediately that they know that this is not. It's just not a number.* (IM11)

A backup obstetrician verbalised that it is important for the relationship to be a mutual one where there is trust and where the midwife knows that the backup obstetrician will answer her calls promptly (DR1).

> *I think it goes both ways as well. I think midwives need to know that., if I call this gynae, I know that I'll be fine or I know I'll be sorted or I won't be left high and dry…I know that they will answer their phone, you understand? So, I think it goes with the basis for relationship and trust does go both ways.* (DR1)

A few participants revealed that the clients themselves are a form of communication between the independent midwives and the backup obstetricians.

> *So, we as midwives need to be very careful how we communicate with important role players because the patient always listens, and they will repeat what you've said.* (IM5)

> *And so, all the way through, the obstetrician hears feedback from the client as to my opinion*. (IM11)

Communication between the independent midwives and the public sector facilities does not seem to be well established in most cases. Clients are sent into the public sector with

accompanying documents where no direct contact is made between the care providers according to an independent midwife (IM2).

> *The biggest communication and way of communication between us and the, if you can call it the gynaes in the government, is probably those antenatal cards and the booklets, that's probably our only and best way of communicating with them.* (IM2)

One form of communication that exists between some independent midwives and a public referral hospital is a WhatsApp group as indicated by some of the independent midwives. They stated that a "WhatsApp group" had been implemented by one of the public tertiary hospitals included in the research. A few independent midwives, local and council clinics use this WhatsApp to inform the hospital of a client who needs an admission.

> *So, we have a …a WhatsApp group…that we… for example will WhatsApp: "the name of midwives' private practice" and she is 41 ½ weeks G1 and does not want to go into labour… then they will come back to us and say okay… "she has to immediately go to ward 6 or whatever" …. There are for example city council clinics as well… … not necessarily state clinic…so their patients also use the WhatsApp group…At times there are over 100 WhatsApp's on this group! But there must be someone dedicated to answering these messages because when a message comes through… it is answered almost immediately… I think that's what this person does. The patients are then referred to where and whatever clinic they need to go to … So, with my patients for example… when they are consulting with me, we wait until the WhatsApp comes through, then I take a screenshot and tell them: 'okay…here is where you have to go'…Then they just go.* (IM7)

> *What they (public tertiary hospital 1) have also done is, they opened up a WhatsApp group… so they have that referral system, which kind of is trying to make it easier.* (IM2)

A labour complex manager went on to explain how and when the WhatsApp group chat was established. She indicated that this initiative improved the communication with the hospital, referral clinics and the independent midwives and brought down the number of unbooked clients coming to the hospital (LCM1).

> *We had already started a WhatsApp group with our local authority clinics that referred to us because we had too many patients just arriving unbooked – not as in unbooked, that they haven't attending clinic but arriving at the hospital without appointments to our antenatal clinic and it was causing major problems at the clinic because there were just too many patients and then they had to be turned away and with COVID we had to reduce the amount of patients that we had. So, we introduced and appointment system with our clinics and the appointment system worked through WhatsApp, and we added these private midwives to our WhatsApp group,*

and we also shared the doctors on call, we shared our SOP that we had created for referral system, and it is working very well. (LCM1)

Another independent midwife participant indicated her experience of communication from the public sector was that it was not a two-way communication but rather only from her side. She indicated where there actually was communication from the public sector, it was to inform her of something that they were not happy with (IM3).

It is very one sided because now it's like, you don't really get feedback from them unless they are very upset with something that you've done, then you get a phone call from a matron or a whatever. (IM3)

Being able to contact the gynae who is on call for the public hospital on a specific day seems to facilitate the transfer of a client into a public hospital as expressed by the participating independent midwife (IM3).

So, what made a big difference with them is they actually got the number for the gynae on call of that specific night and then if, whoever's in charge of the patient, me or (name of independent midwife) or whoever is the primary midwife, if we can speak to the gynae himself over the cell phone, before we refer the patient, then that patient actually gets helped much faster. (IM3)

One of the labour complex managers of a public referral hospital that was interviewed indicated that she thinks that the relationship can be restored, and challenges can be addressed by setting up good communication channels again (LCM2).

It is possible, actually it is possible, just I feel it (collaboration) got lost somewhere because like I said it use to be in place, we used to have that kind of relationship. And then maybe communication breakdown happened and now we are facing these challenges, but it is possible. (LCM2)

4.2.1.3 Other collaborative relationships

Although this specific study looks at the collaborative relationship between the independent midwives and their back-up obstetricians as well as the public sector, it is worth while noting that other collaborative relationships also exist.

One participating midwife (IM5) revealed that collaborative relationships are being established in private facilities. These relationships are especially good where the leadership of the facility supports these relationships and there is buy-in from the staff of the facility.

So, there is a new unit manager at the hospital (a private hospital in JHB) at the maternity ward and she is pro-midwife-led care. She is proactive, she works very

closely with us, she is like: "phone me if you have a problem on my personal cell". So, she wants to facilitate private midwife care and she also keeps her staff in line. So, she's more building the relationship between us to demystify the whole independent midwife process so that we don't get banished to a corner of the ward and left to our own devices, that they come into births with us, come see what we do and maybe even learn from us. (IM5)

Another collaborative process that came up in the interviews is that of collaboration between the independent midwives themselves. A participating midwife (IM8) highlighted benefits of working in collaboration with other midwives especially when starting a new practice. These benefits include knowing who to call, which doctors to refer to and how certain processes work

Because that's what is important for private midwives, or people that are wanting to start midwifery as private practitioner to actually have someone to work with. As a starting point, because that gives you a background knowledge of how to do things, who to call, what hospitals to use, which doctors to use. (IM8)

An independent midwife participant (IM5) highlighted that collaborative relationships also exist between independent midwives themselves. Most independent midwives within the research area are members of an alliance referred to as the PPMA (Private Practicing Midwives Alliance).

I'll be very honest with you…I think the majority of the members of the PPMA practice very safely within their scope because we have created a beautiful thing…. Accountability…because our PPMA is not just a meeting we have every month or second month. (IM5)

The midwife goes on to explain that the alliance serves as a support structure, a resource for information and holds the members accountable to practice safely. Concerns can be shared; midwives can learn from each other and each other's experiences and gaps in the management of clients can be addressed and corrected.

It is a support structure and network of other like-minded professionals who's in the same job description as you are, who hold each other accountable, who support each other, who is a kind ear to listen when needed but also a great resource for advice. So those of us who are younger midwives and who have ten or less years of experience can literally tap into the well of knowledge of midwives who have as much as thirty plus years of midwifery experience. So, there's a rich network of information, there's a massive focus on education and educational resources and that I think it facilitates that we as a group practice safely. (IM5)

The participating midwife went on to explain that the PPMA aims to provide a form of credibility to its members and that this, in turn, positively affects the collaborative relationship with the back-up obstetricians.

> *So, we want to make sure that when we are then going to be representing ourselves to new doctors, new organisations, Department of Health, new hospitals that when we walk in there that they're "oh you're a member of the PPMA, oh wonderful come on through my door, you are welcome here" …. baby steps like that, that facilitate that collaboration because then we're going to end up being "oh you belong to a professional organisation to be an independent midwife" and then that in turn will positively impact on that relationship we have then with (back-up) gynaes.* (IM5)

The support offered by members of the PPMA to other members was highlighted by another participating midwife. According to this midwife, the PPMA hold their members accountable for their actions. This is, however, only limited to its members who are within the research area and not nationally.

> *I think that the people that belongs to it (PPMA), we have good support. So, if something has happened, we can always ask one of the other members to help us, to be with us at the meeting to whatever it is or if I am confused about things, I would post it and you know and ask the question and then get feedback on it, even if it's medical aid brands, even if it's something that's happened with the client or a natural remedy or whatever it is. So in that way it's good and I think that when you belong to the PPMA, you know that you're accountable and others are watching you almost but then a lot of midwives that are not part of the PPMA and we're only based in Johannesburg region so there's so many other midwives there that are still practicing and doing what they're doing.* (IM3)

A midwife (IM2) also indicated that members of the PPMA hold each other accountable for their actions and that this has led to midwives aligning their practices to their scope of practice.

> *I think they do keep people sort of in their scope of practice but unfortunately, it's not wide enough. It's only the people who belong to the PPMA. I know of some of the midwives that are part of the PPMA, that are now practicing within their scope that was previously practicing out of their scope*. (IM2)

4.2.2 Theme 2: Engagement Process: Setting up the Relationship

This theme focuses on how the relationship between the independent midwives, backup obstetricians and referral hospitals in the public sector are set up and how the engagement process unfolds. Participants described how they went about building collaborative relationships with their backup obstetricians and public referral facilities.

Two sub-themes were identified, namely: setting up the relationship between independent midwives and backup obstetricians and setting up the relationship between independent midwives and the public sector.

4.2.2.1 Setting up the relationship between independent midwives and backup Obstetricians

This sub-theme relates to the relationship between independent midwives and obstetricians. Participants revealed how these relationships were initiated. Benefits of a collaborative relationship were mentioned. Participants also indicated factors that influence who they choose to work with collaboratively.

When the independent midwives were asked about how they went about setting up relationships with back-up obstetricians, several of them indicated that they had worked with the obstetricians before going into private practice. They were able to build on this already established relationship and approached these obstetricians to be their back-up as an independent midwife.

> *For me, a lot of the doctors in Joburg knew me…. So, they knew how I worked. They knew how I had been taught and everything, which is basically the same as what they were taught. I think that in the long run this goes a long way to help. (IM4)*
>
> *Some of the OB's I have worked with. (IM2)*
>
> *I found with the 2 main doctors who back my practice…. they got to know me even when we were still working in the state. So, they worked with me as a midwife in the unit and at (Private MOU 1) So, when I decided to go into private practice, I told them my intentions and I just asked straight up: "Doctor would you be comfortable backing me?" And because they literally saw me in action for all those years that I worked at a private MOU 1 and state, they felt comfortable saying, "We know you; we know how you work.... we haven't had incidents or concerns....so I'm willing to back you up." (IM5)*

Another midwife (IM8) indicated that she started out her practice by shadowing another independent midwife or joining an already established independent midwife in practice and hence tapping into the back-up that was already in place.

> *So, what I had was my fortunate space. I had midwives that were ahead of me and that I knew personally that I worked with in a unit. So, I had already people that I can call by name, and they are the ones that actually mentored, I actually mentored with people. (IM8)*

Yet another midwife (IM1) indicated that she started referring clients to the back-up obstetricians that were affiliated with the institution where she had obtained birthing rights.

> *I don't really know how; I kind of initiated and my relationships with the doctors; basically, probably just referring patients to them. The ones that were working at the facility (Private MOU 1) already. (IM1)*

One independent midwife (IM7) revealed that the relationship between herself and the obstetricians started off being a telephonic one that was followed by an in-person meeting.

> *Most of my relationships start with a telephonic interview…a telephonic conversation. Then naturally face… person to person (IM7)*

One of the benefits of having a close relationship with backup obstetricians, according to one of the independent midwife participants (IM11), is that they have direct access to the obstetrician without having to go through other channels and having a client assessed by other care providers when there is an emergency, and the client is transferred to an environment that is unfamiliar to her.

> *And you are standing as that woman's guardian in foreign place…Not knowing the staff, them not knowing you, you are knowing the level of complication that is taking place, and to watch a dithering situation unfold where this one's phoning that one, and then that one's not actually on call this weekend and it's somebody else. And then then they are phoning that one and you know, it's just too horrific. So, a close relationship is a gift to an independent midwife.* (IM11)

During the interviews, it became apparent that not all obstetricians provide back-up to independent midwives for various reasons. This was evident in several interviews done with the independent midwives.

> *I met different of obstetricians two of which do not support independent midwives for their own reasons but then the other two are very supportive and those are the ones that I've been working with (IM6)*

> *The Gynaes that I use are really, really open but you know… You know yourself there is only a small handful that really supports you. (IM7)*

> *Not all doctors are keen on this backup situation. We know that for a fact (IM8)*

A participating backup obstetrician stated very clearly that backup obstetricians do not shy away from withdrawing the backup from midwives who do not practice safely (DR1).

> *But I think the majority of the midwives know how I work. I'm pretty much… I go by the book… if you do dodgy things…. I seriously will block you. I will block you, so and I feel, I mean there's like one or two midwives. I do not back up for that reason because I know they, they do funny things. (DR1)*

This idea was supported by an independent midwife (IM5) who indicated that not all obstetricians will avail themselves to act as backup for independent midwives. Possible reasons given included personal preference, previous experiences, not having similar birth philosophies or challenges with their malpractice insurance.

> *That is very true, they don't all and I know from having interacted with so many different gynaecologists over the years some of them just have personal preference because either they've had a bad experience or they're not pro vaginal birth or their insurance doesn't allow them to work with midwives, there's many different reasons but a doctor very clearly can state to you when you speak to them: "I don't like what you do, I'm not going to back what you do". (IM5)*

During the interviews with the independent midwives, it also became apparent that the midwife participants have their preferences of which backup obstetricians they are willing to work with or not for various reasons.

> *There's several gynaecologists that I just don't want to work with anymore. (IM3)*

> *You know, there are some obstetricians that you wouldn't want to work with again because either you transfer into a hospital environment and he's got his hospital hat on the way that he normally does, for instance, internal examinations. You know, if he's going to do an internal examination on a woman and he's heavy handed or he's not kind or he's…I don't know. Just, you know, not aware of the need of her privacy. (IM11)*

4.2.2.2 Setting up the relationship between the independent midwives and the public sector

While the previous sub-theme dealt with the relationship between independent midwives and obstetricians, this theme concentrates on the relationship between independent midwives and the health professionals and managers in the public sector and refers to processes rather than existing relationships as described in theme 1.

Setting up a collaborative relationship with the public sector does not always seem to be easy and comes with its own challenges. The willingness of some public facilities to engage in a collaborative relationship with independent midwives seems to be at times influenced by past experiences with independent midwives who did not practice safely as revealed by one midwife participant (IM6).

> *When you get into a state hospital it's not easy, some of them are not very friendly …. So I think all in all there's a little, a bit of, they know the good midwives and they know the midwives that take chances and I actually spoke to them and I was open I*

said to them: I'm actually going independent and they said to me no some people practice in Soweto and they know news of the private midwife groups and they know of the ones who take chances and they know the ones that are not compliant. (IM6)

According to this participant, it is important to initiate the relationship with the public sector, to create awareness of independent midwives and how they practice and to be open and honest in all your interactions with them.

But I think if you're compliant and you go and introduce yourself and you are honest with them, they are ready to take over your clients. I have heard of places where they don't take clients who come from private midwives, but I think that depends on how. We need to create a relationship between them and us and that's how they know that we are there. (IM6)

Another midwife (IM1) indicated that she found setting up a relationship with the public sector challenging at first but that this relationship has improved over time.

It's hard to like to get your foot in the door there and for them to understand that you are a legit practitioner…. I find that it's getting a little bit easier. (IM1)

Yet another midwife (IM2) said that the relationship with a public hospital was a work in progress. She indicated that she has contacted the management of a public referral hospital and that there have been conversations about building a collaborative relationship.

I'm working on a relationship… so, what we've done is we met with public tertiary hospital 1, the matrons. And had a talk about the home birth units and our referral to them. (IM2)

4.2.3 Theme 3: Requirements for Effective Collaboration

This theme relates to the requirements for effective collaboration. Participants were asked about what they deemed to be necessary for effective collaboration within the multi-disciplinary team. The responses of the participant are discussed under the following sub-themes: Trust and respect, Time, Role clarification and Safe practice. These sub-themes were the most common among the requirements expressed by the midwives.

4.2.3.1 Trust and respect

Trust between independent midwives and backup obstetricians is an absolute requirement for the relationship to work, according to the independent midwives. Trust is fostered between the midwives and the backup obstetricians by working safely and ethically.

I think it is just a case of proving that you do not take chances. If you prove that you do not take chances, and build up their trust, then your working relationship is wonderful. (IM4)

As a midwife, I need a person that I can trust with a patient's life when I need to. You know, I don't want someone that is still going to be arguing with me. (IM8)

The importance of having a trusting relationship was also identified by one of the backup obstetricians. Obstetricians learn which midwives they can trust over time. Backup obstetricians need to know that midwives are managing patients safely (DR1).

I think it's important to have a trust relationship. To establish a relationship where you are able to trust the midwives looking after your patients, I mean, I'm not there. And then I need to be able to know that the midwife is acting to the best of her ability and to the interest of the patient…. And so, I think from the on start I have the midwives that I know that at this one I can count on if she calls me, I know she really needs me or if she doesn't call me, I think which is more important if she doesn't call me, I know that she's OK. So yeah, when I started it was difficult… But yeah, I learned to know who to trust and who not to. (DR1)

One midwife participant (IM11) stated that the trust between herself and an obstetrician must be reciprocal.

I need to be able to trust them as much as they need to be able to trust me. (IM11)

According to a participating midwife (IM11), when there is trust, an obstetrician does not second-guess a midwife's findings. She goes on to explain that if a midwife deems it necessary that a labouring patient is taken to theatre for a caesarean section, an obstetrician should prepare immediately once informed by the midwife, without delay.

This is why I think it's so important that each independent midwife has a close relationship of trust with her obstetricians. It's that… the trust is: I hear what you're saying. I'm going to phone the theatre. I will get them to open it, and we're transferring immediately to the theatre because the time wasted can just be ridiculous. (IM11)

According to a midwife participant (IM4), a trusting relationship ensures that if there should be a legal case due to an adverse outcome, the obstetrician will support the midwife and the actions taken as s/he is familiar with how the midwife operates. Reciprocal trust was also highlighted by this midwife.

If you know you have worked with them, and you have been open with them, and you have done everything above board, then you can trust them that you will have behind you in court, or whatever. They will sort of be on your side …. And if they know how we work and trust us, then we can trust them too… (IM4)

The backup obstetrician needs to trust that the midwife has practiced safely and within her scope and that there will be no legal repercussions due to negligence as suggested by a participating backup obstetrician (DR2).

> *You need to know that when you are coming in, that the tracings have been done...for appropriate timelines. That you are not walking in, and you are going to be sued. (DR2)*

Another participant backup obstetrician (DR1) indicated that s/he encourages clients to choose a midwife who they trust and who they are comfortable with.

> *Just like, how patients choose midwives. I mean, I always tell patients… if you are going the independent private midwife route…. You need to have somebody you can trust. You need to build a relationship because they are the ones who are gonna look after you. They're the ones who are gonna birth your baby. So, I think it goes both ways.* (DR1)

Independent midwives also refer clients to obstetricians that they trust. A participating independent midwife (IM8) indicated that the trust she has in a backup obstetrician is dependent on certain factors such as reliability, accessibility, professional conduct, and their competency.

> *Patients' needs to understand that that's where we coming from in the relationship is we are going to always send you to a person that we trust. I can trust doctor so and so even with my own family. So, if I can trust them with my family, I will trust them with my clients because I know they are reliable. I know they are accessible. I know they are professional, and I know they can do a good job, so I need to have all the facts.* (IM8)

The clients benefit if there is trust between the care providers. It is important for both the independent midwife and the back-up obstetrician to "speak the same language". A gynae should not be contradicting what a midwife says and visa-versa. The client then gets the same information from both, and it is clear to them that the midwife and obstetrician work together.

> *It benefits the patient in that I think as midwives, we could be more relaxed. Because we know what we could do, and what we cannot do, and that type of thing. But also, I think when they see the gynaecologist, there is that better relationship in that when you know…I do not if clients really think of it…But we know that they are not going to down us and badmouth us, and that type of thing. The patient is still going to feel comfortable coming to the midwife.* (IM4)

When a trusting relationship has been established, there is collaboration between the independent midwife and her backup obstetrician which results in safe practice and the inter-transfer of care as needed.

When she builds up trust with an obstetrician and they can work together, then I think it's a mutual relationship or symbiosis, because the obstetrician will know that low risk mums are safe in that midwives' hands and that he just needs to manage the high-risk moms, which is, in my view the roll of an obstetrician. And that you know that we can transfer mums from one to the other. (IM11)

One participating independent midwife (IM1) indicated that a midwife could cause her back up obstetrician to lose trust in her if she does not listen to their advice and act accordingly:

If you've referred a patient with a problem to them, and they're saying that this and this is, they're not fine with, that you go with what they say and not go and try and do your own thing because I think that's where they start losing trust in us. (IM1)

Building this trusting relationship takes time which could be a challenge for midwives wanting to go into practice without having existing relationships with obstetricians, according to one participant (IM10):

It's very, very difficult to get their trust and build their relationship with them and I think that's what the new independent midwives are struggling with to have good relationships. (IM10)

One independent midwife (IM9) indicated that an independent midwife is responsible to see that the relationship is based on trust. This trust needs to extend from the client to the midwife to the backup obstetrician according to the midwife.

I think the responsibility in in our setup is from the midwife side. We are the glue that colours in this relationship between our clients, the midwife, and the obstetrician, so that at the end of the day we have a calm client that's going to enter births, knowing everything that she needs to know. She's trusting you and she trusts that with that, you're gonna make the right call to the phone doctor and it's all in agreement. (IM9)

The relationship between a midwife and her backup obstetricians is a two-way one in which both parties need to respect each other, according to both midwives and their backup obstetricians:

The level of respect and but going like either way like, they (back-up obstetricians) have to respect your opinion, but you also have to respect their opinion. (IM1)

I think the backup of obstetricians are really trying to help private midwives to be able to work and I think that respect needs to go both ways. (DR1)

The concept that trust and respect are closely associated with each other was stated by a backup obstetrician (DR1).

So, I think there's some sort of understanding amongst the midwives that I do back that this is the way I work, and they respect that, and I respect how they work, and I

will not step on their toes because I feel that we've established this relationship and I can believe and trust in how they would be managing a patient. (DR1)

One participating midwife (IM5) highlighted the importance of respecting the backup obstetrician as well as their qualifications. Respect is shown by the midwife by following the instructions of the backup obstetrician to the letter as expressed by one of the independent midwives.

Because one can get almost too comfortable and then you forget about respect. And respect is still extremely important. Because you need to respect their qualification as well. So, if they give you their opinion, you can't just say: "Oh, what does this doctor know!" You also have to say at times: "ok, you know what. We will listen to what the doctor says, and we will follow these instructions strictly to the tee". (IM5)

Knowing what the backup obstetricians prefer in terms of management of clients and being sensitive to these preferences helps to keep the relationship going strong between the independent midwife and the obstetrician. The midwife knows and respects the preferences of the backup obstetrician.

I do ask their preferences, so a lot of the gynaes I do know what their preferences are so I can respect that and know what their likes and their dislikes are and based on that, that's managed to keep it (the relationship). (IM2)

The importance of referring patients in a timeous manner further aids in strengthening the respect between the care providers according to one participating midwife (IM3).

I find that the gynaes gain quite a lot of respect for us, if we refer the patients in time. (IM3)

Clients pick up if there is respect between the care providers and they appreciate it and feel safer where there is respect and trust between the care providers, as revealed by several independent midwife participants.

I mean you have to show that you respect them, you know, and I mean even a client said you know what she loves the way they treated her together because there was respect, you know, and they communicated honestly what will happen and that's what it was, the doctor said: " I'm not even going to examine because I trust the midwife, I'm just going to go straight to theatre" (IM6)

The patient gets to feel okay, ie she trusts us. And if we trust in the gynae, then she knows that it is not just for the sake of whatever. (IM4)

4.2.3.2 Time

Several midwives indicated that the relationship between the independent midwives and obstetricians develop over a period of time in which both parties get to know each other.

And I think the doctors also kind of have figured that out over the years that I've worked with them, that I don't take unnecessary chances with clients (IM3)

They have also worked with all of us, and I think a lot of them do have their good relationship at the moment with the obstetricians because we've been the same. Independent midwives that worked and they've got used to us and they've had to.. we first started with just a very few doctors that helped us and then there were more that joined and they're not leaving us. (IM10)

One of the benefits of having built a relationship with a backup obstetricians over time and therefore having a long-standing relationship, is being able to call them at any time, night or day, and the obstetrician would take on and have the client admitted in hospital immediately without hesitation as explained by another participating independent midwife (IM7).

You can call the doctor and you can… …if you…but now remember I have a relationship with them, then you can call in the middle of the night…and accept the patient (IM7)

One of the backup obstetricians (DR1) indicated that s/he had learned with time which midwives to trust and which not to trust and who is a safe practitioner and who isn't. The backup obstetrician initially relied on guidance from another obstetrician about which midwife to trust when s/he started providing backup to the independent midwives.

When I started it was quite, it was… I think it was a really a steep learning curve as to who you can trust and who you shouldn't trust, and most of it was through my conversations and my friendship and relationship with a colleague, And he was able to actually guide me and tell me: "OK, this one is fine, that one just watch out for her"… things like that….and as time went on and I got to work more with the midwives… then by working with them. … you kind of establish this relationship and know who knows their story and who doesn't. (DR1)

A participating independent midwife (IM1) went on to explain that over time she experienced that the public hospital to which she refers clients trust her findings more and attend to the clients quicker than in the past.

Generally, I can just say that, that the last few clients that I've had to send, they were kind of helped in time. They didn't have like 12, 13, 14 hours sitting waiting for that Caesarean Section, so they're kind of now I think putting more weight into my referral letter and what I'm suggesting the issue might be of why the labour's not progressing or whatever the case may be and kind of dealing with it a little bit quicker than they used to in the beginning (IM1)

Another midwife (IM3) also thought that the staff at the public hospital to which she was referring clients had gotten to know her over time and this had resulted in the staff being more accepting of the clients and them also realising that she is a safe practitioner.

> *They were not so judged and shouted at and being rude with them and all of those things so I kind of get the feeling that they're starting to know, also realise that I'm not just sending patients at number ninety-nine when that pawpaw has hit the fan already. I am sending them in time. I'm not doing things outside of my scope. (IM3)*

4.2.3.3 Clarification of roles

It is crucial that the obstetricians and independent midwives are clear about each other's roles and responsibilities.

When clear role clarification exists between independent midwives and obstetricians the collaborative relationship works more effectively. This means that both parties practice within their scope of practice and that they agree where one's role ends and the other's role starts, as stated by an independent midwife participant (IM5).

> *There was a gynae that I worked with and from the beginning when I met him, he was very clear, "I will do this, you will do this, you refer these patients to me, I refer those patients to you; we're going to work like this". And that has been working so well, so where the guidelines are clear it works well. (IM5)*

According to this midwife, Guidelines for these different roles exist in various documentation and policies. This midwife uses these policies and guidelines in her consultations with her clients to inform the clients of their risk profile and who their care providers should be.

> *I have the Sensitive Midwifery policy for an active birth unit and a home birth: what's high risk, intermediate and low risk. I will literally in a consult when a patient is high risk take out those guidelines and say: "you see your condition, your problem you're having here, this falls under this". And what I love about the policy, for example, is it clearly says this patient should birth in a hospital, and it also says it's not for midwife-led care, should be cared for by an obstetrician and then the intermediate risk moms is collaborative care between a gynae and a midwife, and low risk moms are for care for by a midwife. (IM5)*

One midwife participant (IM2) indicated that her backup obstetrician at times refers patients to her that are high risk according to her. She highlighted the importance of knowing your limits as a midwife and being clear of your role and capabilities to the obstetricians. Being clear about your scope of practice to your backup obstetrician helps maintain a good relationship.

So, there are selective patients that they would send to me, and I'll do them, but they also know what to send and what not to and to…. when I say both ways, I'm not happy continuing care with this client for me she is a high risk. They do kind of sometimes push that, but I think we stand firm on that which is excellent, so they know that you're not willing to test the boundaries and once they know that that's managed to keep the relationship going right through. (IM2)

Another participating midwife (IM8) indicated that when a midwife calls in her backup obstetrician she needs to step back and support the decisions made by the obstetrician.

Step back and don't interfere when the doctor says: "this is how I'm gonna do this". Let it happen like that. Support the patient and say… hold the patient's hand and say: "we are good, we are fine. I'm happy with the decision" (IM8)

When care providers have a similar care philosophy it enhances the collaboration according to a midwife participant. Midwives prefer to work with obstetricians that have a similar philosophy as theirs.

But I must be honest that the doctors that we are using frequently and more regularly are the doctors that actually are on the same page as us. (IM8)

4.2.3.4 Safe practice

When working within their scope of practice, the independent midwife practices safe care for her patient but also wins the trust of the obstetricians by not overstepping their boundaries as set out in their guidelines, regulations, and policies. Midwives should be able to say that they practiced within their scope of practice regardless the outcome.

I think it is important to stay within your scope, not even just from a medical-legal point of view but because at the end of the day if a patient falls outside of your scope, if you end up with your worst-case scenario where something goes wrong, then you need to be able to say I did what a reasonable midwife would have done. If you are unable to say that; "no I should have maybe done this…. Then you didn't practice in the right way. (IM5)

The most important thing is to be compliant…. you know you go by the guidelines. (IM6)

Independent midwives are aware of their scope of practice and the guidelines that govern their practices. They acknowledge the need to communicate these guidelines to both their clients and the multi-disciplinary team. There is a sense of frustration amongst some independent midwives if the guidelines and regulations are not followed by other practitioners (IM5).

And that's why I sometimes get so frustrated because our guidelines are very clear on how we are supposed to practice and we on a constant basis need to be communicating it with our patients, with our birthing team, our backup, any role player in the process. (IM5)

The backup obstetricians need to know that they can trust the midwives according to an independent midwife. This trust is built on the knowledge that the independent midwife practices within her scope of practice and does not overstep the boundaries and take unnecessary risks. Not practicing within your scope of practice reflects badly on midwifery care in its entirety according to an independent midwife (IM8)

If a midwife does not practice within her scope, she is actually sending out bad vibes to the community number one and making midwifery look bad to the doctor's as well. So, I I'm really tough on this one. They (midwives)*… I have to work within this Scope. No taking chances, that is, that is what is building good relationships. The doctor needs to know that they can trust us. (IM8)*

Another midwife (IM9) agreed with IM8 on the above and added that it is a mutual relationship and that all providers need to practice within their ethical-legal framework in order to ensure safe patient care. Midwives need to practice in such a way that they are always found to have worked within their scope of practice – this demonstrates their integrity.

And then your integrity as a midwife, you have to maintain your standards. You have to make sure that they cannot turn around and say: "But you didn't follow up. You didn't check, you didn't send the client to me". So, it's a two-way relationship pretty much as any relationship is. (IM9)

Another independent midwife participant (IM7) indicated that staying in her scope of practice causes the staff in other facilities to feel relieved and reassured that she practices safely and ethically.

It is surprising to me, when we arrive with a patient and the patient is handled in such a gracious manner. You know… and then they will ask you: "why didn't you try this and this?" And then I will for example say: "we don't do that at the home" …They are relieved then that we practice safely. (IM7)

Proving to the backup obstetrician that you practice safely and ethically and that you are a competent practitioner is a responsibility of a midwife as stated by one of the independent midwives (IM11). The midwife indicated that she also needs to feel safe with her backup obstetrician.

I have always felt that of course it is the midwives' responsibility to prove to her obstetric *backup that he is in safe hands. So as much as I need to be in safe hands by*

selecting that obstetric backup, he needs, or she needs to feel that that they are safe. (IM11)

Another midwife (IM9) agreed that the midwife needs to prove herself to the backup obstetricians. She went on to add that it is important to stay up to date and practice evidence-based practice to ensure safe practice.

You always have to prove yourself first. You have to show that you know what you're doing, that you've got the skills that you have. You've been kept up to date. You are doing evidence-based research. You are literally running with. Everything that you're being taught, you're not thinking like you did 20 years ago, you have to be on top of the latest research. (IM9)

The importance of safe practice was highlighted by another participating midwife (IM3). She stated that she will not put a client at risk by practice unsafely or side lining her backup obstetrician.

If I am in the least little bit worried about something, I rather just cop out. You know what, it's in the end of the day, I'm not going to compromise a mom and a baby just because I want them to have this normal birth and I want to side line the doctor. (IM3)

4.2.4 Theme 4: Barriers to Effective Collaboration

This theme describes the barriers to effective collaboration that were identified. These include insufficient knowledge of each other's role, lack of formal contracts, tarnishing each other's reputation, and ineffective communication. Other barriers identified included: negative attitudes and perceptions towards independent midwives, challenges in the public sector and malpractice, unsafe and unethical behaviour. Each of these barriers identified are discussed as sub-themes.

4.2.4.1 Insufficient knowledge of each other's role

A midwife participant (IM2) explained in one of the group interviews that the backup obstetricians are not always cognisant of the scope of practice of a midwife and that she mitigates this factor by informing the obstetrician of her scope of practice so that they are aware of where her skills set ends and where theirs start.

I must say that all of our OBGYN's, and all of the doctors don't know what's in our scope because sometimes they'd refer things that's out of our scope, so we have to remind them that it's not in our scope and in order to make them understand, and I think that's what they appreciate. (IM2)

Uncertainty of the role of the independent midwife also exists in the public sector. One of the participating labour complex managers (LCM2) indicated that she was unsure whether an independent midwife would take back a client once the client's risk profile allows it.

> *…then if that patient comes from private midwife, I am not sure if they then gladly accept them back once they have referred them to me (LCM2)*

4.2.4.2 Lack of formal contracts

There does not seem to be any formal agreement in place between independent midwives and the obstetricians that act as their back-up. One participating independent midwife (IM5) explained that certain facilities require a letter from the backup obstetrician confirming that they do indeed provide backup to the midwife.

> *We don't have an actual contract or service level agreement. It is more a written letter that the doctor has signed to say that I back this person or these services and that was something that was actually a requirement for some of the hospitals where I have practising rights to have a letter like that where a doctor has physically written and said I back the independent midwife and her practice. (IM5)*

Another midwife participant (IM4) also indicated that she does not have any formal contract or agreement with the obstetricians that provide her practice with backup.

> *No, it is all informal. I have never had a formal written agreement with them. (IM4)*

One backup obstetrician (DR1) described her/his relationship with the independent midwives as a "collegial relationship" and stated that there was no formal contract in place.

> *There's no formal contract in place. I think from relationships that was established already. I think it's a collegial relationship. …we just kind of fell into it and we didn't establish any protocols or any guidelines.* (DR1)

When asked in the interview whether there is any formal agreement between the public tertiary hospital identified in the study and independent midwives, the labour complex manager indicated that no formal agreement currently exists (LCM2).

> *Not that I have seen on paper, but when I came in in 2009, we were told that the private midwives together with private obstetricians and other institutions in the cluster they refer their patients here, that is what we were told but I have not seen anything written down.* (LCM2)

4.2.4.3 Reputational damage

Unfortunately, the relationship and trust between independent midwives and backup obstetricians can be harmed through negative and unethical behaviour. This behaviour leads to a break down in the relationship where backup obstetricians don't trust a midwife anymore. Negative behaviour may include bad-mouthing the members of the MDT as suggested by an independent midwife participant (IM5).

> *So, specifically what I see with colleagues is, they're very quick to bad mouth the doctor. So, instead of them being: "you know what? This is not a midwife's patient, this is the gynae's patient. By all means go", they will sit in front of a patient and say: "oh doctor so and so, oh, I know about his reputation he just does caesarean sections". So, that breaks down the relationships we have with doctors, because we bad mouth them and they bad mouth us and then we break down the lines of communication.* (IM5)

The midwife went on to explain that bad mouthing the referral hospitals further breaks down the relationship within the MDT. Backup obstetricians withdraw their backup should they find that a midwife talks badly about the hospital where they practice.

> *So, it damages our reputation actually with that hospital because we have broken down the relationship and then you can't rely on your backup doctor to support you because he's going to withdraw cover and say "you know what? If you're going to be like this towards the hospital, I can't damage my relationship with the hospital, so I will distance myself from you."* (IM5)

One backup obstetrician (DR2) confirmed that the collaborative relationship gets broken when the participants trash each other's reputation and criticise them publicly. The obstetrician added that relationships break down when midwives criticise and speak unfavourably about them.

> *We are supposed to work together. Not if you are telling everybody that we are useless, and we cannot do anything, and all we want to do is cut you… That is not the way to validate your good relationship between the doctors that you are working with, that you are criticising them. You are telling them they are useless*. (DR2)

4.2.4.4 Ineffective communication

One of the backup obstetricians (DR1) identified the fact that communication between midwives and obstetricians may at times be hindered by the mindset of certain obstetricians. S/he went on to highlight the importance of the existence of dialogue between the care providers.

> *Because I find some gynaes can be really: It's their way or the highway. And there's really no, no communication. It's like: "whatever I say stands and you don't… you can't have an opinion. You can't say anything." Whereas I think it should be dialogue.* (DR1)

Communication channels within the public sector do not seem to be well established. Independent midwives have met with the management of public sector facilities and have started developing a working relationship. This has, however, not filtered down to the staff on the units and because of this there remain certain challenges when transferring clients when the management of the hospital is not present.

> *I think it helps from a management point of view but when we're referring, obviously management's not there*. (IM2*)*

The interviews done with the labour complex managers from the two state facilities both indicated the willingness of these facilities to work in collaboration with independent midwives. This, however, does not reflect the opinion and experiences of all the independent midwives. It would appear that there is a breakdown of communication causing confusion and misunderstanding of the public sector's willingness to work in collaboration with the independent midwives.

> *So, the biggest challenge ….is that the line of communication with our public facilities that practice in our area like public tertiary hospital 1 and public tertiary hospital 2, Public tertiary hospital 3, those places. They are not open to any form of collaboration with independent midwives. So even when there have been attempts to discuss things with nursing management or hospital management, they've either had doors slammed in their faces or just outright told: "No you work in the private sector, we're in the public sector we cannot work together"* (IM5)

This breakdown in communication was also identified by one of the labour complex managers (LCM2). She further went on to explain that the breakdown of communication is not only with the independent midwives but also with their own clinics that refer to the hospital.

> *I do not know where that system got lost that at the end of the month when the call rosters are released then the midwives that were falling in this public tertiary hospital 2 cluster will get the call rosters as well so that they know who is the doctor on call today, if I have a patient that I am worried about who do I contact at maternity admissions, who do I contact at the antenatal clinic but it looks like it is not happening anymore because even our clinics in the cluster… the public midwives sometimes are struggling with that call list as well, I am not sure what happened.* (LCM2)

4.2.4.5 Negative attitudes and perceptions towards independent midwives

Comments from the independent midwives indicated that they were not always treated with respect and acceptance in the public facilities. Independent midwives were, at times, deemed to be in a better financial position than public midwives and this caused a sense of frustration that led to decreased collaboration between the parties.

> *The way they even treat you is "who does this woman think she's better than I am?" and then there's also a financial aspect to it because they know that we are self-employed, and we run our own businesses and they're often: "These midwives that live this cushy lifestyle"; because they think we're rolling in it. But meanwhile back at the ranch, we're just earning our living.* (IM5)

Another independent midwife (IM6) voiced her desire to be treated as a colleague when going to a public facility. She reiterated that a possible reason for negative attitudes towards her is the perception that being an independent midwife is a lucrative career.

> *But I think also with the state they should also relate to us as their colleagues. You know I mean sometimes you go there you don't get very nice people it doesn't matter whether you are a midwife, they won't be that nice. It just depends on how they look at you, I mean they might think being a private midwife is money making but it's not always the case*. (IM6)

Another independent midwife (IM1) described clients as being treated with hostility and ugliness when transferred to a public facility.

> *There is a lot of that hostility among staff members because remember, they feel they have or they don't look at it as, they're working and getting a salary. When you bring your private clients, they are, they feel they have birthed four mothers and you are birthing one mother, you got paid for it. Your facility got paid for it. That mother had money to pay you, but she doesn't have money to pay them, so there's a lot of that that comes out. That hostility and ugliness and that is what sometimes handed it down to the clients.* (IM1)

Independent midwives have at times experienced that their clients are treated with negative attitudes from the staff in the public sector. One independent midwife (IM5) stated that her clients have been scolded and shouted at by staff in the public sector.

> *So instead of treating the problem they are: "oh no this person is over exaggerating" or "why did you come here, why not go back to your doctor?" ….. And I often find that mommies when they go to a public hospital, they get shouted at. They get told they don't have the right paperwork. They are scolded: "Why did you go to a private doctor… you think you so fancy, why are you coming here now?" and I have also recently had a mom in the last two months who I transferred in labour with the*

> *actual maternity case record book completed, referral documents. I filled out the SBAR form, for the referral during labour. They literally still told her "You have the wrong paperwork.*" (IM5)

Another independent midwife (IM1) indicated that her clients have been judged since they were needing care in a public facility where previously they had sought care in the private sector.

> *They kind of judge your patient going there because they have enough money for a private midwife but when the papaw hits the fan then they're good enough again, that's the kind of mentality that they have.* (IM1)

Yet another independent midwife (IM10) went on to describe the attitude and care given by certain staff in the public sector as less than adequate.

> *Provincial hospitals, they're training midwives. And yet when you, you know, transfer a patient, they they're lousy to the moms, you know, some of the staff are horrible to them*. (IM 10)

One independent midwife (IM5) went on to voice her frustration that it appears that clients must have money to get quality midwifery care.

> *So, it's incredibly frustrating because the mommies who don't have medical aid get treated poorly and it's as if in South Africa the pay gate for quality care, you need to have money for it*. (IM5)

One midwife (IM2) indicated that they had addressed the negative attitudes of staff with the management of a public tertiary hospital. Unfortunately, a solution has not yet been found.

> *We addressed the nastiness…The staff being ugly. They are aware of it. They don't know what to do about it.* (IM2)

One of the labour ward complex managers (LCM2) that was interviewed indicated that she was unaware of such practices in her hospital, and she strongly disapproved of condoning a client's choice of care provider.

> *I have never picked such because at the end of the day if there were comments like that but then is it not their choice of a woman to decide, it is not about being good enough for who… It is a choice, that is why I think sometimes we forget that at the end of the day no matter what we say it is the woman's choice, if she says I want to attend at community health centre she will go there, if she says I want an obstetrician she will attend there. And then if she wants a midwife, at the end of the day it is about her and the baby and the well-being*. (LCM2)

Midwives learn which obstetricians are supportive of them and which are not by talking to the nursing staff members of a facility.

> *… and quickly pick up how they feel about you…Because … if you then… if you then go the hospital, then you pick up whether those Gynaes are negative towards you or if they have a positive attitude by the way the staff talks to you…* (IM7)

One of the participating backup obstetricians (DR1) felt that it was possible that certain obstetricians felt threatened by the independent midwives. The backup obstetrician did not understand where this animosity stemmed from and felt that independent midwives were possibly judged on times gone by.

> *Sometimes I feel that obstetricians are very threatened perhaps… So sometimes I cannot understand where this animosity almost stems from… is it because of the legal things?... is it because of what people have said?... what's the basis for of this? I mean sure, historically I think, yes, there were issues. But I think we've come a long way, you understand? And sometimes I feel like sometimes obstetricians are still judging independent midwives as well as private MOU1 from what happened previously, and they haven't really moved on from that. And a lot has changed then a lot has changed, yeah. For the for the better.* (DR1)

4.2.4.6 Challenges in the public sector

A general consensus among participants who were interviewed was that there are various challenges in the public sector. One midwife participant (IM9) pointed out that the current economic conditions in South Africa are causing a decline in clients who can afford medical aid. She expressed concern that these clients are going to need care in the already overburdened public sector.

> *Obstetrics in South Africa is facing a real disaster because the patients that has the mean to pay and the medical aids is getting smaller, and the public sector is so overburdened with clients.* (IM9)

Another independent midwife (IM7) also agreed that the public sector is overwhelmed and that the staff are overworked. The midwife identified this as a reason for poor service delivery.

> *Public tertiary hospital 1 just has too much work. That … that's why the standard of care is so poor*. (IM7)

The independent midwives inform their clients of this challenge that the public sector faces by telling them that it's not about care as much as it is about managing workload.

> *You paint the picture for the patient to say like: It's all about numbers, it's really not about care. It is about how many midwives are there for a number of people that are presenting themselves to the midwife who is alone.* (IM8)

Another midwife (IM7) indicated that she does not think that the relationship between independent midwives and the government sector is a good one; she identified as a possible cause that the midwives in the government sector are working under huge amounts of pressure.

> *I don't think the relationship is working … those…midwives are totally overworked.* (IM7)

Independent midwives are concerned about the delay in treatment when sending patients to the public sector. One independent midwife (IM9) voiced this concern that clients are not seen promptly leading to greater problems.

> *I fear sometimes that… I worry that… If they get there and we already see there's something needs to be done…..Umm. And they get there and they still wait for something to be done or another 12 hours. It's gonna be a problem. That is, that is my fear of sending somebody to the public sector at this stage.* (IM9)

Another issue raised by the participants was that the public sector was a resistance to change. The staff in the public sector was described as "being set in their ways" according to an independent midwife participant.

> *I think that's one of the biggest frustrations even when you work there because they are very set in their ways, and they don't like new things. Even if change is implemented on a national or provincial level change is always slow and there's a lot of people and things that hinder progress. So, you would really have to shake up the public health care sector quite a lot.* (IM5)

This challenge of some staff members working in the public sector being resistant to change was confirmed by one of the labour ward complex managers (LCM1).

> *Because some of our staff have worked for years and they are so set in their ways, and they are not working with evidence-based medicine any more…. I was taught this so many years ago, and I am still doing it that way even though there is evidence that things have changed.* (LCM1)

A perception of one of the independent midwives was that the staff in the public sector do not seem to trust the findings of an independent midwife. So, instead of continuing with the care that the client needs, the clients care would be started from scratch once admitted to a public referral hospital.

> *I don't know what more we can do. For us, a common problem is that they* (public sector) start *the care from the beginning … you understand? You provide them with your partogram, and you give them your CTGs and then firstly they want to see if you are lying… or if it's really true. It's then that I feel chances are being taken, that they don't… they don't continue the care where we stopped. They begin anew.* (IM7)

A possible reason for having to start care from scratch was given by one of the labour ward complex managers. She explained that it often happens that clients come to the public hospital without any documentation, as if they had never been seen and then the hospital needs to treat them as unbooked and having had no care of investigations done (LCM1).

> *What our expectations are regarding what we would like on the referral letter. Also, the antenatal records so that it shows that the patient is a booked patient because many of them came in as if they weren't even booked, you know. And so, you have to start a fresh with everything, blood results and you name it.* (LCM1)

If a client needs to be transferred from a birthing unit to a higher level of care within the public sector, the midwife transfers the client to the nearest public facility that is closest to the birthing unit.

> *Midwives are sending to the hospitals that is closest to them. So, for example, I would send to public tertiary hospital 1 because it is literally 5 kilometres from where I'm doing the birth home but if the client comes from Lens, she should be sent to public tertiary hospital 3. So, she shouldn't be sent to the public tertiary hospital 1.* (IM2)

However, the public facility requires the client to be transferred to the facility that is closest to the clients' actual residential address. One of the labour complex managers (LCM1) explained the reasoning behind the need for a client to go to the clinic or hospital closest to their residential address. She indicated that clients need to be referred to these facilities since facilities are unable to accommodate additional clients who are not in their catchment area.

> *What we did say to them* (independent midwives) *was that they must please send us patients that is in our catchment area because we are so busy. We can't take on patients from other catchment areas. They* (independent midwives) *don't have a catchment area for their patients. But if their patient don't have a medical aid we advise them to let their patients book in a local clinic and the clinic will write the facility where they should delivery on their antenatal card because that is an expectation and if there are complications, the patient must be referred to that delivery facility and not to government hospital 1 if we are not their referral clinic because we really can't take on additional patients.* (LCM1)

Substandard care in the public sector was a concern raised by an independent midwife. This midwife shared her experience of what she had witnessed in a public hospital. She described the experience as horrible and indicated that the clients were not treated with the necessary care and dignity (IM11).

> *The only other time I have had to use the Government was public hospital 5. Out there far, faraway which was a huge experience for me, because what I witnessed was all the pregnant mums were sitting on benches in passageways or in labour, as*

they got to making sounds of second stage, they would be taken into the labour room. They were forced to put the sheets on the bed themselves; clean the bed afterwards. It was a horrible experience. And then they would be given their babies and told to sit back in the passageway, back on the bench… and then they would wait, until there was a bed on the postnatal ward for them to be transferred. (IM11)

4.2.4.7 Malpractice, unsafe and unethical behaviour

During the interviews it became clear that there was a sense of anxiety about the possibility of being sued for medical negligence and that the participants therefore had a heightened concern that other health providers may create situations that could lead to them being sued.

Knowing who to trust and which health care provider is competent is very important, as one of the participating obstetricians indicated (DR1).

then by working with them. …, you kind of establish this relationship and know who knows their story and who doesn't. And I think for me that was very important especially in in the environment in which we have today which is very, very litigious. (DR1)

One midwife (IM10) stated that she does not want to be sued hence she sends all relevant documents with a patient on transfer knowing that she practiced within her scope.

I give them a thorough transfer with the PARTOGRAM, with the CTG so that they know exactly what they get into that if there is a hiccup after that. I know that I'm totally in the clear I don't want to at my age be sued for anything or get reported for anything. (IM10)

A midwife participant (IM2) revealed that she had been informed by an obstetrician that obstetricians are concerned about the midwives practicing unsafely and out of their scope. She went on to describe a scenario where an obstetrician is called where complications have already occurred due to decisions made by the midwife.

One of the gynaes did mention that a while ago, they're so afraid to work with midwives because they get called out when the uterus is already rupturing and then might lose the mother you know so, at that point in time, the midwife is stepping out because it's not her field or she can't do anything and then the gynae takes full responsibility…(IM2)

She indicated that when the obstetricians take over, all responsibility is on them. Obstetricians are also then at a higher risk to face legal charges in the event of an adverse

incident. The midwife showed understanding of the obstetricians' higher charges for services to midwife clients because of this increased risk to them.

> *All responsibility is then placed on the obstetrician. and then yes, he's in line for that malpractice lawsuit and the then we all complaining bitterly about their consultation fees, which is about R2800 for consult and their clients are paying a fraction of the cost but it's because they feel that they're liable for somebody else's non-compliance and somebody else's observation, where they don't have control over so*…(*IM2)*

A backup obstetrician (DR1) confirmed that there are certain challenges with their malpractice insurance when they are providing backup for independent midwives.

> *We're having issues with our in insurance, OK, cause insurance don't want to cover obstetricians who cover private midwives because private midwives are underinsured. And it's something that that we need to work on*. (DR1)

One of the backup obstetricians (DR2) who was interviewed felt that some midwives did not follow the guidelines, did not refer clients in a timeous manner, documented dishonestly and put the blame of a negative outcome solely onto the doctors' shoulders.

> *The guidelines are not followed…. there is no timely manner… The thing about it was if you watch how the documentation occurs…it is retrospective. So please what is written down, is not actually what happened in the labour. So, the midwife sits down and writes everything retrospectively, and documents what she has…So it is coloured in. Protocols are there because I went and read the guidelines… It is just ignored… The midwife guidelines in South Africa are there. It is just ignored…After a while I also got a bit weary, because when it was a problem, it was solely pushed onto the doctor… It was the doctor's fault.* (DR2).

Midwives acknowledge the concern that obstetricians have with regards to not being informed in a timeous manner when the client needs an intervention and that if an emergency unfolds, the backup obstetrician is blamed should there be an adverse event.

> *But they've got a reservation and the reservation is real. I know. And I understand it. What their main concern was. It was called late. That's all they said they are not opposed midwifery. They are not opposed to helping us, but the timing. And at the end of the day, when the timing is not correct, then the end person, the one that does the best eventually is the person that takes the blame*. (IM8)

This idea was supported by a backup obstetrician who thought that some independent midwives did not refer clients timeously since their clarity of judgement was clouded because of financial loss when referring or their desire to have a normal delivery at all costs, possibly fuelled on by a too close and personal client-caregiver relationship.

> *For one with financial issues, because do you get paid, do you not get paid? And two, it is this absolute need to create this normal delivery that the patients want. You do*

> *not forget your medical training, but you are trying to colour it with that emotional colouring of, "I know you. I know what you want." And the personal relationship works in against you. It is clouding your judgment. It is making you want to please rather than, okay, this is a problem. This is a medical professional. This is how I am handling it.* (DR2)

Not referring a client in a timeous manner for specialised care to an obstetrician or the public sector by an independent midwives caused a delay in the management and may put a client at risk. An independent midwife (IM5) pointed out that she is aware of midwives holding on to patients and not always referring when needed.

> *Sometimes you shouldn't hold on to a patient because you're concerned about income, or you don't want to damage the relationship with the patient. There are many reasons. Sometimes you just have to let go and say: Actually, you are a doctor's patient. I see this a lot amongst colleagues.* (IM5)

Delay in referring a client to a higher level of care is not only specific to the private sector as one of the labour ward complex managers identified when describing an incident where a client had not been referred by a public sector midwife timeously and subsequently lost the baby (*LCM2)*.

> *I have picked up on one or two a patient had a border line BP booking like 140/90 kind of booking and the patient was started on Aldomet 250, three times a day and the patient continued to be seen by the midwife but then when she was actually presented to us I just felt she was late, then she became my high care patient and she actually lost the pregnancy, she went into abruptio, that was some time last year.* (LCM2)

An unfortunate result of one midwife acting out of her scope of practice can have a ripple effect on the practices of other independent midwives. One individual's action can have a negative reflection on the entire community of midwives. Midwives are then confronted by their clients who are concerned that they too may be practicing unethically.

> *Even to this day I will still have mommies come and book with me with the first appointment and ask me: " oh I heard there was a midwife in the news last year, I want to find out how you practice to kind of ascertain if you practice in the same way" or "I've met patients that have birthed with her and who are concerned over the way that their partner was cared for then, if mommy will get the same treatment now?" Are we then all the same? Do we all practice unethically?* (IM5)

One independent midwife (IM2) mentioned tongue in cheek that she is uncertain of what exactly is in her scope of practice because it would seem as if some actions performed by certain midwives are now seen as being acceptable to perform as a midwife since there are some midwives who blatantly post these actions on social media, and it seems to be accepted as correct with no apparent consequences or being held accountable.

I don't even know what's in my scope anymore. Sometimes I get so confused because people are posting things that I felt was out of my scope, that's on social media and I feel like, if it's out of your scope, what gives you that courage, you're so courageous to put it out there and then I start questioning what my scope is and are we allowed to do it or not, so I can't understand how we see it and we don't condemn it and it's happening and now; I'm even questioning, is it okay to do or not to do, I know it's wrong but it's been happening so often and it's out there on all the pages in social media so, vbacs at home, there's not only one that, there's a few birthing units that's doing it and even at one point I even asked, is it allowed? Are we like allowed to do this now, all of a sudden like we get the okay's then, it was no, it's not allowed so, if it's not allowed, it's posted on social media. Is it okay? So, I don't even know, because we are not; it's almost like we can't do anything to stop that, which is out of the scope and once that's out of scope, those clients are birthing beautifully, so it's almost like the ones that are trying to abide by it is being condemned. (IM2)

Yet another midwife (IM5) voiced her frustration and disapproval of certain independent midwives practicing out of their scope of practice and posting this on social media with no apparent consequences.

We know that there are midwives that practice unethically who are quite guilty of misconduct and malpractice and who are not practising safely because they are posting on social media the wrongful births that they are doing at their birthing centres with high-risk moms who have blood pressures and diabetes, previous C-sections times two who are doing home births on previous Caesareans who are doing a number of wrongful things including inducing with Cytotec without the patients' consent. (IM5)

Another midwife participant (IM2) highlighted that backup obstetricians should be firm and not provide backup to midwives practicing unsafely. She voiced her frustration that not all midwives take unnecessary chances and hence, according to her, not all midwives should be treated in the same manner.

The thing is I cannot understand why the gynae would still cover for somebody that he's not happy to cover for….and then you hear that all these lawsuits are happening and then the gynae says, "Oh, but I don't trust midwives." And then we all fall under that midwife when this happens. (IM2)

4.2.5 Theme 5: Strategies to Improve Collaboration

This theme highlights strategies to improve collaboration as suggested by the participants. There was agreement amongst the participants that collaboration needed to be focused on and encouraged. The strategies that were identified are discussed as sub-themes.

4.2.5.1 Support of management for collaborative care

When asked about how the collaboration could be improved between independent midwives and the public sector, one midwife (IM5) suggested a "top-down" approach where management supports collaborative care. She suggested that the Department of Health should initiate the process of collaboration by being clear on the need to work together collaboratively.

> *It has to actually start from the top. Your national and provincial government in terms of your Department of Health needs to facilitate the collaboration between the private and the public health care sector because they have to put their foot down and say this is absolute nonsense. We work together we are all the same people we are all the same country; patient care is our focus…. Everybody is going to have to look at upper leadership and upper leadership's going to have to say this is nonsense public and private health care should collaborate… it's in our guidelines they should collaborate and it's going to filter down.* (IM5)

A labour complex manager (LCM1) indicated that the Department of Health is supportive of collaborative relationships and that one result of working collaboratively is improved health outcomes for the clients.

> *But as a Department of Health, they are really pro the public-private partnerships…. So, by us actually encouraging you know that type of relationship, it will give us better health outcomes overall, you know*. (LCM1)

4.2.5.2 Effective communication

When asked about solutions for the way forward, effective communication was at the top of one of the labour complex manager's suggestions. Communication would enable the care providers to understand each other and understand how best to assist each other to ensure quality midwifery care.

> *Communication, because that is actually when we get to know what do the midwives know, what kind of guidance do they need in terms of referral and if there is a*

complication one will actually pick if there is some gaps like that….And if we can sort out communication, I am telling you, think everything will just flow because everyone will know what to do and we will also know that if now I need to step down a patient from public tertiary hospital 2 where should the patient go because I do not think I personally have ever stepped down a patient to a private midwife. I do not think I have…. Whether it is written, telephonically. But I think communication I think it is the key, if we can strengthen that I think we will be fine. (LCM2)

Another labour complex manager (LCM1) indicated that although the hospital does not have regular meetings with independent midwives, the midwives are welcome to attend their Morbidity and Mortality (M&M) meetings.

We don't have regular meetings with them, but they are welcome to join our M&Ms because we do put it on the group (WhatsApp group). *So, if they would like to attend, they know it is on a Wednesday. They can either come physically or they can join the TEAMS meeting.* (LCM1)

A willingness from independent midwives exists to meet with the public sector, to build on a collaborative relationship and to improve communication. An independent midwife (IM9) indicated the need to understand how the public sector works to improve the relationship.

I think if we are willing and start with the negotiating and get to know the people in the wards, in the maternity wards, I always say there's two sides of a coin. If we understand what is happening in the public sector, we might have a better relationship with them and…Yeah, I don't think we can just make it work, but we can start by trying to understand and start to collaborate and start to talk and having discussions. (IM9)

Another independent midwife (IM5) also shared a willingness to attend meetings in the public sector, on invitation, to improve the relationship. She went as far as to say that she is open to have her birthing facility inspected by the management of public referral hospitals to establish whether she is a safe practitioner.

I'll go to any meeting that I get invited to but then people need to be open to the formation of a relationship and I'm not saying trust me on the first go. Come inspect my facility, come see what I do, come look at my guidelines and my policies that I practice under. I'm willing to provide all the paperwork what I do… I'm happy to provide any evidence they require; all I want is an opportunity to do so. (IM5)

Another participating midwife (IM2) echoed this invitation to have the management of public facilities come and see how and where she works to establish whether she practices safely. This midwife's sentiment was that all care providers should work together for the greater good of the client.

It will be amazing if we can figure out together because …. you can't do it alone. You have to group… to go together, stand together, go and do it. Try and see what they want, maybe even call them for coffee at your birth unit, so bring them out of their base. (IM2)

A participating obstetrician (DR2) offered two suggestions to improve collaboration between the obstetricians and the independent midwives to ensure safe and supported obstetric care. The first suggestion revolved around finances and incorporating medical aids in the discussions. The second was improving the communication lines between obstetricians and independent midwives.

Yes, you want safe deliveries that are supported. And the thing about that, I think, is one, how to work around the costings with the medical aid, and two, how to get the communication between the two groups. Because it is severely broken down. (DR2)

4.2.5.3 Collaborative education

In this sub-theme the ideas of participants relate to collaborative education. During the discussion it was clear that midwives, whether independent or working as a labour complex manager in the public sector, were in favour of collaborative learning.

A participating independent midwife (IM10) emphasised the need to train midwives to replace other midwives as they retire.

We need new midwives and younger midwives taking the place of older midwives as they retire. (IM10)

One independent midwife (IM2) suggested that student midwives spend time with the already established midwives to learn what being and independent midwife entails.

…can't they (student studying midwifery) *come to a home birth unit and see a few home births and be with us to learn and maybe in that we both so just so they'd learn that? Is there any way of doing that*? (IM2)

The participating labour ward complex managers also both concurred that it would be of great advantage if midwives could learn collaboratively and hone their skills together.

It would be lovely you know; I hope that actually happens. (LCM2)

One participating labour ward complex manager (LCM1) commented that she would embrace having workshops together with the independent midwives so that ideas could be shared leading to providing better client care.

But I am very pro that type of relationship where someone will come in and maybe have a little workshop or something and you know say: let's share ideas, let's see

what other people do and how can we improve our care…. I think that having workshops between the two would really, really improve relations. (LCM1)

The labour ward complex manager embraced the idea of collaborative learning and expressed her hope that relations with higher education departments could be established and built on in order to build a good foundation of midwifery knowledge.

I really am for that, and I am hoping to forge good relations with, you know, the higher education department to have little workshops. Getting back to basics. (LCM1)

4.2.5.4 Standardised documentation

The government sector uses a maternity case record as the official communication tool between different levels of care and public health facilities. These records were introduced in 2010 as one of the key interventions to improve the care of pregnant women. It is a comprehensive record and has standardised the record keeping and documentation of care for pregnant women.

If this same record was to be made freely available for independent midwives, they too could use it and complete it when transferring clients to a government facility. This would make for more standardised and comprehensive transfer of care according to a participating independent midwife (IM6).

But maybe with the government they must be able to allow us to have those books so that you know when we send the patients there you know it makes it easy because the patient doesn't get turned away (IM6)

When transferring a client to another care provider or facility it is of the utmost importance that a private midwife sends the correct documentation with the client to ensure continuation of care. Another practice that speeds up the process of transferring care of a patient is when the independent midwife accompanies her patient to the facility to where she is being transferred as one of the midwives explained:

Our documentation is always correct, and we send our CTGs with, we send our partograms. We send everything binded and I'll write what I… …attached…and …I take that, and I do a handover of my patient to the staff…. I think it makes a big difference, especially in the private sector. The state sector is an entirely different ball game…. But in the private sector…I find they are very …very open and they are very friendly, and they receive the patient in a very gracious manner. (IM7)

4.2.5.5 Promoting mutual understanding

The suggestions raised under this sub-theme relate to how a multi-disciplinary team can work together and function harmoniously.

A participating obstetrician (DR1) pointed out that the members of a MDT should not be working in silos and in opposition to each other, they should rather complement each other and work collaboratively.

> *I think we need to work on this relationship. Instead of "an us versus them". … to know that we are actually a multidisciplinary team. We work together. It shouldn't be like either or, but it should be together. You understand? and it goes both for midwives and obstetricians.* (DR1)

A few of the independent midwives interviewed felt that the collaborative relationship would benefit if they were allowed to work a couple of shifts in the public sector to get to know the facility better and to allow the staff to get to know the independent midwives.

> *I would like to maybe do like just volunteer at the maternity units in the hospitals at some stage. Yes, so that they can see how we practise.* (IM2)

> *Maybe if we can have the, you know I'll volunteer I mean I really don't mind I really want to come in and do a bit of overtime in a public hospital more than in a private so that at least you know I can even get more hands-on you know.* (IM6)

> *I'm willing to come once or twice a week to just work… I don't have to birth anybody, but I can do CTGs I can. I can do blood pressures. I can do your bloods. I can do anything, you know. And then I can progress a patient and call you to come and birth the patient. I don't have to be paid.* (IM8)

One midwife participant (IM6) suggested the possibility of allowing the independent midwives to assist the staff in public hospitals with taking care of patients that are referred and in doing so alleviate some of the pressure and workload of the staff within the public sector.

> *So maybe if they can allow us then that's some pressure off them even if we take our clients there.* (IM6)

Legal implications and indemnity cover were identified as challenges to the suggestion of independent midwives working in the public facilities and not being employed by that facility.

> *…but that is also a little bit challenging on its own because …. the thing is you can't just work, you can't just walk in there and volunteer as a midwife okay. You're going to have to get an honouree post or something to that effect otherwise their legal system and their indemnity and whatever, is not going to cover you, if there is a*

problem. If something happens. So, it's also a little bit more of a complicated situation to try and get that sorted. (IM2)

A midwife (IM3) indicated that there had been talks held with the management of a public referral hospital about whether independent midwives were able to assist the staff of the facility when transferring a client to them. The matron had indicated that they would not be able to do so since they were not known to the facility nor were their qualifications known.

So, we actually with that matron's meeting that we had, when we spoke to the matron, we actually said to her that if we bring our patient in, can we assist them by putting the patient on the machine and so on? And she actually said that, because she doesn't know us and our qualifications and all of that. They can't just allow any kind of person to come in there. (IM3)

The midwife went on to explain that they would need to submit proof of their qualifications and registration at SANC and any other documents as required by the facility first before being permitted to perform nursing duties.

We have to submit all our documents to them… before we start and then do some volunteer work there. (IM3)

Another independent midwife (IM1) had a different opinion in that she thought working in the public sector was not a viable option due to the public sector not having sufficient funds to pay for agency staff. She pointed out that the public sector is already trying to minimise the use of agency staff to cut costs. This means that if a public facility could not pay agency staff, they would also not be able to pay independent midwives according to the participant.

So, with agency staff, they try to minimise the call out because they were, the government was unable to pay the agency to pay the staff. So, they kind of decreased that because there is no money in the facility to pay agency staff, so they weren't utilising a lot of the agency staff recently. (IM1)

When one of the labour ward complex managers was asked about the possibility of the independent midwives working a couple of shifts on her units to get to know the staff, she received the suggestion with great enthusiasm (LCM2). She commented that in doing so, the private midwives would also get to know the environment to which they are referring their clients.

It will be lovely. That will be lovely and let me tell you this; that is a system that we use for anyone that wants to come and work a shift not just private midwives. Let us say for example agency staff before they start working for the paying shifts they come and do the shifts so that we get to know everybody, you build a relationship with them and know that when you're actually referring a patient to maternity admissions for example where exactly is the person going, what kind of environment it is, what is likely to happen to the patient when she gets there. (LCM2)

4.3 Discussion

4.3.1 Theme 1: Collaborative Practices

Collegial relationships between independent midwives and backup obstetricians do exist, although there are more and better-established relationships in certain areas compared to other areas. However, not all obstetricians are willing to provide backup to independent midwives. Midwives also have their preference of obstetricians with whom they would prefer to collaborate.

The relationship between independent midwives and the public sector seems to be different for almost each midwife. Some midwives have a fairly well-established relationship while other midwives do not have a solid relationship. A need for collaboration between independent midwives, obstetricians and public referral facilities exists, with the benefits of effective collaboration including improved patient care, improved outcomes, and holistic and comprehensive care to clients.

These findings are similar to the findings in the research of Behruzi, et al. (2017). According to their research, interprofessional collaboration between midwives and other maternity care professionals of a MDT benefits the health care of mothers and children (Behruzi, Klam, Dehertog, Jimenez, & Hatem, 2017). So much more can be achieved through collaboration and working together compared to working alone. This was a major lesson learned through the COVID pandemic (World Health Organization and the United Nations Childrens's fund (UNICEF), 2022).

Independent midwives have established other collegial relationships that include working collaboratively with private hospitals and amongst themselves. Having collegial relationships amongst themselves has various benefits including support, providing credibility, accountability and it is a valuable resource network.

According to O'Connor, Casey, Fealy, et al. (2018), health care professionals need to work collaboratively across disciplinary boundaries to embrace integrated models of health care. These models of care require constant improvement to ensure efficiency (O'Conner, et al., 2018). Patients require a wide spectrum of knowledge and skills that can only be given by various health care professionals (Shamian, 2014) .

Independent midwives and backup obstetricians refer patients to each other depending on the client's choice of care provider and their risk profile. Well established communication lines between midwives and obstetricians ensure that these transfers mostly happen with minimal challenges.

When clients are no longer deemed as low risk and they do not have the financial means to afford private medical care, independent midwives refer them to the public sector hospitals.

The public sector's referral system is not always well understood by independent midwives, causing midwives to refer clients to the incorrect facilities at times. Patients who do not meet the admission criteria of referral hospitals are then re-routed to the correct public facility, causing undue friction and frustration.

There is no standard required documents that need to accompany a client on transfer. The use of own documentation, a referral letter, the maternity case record, a copy of the maternity case record and the antenatal card are all examples of documentation that are used by independent midwives when transferring a patient. The public referral hospitals each have their own requirements of documents that are needed on a transfer.

Guidelines for clinical in-patient record keeping within and between the government facilities are clearly described in the Guidelines for Maternity Care in South Africa. The documentation required when a patient is transferred from the private sector is not stated (National Department of Health, Republic of South Africa, 2015).

Good communication and a standard referral system, indicating required documentation and knowledge about admission criteria of referral facilities, were mentioned as possible solutions for the challenges identified. Effective midwifery care is attainable where midwives are integrated into the health care systems, collaborative care is rendered and where there are established referral mechanisms supported by sufficient resources (Renfrew, McFadden, Bastos, et al., 2014).

Good communication among independent midwives, backup obstetricians and public referral hospitals is vital to ensure good collaboration and quality care to clients. It ensures that everybody has the same understanding of a client and that the care rendered is consistent. Good communication among a MDT is important for effective functioning of the team since it encourages positive interpersonal relationships, facilitates conflict resolution and assists in breaking down professional barriers (Beasley, Ford, Tracy, & Alec, 2012).

Minimal to no direct communication seems to exist between the independent midwives and the public referral hospitals. Communication lines between the midwives and these facilities are not well established in most cases. One form of communication that does exist between one of the referral hospitals and the independent midwives is a WhatsApp group chat which is used to communicate the referral route of clients to the public facilities.

Ongoing discussions and communication between key stakeholders to establish standards of care collectively and collaboratively in which collaboration is encouraged is needed as identified in a study done by Munro et al. (2013), (Munro, Kornelsen, & Grzybowski, 2013). Collaboration can further be fostered and improved where there are clear communication channels to address concerns (Du Plessis & Roets, 2014).

4.3.2. Theme 2: The Engagement Process: Setting up the Relationship

The relationships between independent midwives and backup obstetricians have different origins as indicated by various participants. Some relationships were already well established before the midwife went into private practice. Other relationships were made through another independent midwife or by tapping into already existing relationships between obstetricians and the facilities used by them.

Both the independent midwives and the obstetricians practice their right to choose with whom to set up a collaborative relationship. Possible reasons for not wanting to work collaboratively include personal preference, previous experience, not having similar birth philosophies or challenges with malpractice insurance according to the participants.

Past experiences, especially if they were negative, have led to public sector hospitals not always being keen to foster collaborative relationships with independent midwives. Some independent midwives have found it challenging to initiate a relationship with the public sector and others found that their relationships have improved over time, yet for others it is still a work in progress.

According to Waldman, et al (2012) commitment, effective interpersonal skills and collaboration within the MDT is required to enhance collaborative practice between the various maternity care providers (Waldman, Kennedy, & Kendig, 2012).

4.3.3 Theme 3: Requirements for Effective Collaboration

Participants indicated that mutual trust and respect, role clarification, safe practice and a lapse of time were all requirements for effective collaboration.

Trust can be built over time and is fostered by working safely and ethically. The trust in a relationship between an independent midwife and a backup obstetrician needs to also extend to the client. Transparent, quality, effective and efficient care is rendered where there is reciprocal trust.

Another benefit of a trusting relationship is that midwives and obstetricians support each other's decisions – even if an adverse event occurs and if there are legal repercussions. Factors such as reliability, accessibility, professional conduct, and competency influence the trust in a relationship.

Trust between care providers can be broken down and lost when care providers act out of their scope of practice or when independent midwives do not adhere to the advice of their backup obstetricians.

These findings are supported by similar findings in research done by Chodzaza, et al (2020) where it was found that mutual trust was sought after by care providers who provide care in a hospital maternity unit (Chodzaza, Mbiza, Gadama, & Kafulafula, 2020).

Respect and trust are intertwined. Getting to know the preferences of backup obstetricians, following their advice, and referring clients timeously strengthens the respect in a relationship.

Clients are sensitive to the relationship between care providers and feel safe if they sense that the relationship is a respectful collaborative one that is based on mutual trust.

Beasley et al. (2012) identified distrust between care providers and a lack of respect for other professions as reasons for ineffective collaboration (Beasley, Ford, Tracy, & Alec, 2012).

As time goes by and the independent midwives, backup obstetricians and staff in the referral hospital get to know each other the collaborative relationship can become stronger. Over time, midwives become more comfortable to call the obstetricians when there is an emergency regardless of the time of day or night and staff in the public sector tend to not question the findings of independent midwives when accepting a client from them.

This is supported by Smith (2014) who stated that interprofessional collaboration is a process that develops over time (Smith, 2015). Working collaboratively over a long period of time can foster trust and familiarity between care providers (Warmerlink , Wiegers, de Cock, Klomp, & Hutton, 2017).

Having clear boundaries, knowing each other's scope of practice and having a similar philosophy of care are all important to establish a collaborative relationship. Guidance on these is found in various documents including the South African Maternal Guidelines.

A study done by Chodzaza et al. (2020) suggested that each profession's scope of practice should consider the different philosophies and levels of expertise brought by members of a multi-disciplinary team.

The importance of communicating one's scope to other parties and supporting each other's decisions helps to establish a good relationship. It is also important for a midwife to step back and allow an obstetrician to make the decisions when she has requested assistance and called upon an obstetrician's expertise.

Du Plessis and Roets highlighted the importance of having detailed practice agreements between independent midwives and backup obstetricians in case of an obstetric emergency (Du Plessis & Roets, 2014).

When a midwife practices safely, ethically and within her scope of practice, she not only wins the trust of backup obstetricians but that of the staff in the public sector facilities as well. When a midwife practices out of her scope she brings disdain to the midwifery

community. Staying within her scope of practice shows integrity, competency and proves to others that she is a safe and ethical practitioner.

It is the responsibility of midwives to stay up to date and practice safe, scientific evidence-based care and to know her scope of practice including her limitations (SANC, 2005).

4.3.4 Theme 4: Barriers to Effective Collaboration

Not having clear boundaries and not being knowledgeable of the roles of the care providers within an MDT could cause confusion and mismanagement of clients. It is up to a midwife to inform a backup obstetrician and to create awareness of her scope of practice.

There is uncertainty in the public tertiary facilities about the role of independent midwives, specifically whether they accept a client back from a public facility if her risk profile allows it.

No formal agreements exist between independent midwives and obstetricians or independent midwives and public tertiary hospitals. This can lead to boundaries and decisions being unclear and blurred.

A study done by Chodzaza et al. (2020) indicated a need for all care providers and stakeholders involved in providing maternity care to agree collectively on a professional framework of collaborative practice. (Chodzaza, Mbiza, Gadama, & Kafulafula, 2020).

Du Plessis and Roets (2014) developed guidelines to improve collaboration from their research in which they indicated the need for a formal agreement for collaboration between independent midwives and backup obstetricians. They went on to add that protocols, guidelines and standards should form part of the agreement to establish clear boundaries for safe practice (Du Plessis & Roets, 2014).

Although, according to Smith (2015), these written collaborative agreements should not be proscriptive as to then become a barrier for collaboration within an MDT (Smith, 2015). Shared decision making is a requirement for collaboration (Beasley, Ford, Tracy, & Alec, 2012).

Tarnishing each other's reputation breaks trust and this can cause reputational damage which leads to the disintegration of relationships. It could cause backup obstetricians to withdraw their support.

Ineffective communication between the care providers is caused by various factors and has a negative effect on the care given in private and public settings. Delay in care that may lead to complications was identified as a possible outcome of ineffective communication within a multi-disciplinary team.. Dialogue and respecting each other's training and viewpoints promote effective communication.

Effective communication was identified as a strategy to improve collaboration between MDT members in maternity care (Chodzaza, Mbiza, Gadama, & Kafulafula, 2020).

A breakdown in communication between independent midwives and public tertiary hospitals was identified by both the independent midwives and the labour complex managers. There does not always seem to be good communication between management and staff in public facilities regarding decisions and agreements made about and with independent midwives, causing confusion and misunderstandings.

From the information shared by the independent midwives, it was apparent that they are not always treated with respect and acceptance in public referral facilities. Staff attitudes are thought to be negatively influenced by the perception that independent midwives have a more lucrative income.

According to a study done by Du Plessis and Roets (2014), bullying behaviour towards independent midwives by other health care providers and nursing managers is not an uncommon phenomenon (Du Plessis & Roets, 2014).

Patients were at times judged, shouted at and treated with less-than-optimal care if they were referred to a public facility by an independent midwife. The management of the public facilities condone such behaviour.

At times obstetricians also view independent midwives with a certain amount of animosity. Possible reasons include feeling threatened and judging independent midwives on historic adverse events.

For collaboration to be effective between health care providers and facilities, it is vitally important that the concerns of all involved need to be acknowledged and addressed. (Chodzaza, Mbiza, Gadama, & Kafulafula, 2020).

Independent midwives are aware of many challenges within the public health care system. Staff being overworked and overwhelmed by high volumes of patients, a resistance to change and poor communication channels were factors identified that lead to substandard care in some public facilities.

The lack of health care providers versus patients, medical and patient resistance and role confusion were also identified as challenges experienced by midwives in other countries (Carr & Gonzales, 2007).

Staff in the public sector not trusting the findings of independent midwives and then doing their own assessments was highlighted as a possible cause for not managing emergencies swiftly.

Independent midwives suggested that a rigid admission criterion without reviewing clients' individual needs and a fixed attitude to only admitting clients within a certain catchment area made referring clients to the public sector challenging at times.

Du Plessis and Roets suggested in their research that collaboration between independent midwives and professional nurses in referral institutions can be fostered by organising monthly meetings between independent midwives and the midwives working in the institutions (Du Plessis & Roets, 2014).

A consensus among participants was that obstetrics is currently a very litigious environment in which to work. It is important for health care providers to know who to trust and who not to trust. Challenges with malpractice insurance exist. Obstetricians pay a much larger amount for malpractice insurance compared to independent midwives.

Research done by Peterson et al. (2007) support these findings as they identified liability and insurance as a barrier to collaborative care. The researchers found that differences in insurance coverage and financial liability impeded collaborative care (Peterson, Medves, Davies, & Graham, 2007).

Through discussions with the midwives and the obstetricians it became apparent that there are certain midwives who practice out of their scope of practice. These midwives cause the backup obstetricians to lose faith in independent midwives.

Certain independent midwives become frustrated due to a lack of accountability for those practicing unsafely. An independent midwife delaying transferring care of patients to a higher level of care due to poor judgement, concern about financial loss and being overly emotionally invested to a certain outcome were all raised as concerns by all the participants.

The effect of a minority of independent midwives practicing unsafely and not within their scope of practice has a ripple effect on how all independent midwives are viewed. This effect can also be seen in clients who question the safety and integrity of independent midwives.

4.3.5 Theme 5: Strategies to Improve Collaboration

Participants in the study shared various suggestions on how to improve and build strong collaborative relationships. One such suggestion was the need for a “top-down” approach where management buys in and supports collaborative relationships. This suggestion entails the Department of Health initiating the process of collaboration and communicating it to the public health facilities.

The importance of policies to support interprofessional collaboration as well as the need for decision makers to take action and facilitate the process needed to implement these policies was identified in a study done by Munro et al. (2013) about the barriers and attributes of interprofessional collaboration with midwives (Munro, Kornelsen, & Grzybowski, 2013).

Peterson et al. (2007), also identified in their research that support of local and national leaders is required as a strategy to facilitate collaboration (Peterson, Medves, Davies, & Graham, 2007). Collaboration among members of an MDT and effective teamwork among all stakeholders providing maternal child health is necessary at local, regional and international levels (Shamian, 2014).

Improving communication between independent midwives and public facilities as well as with obstetricians featured highly when it came to suggestions on how to have better collaborative relationships. All participants indicated their willingness to engage in steps to ensure effective communication. Good communication would ensure that key players know their roles as well as the roles of others, it would enable practitioners to provide safe and supported collaborative care and ensure a smooth transition of care of clients where needed.

The implementation and use of standardised documentation by all independent midwives, obstetricians and public facilities would ensure a comprehensive and holistic transfer of care and ensure that all relevant information is handed over to the next care provider.

Collaborative learning, education and training would improve relationships, build a good foundation of midwifery knowledge, and allow care providers to hone their skills. Workshops, mentoring student midwives and implementing collaborative training in higher education were suggested to facilitate collaborative learning.

Integrated education programmes to facilitate understanding of the education of each member within a multi-disciplinary team was suggested by Peterson et al. (2007) as a possible way to promote and facilitate multidisciplinary collaborative maternity care (Peterson, Medves, Davies, & Graham, 2007). Teaching interprofessional competencies would require staff within the midwifery faculty to work collaboratively with other faculties when considering incorporating interprofessional simulations (Shaw-Battista, Belew, Anderson, & van Schaik, 2015).

Munro et al. (2013) suggested in their research that institutions could look at adapting and expanding education programmes and include interprofessional education as well as offer professional development programmes where collaboration between disciplines are encouraged (Munro, Kornelsen, & Grzybowski, 2013).

Promoting experiential learning by allocating medical students for work integrated learning with an independent midwife and publishing research results of both midwives and obstetricians in peer reviewed medical and allied health professional journals would create awareness and encourage collaboration according to Du Plessis and Roets (Du Plessis & Roets, 2014).

A multi-disciplinary team that works well together and functions well are able to provide effective and high-quality care to their clients. Several independent midwives indicated that they were willing to spend some time in public facilities and work alongside the staff to

foster and nurture collaborative relations. Although this suggestion does come with some challenges, such as indemnity cover, it was also received with active interest by the labour complex managers in the public tertiary facilities.

4.4 Conclusion

The findings and discussions of the research were presented in this chapter. The themes and sub-themes were identified from the data analysis of the interviews held with the research participants. The following chapter is the final chapter of this research report, where the summary, main findings, limitations, and recommendations are presented.

Chapter 5: Summary, Main Findings, Limitations, Recommendations and Conclusion

5.1 Introduction

The introduction and background of this research was provided in chapter one. The purpose of this study was to describe the current relationships between the independent midwives, obstetricians, and referral facilities in the government health care sector and how these relationships influence the quality of maternity care provided within a multi-disciplinary team.

A literature review of available literature regarding maternity care in South Africa, different providers of maternity care as well as the settings in which these care providers practice in was explored in chapter two. To date, there has been limited exploration of collaborative practices among independent midwives, backup obstetricians and public referral facilities.

Chapter three described the research design and methodology used. The study used an explorative, descriptive qualitative design. The participants consisted of eleven independent midwives practicing in Johannesburg, two obstetricians who offer back-up to independent midwives and two labour complex managers in public tertiary hospitals. Interviews were conducted with all participants.

The two obstetricians, two labour complex managers and six independent midwives were interviewed individually. Five independent midwives were interviewed in small groups with two and three participants respectively. All interviews were audiotaped and transcribed verbatim. Data was analysed using thematic analysis.

The findings and discussions of the research were presented in the previous chapter. In this last chapter of the research report a summary, main findings, limitations, and recommendations are discussed.

5.2 Summary

The collaborative relationship between independent midwives in Johannesburg and their backup obstetricians as well as the relationship of the independent midwives and the public tertiary facilities was explored in this study.

The study found that collegial relationships between independent midwives and backup obstetricians do exist, although there are more and better-established relationships in certain areas compared to other areas. The relationship between independent midwives and the public sector seems to be different for almost each midwife. Some midwives have a fairly well-established relationship and other midwives do not have a solid relationship.

This study found that there are several requirements for effective collaboration and that certain barriers can and do prevent collegial practice. Certain strategies to improve collaboration do however exist but these are not always implemented.

All participants concurred that collaboration between the different care providers and facilities is needed and identified improved patient care, improved outcomes, holistic and comprehensive care to clients as benefits of collaboration.

5.3 Main findings

Collaboration between care providers of maternity care do exist. However not all these relationships are well established and work effectively.

Both the independent midwives and the obstetricians practice their right to choose with whom to set up a collaborative relationship. Possible reasons for not wanting to work collaboratively include personal preference, previous experience, not having similar birth philosophies or challenges with malpractice insurance according to the participants.

Past experiences, especially if they were negative, have led to the public sector hospitals not always being keen to foster collaborative relationships with independent midwives. Some independent midwives have found it challenging to initiate a relationship with the public sector and others found that their relationships have improved over time, yet for others it is still a work in progress.

At times due to complications arising in the client's pregnancy journey, the independent midwife needs to refer the client to either a back-up obstetrician or a government facility.

The public sector's referral system is not always well understood by the independent midwives causing midwives to refer clients to the incorrect facilities at times. Well established communication lines between the midwives and the obstetricians ensure that transfers to the obstetricians in the private sector mostly happen with minimal challenges.

Good communication, a standard referral system indicating required documentation and knowledge about admission criteria of referral facilities were mentioned as possible solutions for the challenges identified.

Both the independent midwives and obstetricians indicated that different modes of communication are used, depending on the urgency of the matter as well as personal preference.

The study found that mutual trust and respect, role clarification, safe practice and a lapse of time were all requirements for effective collaboration.

Transparent, quality, effective, and efficient care is rendered where there is reciprocal trust. Trust between care providers can be broken down and lost when care providers act out of

their scope of practice or when independent midwives do not adhere to the advice of their backup obstetricians.

Barriers to effective collaboration identified included ineffective knowledge of each other's role, lack of formal policies and guidelines, reputational damage, and ineffective communication. Other barriers identified were negative attitudes and perceptions of independent midwives, challenges in the public sector and malpractice, unsafe and unethical behaviour.

A general consensus between participants who were interviewed was that there are various challenges in the public sector. Staff being overworked and overwhelmed by high volumes of patients, a resistance to change and poor communication channels were factors identified that led to substandard care in some public facilities.

Through the discussions with the midwives and obstetricians it became apparent that there are certain midwives who practice out of their scope of practice. These midwives cause the backup obstetricians to lose faith in independent midwives. Certain independent midwives become frustrated due to a lack of accountability for those practicing unsafely.

Strategies identified to improve collaboration were the need for a "top-down" approach, effective communication, standardised documentation, collaborative education as well as implementing practices that promote mutual understanding such as independent midwives working alongside staff in public facilities for some shifts.

The implementation and use of standardised documentation by all independent midwives, obstetricians and public facilities would ensure a comprehensive and holistic transfer of care and ensure that all relevant information is handed over to the next care provider.

Collaborative learning, education and training will improve relationships, build a good foundation of midwifery knowledge, and allow care providers to hone their skills. Workshops, mentoring student midwives and implementing collaborative training in higher education were suggested to facilitate collaborative learning.

5.4 Limitations

In reviewing the research question the researcher realised that there were limitations to the study.

The study was conducted only in one city in one province in South Africa and two tertiary hospitals, which may result in the findings not being able to be generalised in other settings.

The study sought to examine the relationships between independent midwives and backup obstetricians, however as only two backup obstetricians made themselves available, it created a limitation for the study.

This study described the relationship between independent midwives and two tertiary referral facilities in the government sector. In retrospect the researcher realised it would have assisted the study if the term "referral facilities" in the research question had been expanded to not only tertiary referral facilities but also other referral facilities within the government sector such as MOUs, CHCs, district and regional hospitals. This is due to the fact that midwives refer clients to other care providers due to medical reasons as well as other reasons including financial ones.

When the research proposal was developed the intention was to conduct face to face focus groups with the independent midwives. Due to the COVID pandemic this was not possible and the individual nature of several of the interviews may have limited the depth of discussions of shared experiences.

Due to the closed nature of the research community, there may have been an element of social desirability bias in the responses of the participants.

The study was limited due to the fact that it was conducted for a research report and therefore, of necessity, had to be restricted. A larger study would have enabled triangulation of data.

True collaboration in health care includes the client themselves as an active participant. This study did not include collaborative relations between the independent midwives and their patients.

This research did not examine the collaborative relationships between independent midwives and other health and maternity care providers and complementary health care practitioners such as doulas, paediatricians, homeopaths, chiropractors, and paramedics.

5.5 Recommendations

The following recommendations are made based on the findings of this research:

5.5.1 Recommendations for Practice

During the process of contacting possible independent midwives to participate in the research the researcher found that there is currently no formal listing of independent midwives. This issue could be resolved if the member based professional societies took on this responsibility. Such a data base would ensure accessibility to independent midwives (by researchers, other health care providers as well as prospective clients) and an element of peer accountability.

Professional associations such as the Private Practicing Midwives' Alliance (PPMA) need to work together with their members to ensure safe practice within independent midwifery

practices. Policies and guidelines could be created and shared amongst members to encourage safe practice.

The drawing up of mutually agreed upon guidelines and protocols about care rendered to clients in obstetrics and the transfer of clients between care providers would ensure that clients are managed safely and transferred correctly and timeously.

Poor communication between stake holders as well as ineffective knowledge of the referral system in the public sector by the independent midwives impede effective collaboration. Improved lines of communications, a standard referral system indicating required documentation and knowledge about admission criteria of referral facilities need to be communicated to care providers. Transfer pathways within the public health care system should be communicated to all relevant stake holders. This would require a joint effort between the care providers and the referral facilities.

Professional organisation/s could meet with management of referral hospitals or clinics to familiarise themselves to the admission criteria, transfer pathways and documentation needed when transferring patients to the government facilities. This knowledge could then be documented and distributed to their members. This would further assist in developing established lines of communication.

Professional associations and the Department of Health could consider a national strategy on implementing collaboration between health care providers and the public sector with the aim of improved care are to be established on an ongoing basis.

Due to the individual nature of experiences of midwives it is not possible to develop a policy that would support improved relationships between them and backup obstetricians, however it would be useful to develop guidelines which should be distributed to all stakeholders. Professional associations in collaboration with the Department of Health need to address this.

The lack of standardised documentation was highlighted in the research. Standardised documentation for all pregnant women – whether in the public or private health care systems - need to be encouraged. This would ensure continuity of care when the care of clients is transferred between care providers. The use of the SBAR clinical report on maternity situations included in the revised maternity case records should be encouraged.

A platform for discussion and sharing of experiences should be established to iron out negative perceptions between independent midwives and their public sector counter parts. This platform could also be used to develop mutual understanding of the referral patterns entrenched in the government health policy.

Professional concerns raised by health care providers need to be addressed in each facility. Solutions to the barriers to collaboration need to be found so that collaborative care can become the norm. Possible solutions may include holding regular meetings with the

independent midwives or professional associations and the management of referral facilities. The attendance of Morbidity and Mortality meetings (M&M meetings) by independent midwives could be considered.

Collaborative initiatives such as workshops, meetings and training opportunities should be encouraged and presented on a continuous basis in all maternity care facilities. Care providers within these facilities as well as care providers referring to these facilities should be invited to attend. Professional associations, educational facilities as well as the referral facilities, both in the private and public sectors, could be involved with this.

The need for mentorship was identified in the research. Independent midwives should be encouraged to act as mentors for midwives in practice who are considering practicing independently to help strengthen and solidify their knowledge and to give guidance on best practice.

5.5.2 Recommendations for Nursing Education

Participants in the research indicated the need for collaborative learning practices to encourage a culture of collaboration.

Health science faculties need to consider interprofessional education programmes to promote collaboration. Integrating collaborative interprofessional teaching and learning into both basic and post-basic health science programmes to promote improved communication, a better understanding of the scope of practice of different care providers, the sharing of knowledge and skills, and to foster mutual respect between care providers is important.

Students must be exposed to various maternity care environments, both in the public as well as the private sectors, to enable them to have a comprehensive understanding of maternity care.

5.5.3 Recommendations for Research

Future research should focus on ways to implement collaborative practice within our health care systems. Other collaborative relationships should also be explored and described and ways to improve relationships and address barriers to collaboration should be researched.

Further research could be done on what impact financial decisions have on the care given including researching how medical aid schemes affect care rendered.

The impact of litigation on care provided should be researched in more depth. Whether care provided is evidence based or whether it is more defensive medicine should be looked at.

Research on how to include collaborative teaching and learning in health care curricula should be done.

A larger study could be conducted which would allow for triangulation of data, for example, the data obtained from obstetricians, the data obtained from midwives and data from literature could be triangulated. Alternatively, a mixed method study with a quantitative and a qualitative method would be useful.

5.6 Conclusion

The aim of this research was to describe the current relationships among independent midwives, obstetricians, and referral facilities in the government health care sector and how these relationships influence the quality of maternity care provided within MDTs.

This study has demonstrated collaborative maternity care is possible and that different members of multi-disciplinary team are willing to work collaboratively, regardless of the challenges and barriers experienced. The quality of maternity care provided increases and is more effective and efficient when there is well established collaboration between care providers.

This chapter concludes the research report and presented the summary, main findings, limitations and recommendations of this research.

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ANNEXURE 1 Information Letter: Focus Group

April 2022

Dear Independent Midwife

Hello, my name is Jeanell du Plessis; I am a student at the University of the Witwatersrand, studying for a Master Degree in Nursing Education. As part of the course requirements, I am expected to conduct a research report under supervision.

The title of my research is:

Collaborative Maternity Care: The Relationship between independent Midwives and the Interprofessional Care Providers in Johannesburg, South Africa.

The question that I aim to answer in the study is: How does the current relationship between the independent midwives in Johannesburg and the backup obstetricians as well as the referral facilities in the government sector influence the quality of collaborative maternity care?

I hope that findings in this study may assist in the development of policies and guidelines between maternal care providers in order to facilitate collaborative care. I further hope that these findings may also aid nurse educators to identify the importance of introducing the topic of interprofessional collaboration within a South African context in current training programs.

I am inviting you to take part in this research study. Should you agree to participate, you will be requested to participate in a focus group consisting of independent midwives to discuss the topic as described above. Focus groups will be conducted electronically via the TEAMS application. The duration of the discussion is scheduled to last 60-80 minutes.

I acknowledge that even if you do agree to attend the focus group discussion, the nature of your work may prevent you from attending on the specific day.

Participation is voluntary and all information will be treated confidentially. Anonymity within the focus groups cannot be guaranteed, due to the nature of a focus group, but the researcher will take every precaution to maintain confidentiality of the data. **Reports of the research findings will not include any identifying information of participants**.

With your permission, the focus group will be audio-recorded in order to accurately capture what is said. If you participate in the study, you may request that the recording be paused at any time. You may choose how much or how little you want to speak during the group. You may choose to leave the focus group at any time.

Participants will be reminded to respect the privacy of all fellow participants and not to repeat what is said in the focus group to others. Data collected will be stored securely and safely on a password-protected computer. Consent forms will be stored separately from the recording and transcripts in a locked and secure location. Audio-recordings of the focus group will be kept on a password-protected computer. Only the researcher and the supervisors will be able to listen to the recording and read the typed version of the recording.

Participating in this study may not benefit you directly, but it will help us to understand and learn about collaboration in maternity care. No significant risks related to the participation in this study is envisioned. There will be no financial benefits to participants if you choose to participate in this study, however, participants will have access to the findings of the study on completion.

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Dr Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Contact details of the researcher and supervisors:

Researcher: Jeanell du Plessis (083 552 8516) jeanell.duplessis@wits.ac.za
Supervisors: Dr Sue Armstrong (011 488 4061) sue.armstrong@wits.ac.za
Dr Barbara Hanrahan (011 488 4061) barbara.hanrahan@wits.ac.za

Thank you

Jeanell du Plessis

ANNEXURE 2 Information Letter for interviews (one-on-one discussion)

April 2022

Hello, my name is Jeanell du Plessis, I am a student at the University of the Witwatersrand, studying for a Master's Degree in Nursing Education. As part of the course requirements, I am expected to conduct a research report under supervision.

The title of my study is:

Collaborative Maternity Care: The Relationship between independent Midwives and the Interprofessional Care Providers in Johannesburg, South Africa.

The question that I aim to answer in the study is: How does the current relationship between the independent midwives in Johannesburg and the backup obstetricians as well as the referral facilities in the government sector influence the quality of collaborative maternity care?

I hope that the findings of this study may assist in the development of policies and guidelines between maternal care providers in order to facilitate collaborative care. I further hope that these findings may also aid nurse educators to identify the importance of introducing the topic of interprofessional collaboration within a South African context in current training programs.

I am inviting you to take part in this research study. Should you agree to participate, you will be interviewed by me to discuss the topic as described above.

Interviews will be conducted electronically via the TEAMS application. The date and time will be agreed upon by both parties. The duration of the interview is scheduled to last 30-40 minutes.

Participation is voluntary and all information will be treated confidentially. Anonymity and confidentiality will be attained by not using full names of participants in the interviews. **Reports of the research findings will not include any identifying information**.

With your permission, the interview will be audio-recorded in order to accurately capture what is said. If you participate in the study, you may request that the recording be paused at any time. You may choose how much or how little you want to answer to the questions. You may choose to end the interview at any time.

Data collected will be stored securely and safely on a password-protected computer. Consent forms will be stored separately from the recording and transcripts in a locked and secure

location. Only the researcher and the supervisors will be able to listen to the recording and read the typed version of the recording.

Participating in this study may not benefit you directly, but it will help us to understand and learn about collaboration in maternity care. No significant risks related to the participation in this study is envisioned. There will be no financial benefits to you if you choose to participate in this study, however, participants will have access to the findings of the study on completion.

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Dr Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Contact details of the researcher and supervisors:

Researcher: Jeanell du Plessis (083 552 8516) jeanellduplessis@wits.ac.za
Supervisors: Dr Sue Armstrong (011 488 4061) sue.armstrong@wits.ac.za
Dr Barbara Hanrahan (011 488 4061) barbara.hanrahan@wits.ac.za

Thank you

Jeanell du Plessis

ANNEXURE 3 Participants consent to participate in focus groups

I, _____

Hereby confirm that I have received, read, and understood the information letter for participants explaining the purpose and nature and the study entitled:

"**COLLABORATIVE MATERNITY CARE: THE RELATIONSHIP BETWEEN INDEPENDENT MIDWIVES AND INTERPROFESSIONAL CARE PROVIDERS IN JOHANNESBURG, SOUTH AFRICA"**

- I voluntarily agree to participate in this research study.
- I confirm that I have been provided the opportunity to ask questions; all of which have been answered to my satisfaction.
- I am aware that all information collected will be treated confidentially and that the results of the study, including any personal details, will be anonymously processed into a study report.
- I understand that in any report on the results of this research my identity will remain anonymous. This will be done by changing my name and disguising any details of my focus group which may reveal my identity or the identity of people I speak about.
- I understand that taking part in the study is voluntary and that I may, without prejudice, withdraw at any time.
- I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.
- I understand that participation involves being part of a focus group to explore current trends, challenges, barriers and contributing factors to collaborative care between independent midwives, obstetricians, and the public sector.
- I understand that I will not benefit directly from participating in this research.
- I agree to the focus group being audio-recorded.

- I understand that disguised extracts from my comments during the focus group may be quoted in the research dissertation, conference presentation, published papers etc.

- I understand that signed consent forms and original audio recordings will be retained and stored in a locked in a locked secure location by the researcher for a minimum of 2 years after which they will be destroyed.

- I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

Researcher:	J du Plessis	jeanellduplessis@gmail.com	083 552 8516
Supervisors:	Dr S Armstrong	sue.armstrong@wits.ac.za	011 488 4061
	Dr B Hanrahan	Barbara.Hanrahan@wits.ac.za	011 488 4061

I hereby give consent to take part in this study.

Research Participant's name: _____

Research Participant's Signature: _____ Date:_____

Researcher:

I hereby confirm that the above participant has been fully informed about the nature, conduct, risks, and benefits of the study and that informed consent has been given to participate in the study.

Researcher's name:_____

Researcher's Signature: _____ Date:_____

ANNEXURE 4 Informed Consent for audio-recordings and transcribing of Focus Groups

I, _____

Hereby confirm that I have received, read, and understood the information letter for participants explaining the purpose and nature and the study entitled:

"**COLLABORATIVE MATERNITY CARE: THE RELATIONSHIP BETWEEN INDEPENDENT MIDWIVES AND INTERPROFESSIONAL CARE PROVIDERS IN JOHANNESBURG, SOUTH AFRICA"**

This study involves the audio taping of your focus group in order to accurately capture what is said. Neither your name nor any other identifying information will be associated with the audiotapes or the transcript. Only the research team will be able to listen to the audio recordings.

The audio recordings will be anonymous, and you can leave the focus group at any time. Should you choose to withdraw, all your comments prior to withdrawing will be removed.

Data collected will be stored securely and safely on a password-protected computer. Consent forms will be stored separately from the recording and transcripts in a locked and secure location.

By signing this form, you are consenting to:

☐ Having the focus group recorded;

☐ to have the recording transcribed;

☐ use of the written transcript in the research report.

By checking the box in front of each item, you are consenting to that procedure.

This consent for recording is effective for a minimum of 2 years after which the original audio recordings will be destroyed.

Research Participant's name: _____

Research Participant's Signature: _____ Date:_____

ANNEXURE 5 Participants consent to participate in research interview

I, _____

Hereby confirm that I have received, read and understood the information letter for participants explaining the purpose and nature and the study entitled:

"**COLLABORATIVE MATERNITY CARE: THE RELATIONSHIP BETWEEN INDEPENDENT MIDWIVES AND INTERPROFESSIONAL CARE PROVIDERS IN JOHANNESBURG, SOUTH ARICA"**

- I voluntarily agree to participate in this research study and understand that I may, without prejudice, withdraw at any time or refuse to answer any questions without any consequences of any kind.

- I confirm that I have been provided the opportunity to ask questions; all of which have been answered to my satisfaction.

- I am aware that all information collected will be treated confidentially and that the results of the study, including any personal details, will be anonymously processed into a study report.

- I understand that in any report on the results of this research my identity will remain anonymous. This will be done by changing my name and disguising any details of my interview which may reveal my identity or the identity of people I speak about.

- I understand that I can withdraw permission to use data from my interview within two weeks after the interview, in which case the material will be deleted.

- I understand that participation involves being interviewed to explore current trends, challenges, barriers and contributing factors to collaborative care between independent midwives and obstetricians.

- I understand that I will not benefit directly from participating in this research.

- I agree to my interview being audio-recorded.

- I understand that disguised extracts from my interview may be quoted in the research dissertation, conference presentations, published papers etc.

- I understand that signed consent forms and original audio recordings will be retained and stored in a locked in a locked secure location by the researcher for a minimum of 2 years after which they will be destroyed.

- I understand that a transcript of my interview in which all identifying information has been removed will be retained for a minimum of 2 years.

- I understand that I am entitled to access the information I have provided at any time while it is in storage as specified above.

- I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

Researcher:	J du Plessis	jeanellduplessis@gmail.com	083 552 8516
Supervisors:	Dr S Armstrong	sue.armstrong@wits.ac.za	011 488 4061
	Dr B Hanrahan	barbara.hanrahan@wits.ac.za	011 488 4061

I hereby give consent to take part in this study.

Research Participant's name: _____

Research Participant's Signature: _____ Date:_____

Researcher:

I hereby confirm that the above participant has been fully informed about the nature, conduct, risks, and benefits of the study and that informed consent has been given to participate in the study.

Researcher's name:_____

Researcher's Signature: _____ Date:_____

ANNEXURE 6 Informed Consent for audio-recordings and transcribing of Interviews

I, _____

Hereby confirm that I have received, read, and understood the information letter for participants explaining the purpose and nature and the study entitled:

"**COLLABORATIVE MATERNITY CARE: THE RELATIONSHIP BETWEEN INDEPENDENT MIDWIVES AND INTERPROFESSIONAL CARE PROVIDERS IN JOHANNESBURG, SOUTH AFRICA"**

This study involves the audio taping of your interview in order to accurately capture what is said. Neither your name nor any other identifying information will be associated with the audiotapes or the transcript. Only the research team will be able to listen to the audio recordings.

Immediately following the interview, you will be given the opportunity to have the recording erased if you wish to withdraw your consent to taping or participation in this study.

Data collected will be stored securely and safely on a password-protected computer. Consent forms will be stored separately from the recording and transcripts in a locked and secure location.

By signing this form, you are consenting to:

☐ Having your interview recorded;

☐ to have the recording transcribed;

☐ use of the written transcript in the research report.

By checking the box in front of each item, you are consenting to that procedure.

This consent for recording is effective for a minimum of 2 years after which the original audio recordings will be destroyed.

Research Participant's name: _____

Research Participant's Signature: _____ Date:_____

ANNEXURE 7 Interview Guide for Obstetricians:

- How would you describe your relationship with the independent midwives?
  Probes:
  - Relationships within multi-disciplinary team?
  - Relationships with midwives as individuals?

- How do you go about deciding whether to agree to backup an independent midwife?
  Probe:
  - Are there and specific guidelines/work methods that you follow when working with independent midwives?
  - Have you formalized the relationship in any way?
  Probes about guidelines/work methods:
    - Accepting clients
    - Referral procedures
    - Communication and reporting
    - Safe client management
    - Reimbursement

- Can you identify benefits of collaborating with independent midwives?

- What concerns do you have, or constraints that you encounter relating to the working practices of the independent midwives and their scope of practice.
  Probes:
  - Home births
  - Birthing units
  - malpractice insurance
  - Medical aid
  - your reputation amongst your peers/colleagues
  - Client satisfaction

- Is there anything that you would like to add?

ANNEXURE 8 Focus Group Guide: Independent Midwives

- How would you describe your relationship and working methods with your back up obstetricians as well as the public sector facilities?

  Probes: In terms of

  - Accepting clients
  - Referral procedures
  - Communication and reporting
  - Safe client management
  - Reimbursement
  - Challenges

- What factors comes to mind that could contribute or limit collaborative care between health care providers and facilities?

  Probes:

  - Role clarification
  - Attitude
  - Policies and guidelines
  - Hierarchical culture
  - Communication
  - Medical aid
  - Malpractice

- What solutions would you suggest for the challenges?

- Is there anything that you would like to add?

ANNEXURE 9 Interview Guide for Labour Complex Managers

- How would you describe your relationship with the independent midwives?
  Probes:
  - Relationships within multi-disciplinary team
  - Perceptions of staff about independent midwives

- Does your facility have and specific guidelines/work methods that you follow when working with independent midwives?
  Probe: Are there specific midwives you work with?
  Have you formalized the relationship in any way?
  Probes about guidelines/work methods:
  - Accepting clients
  - Referral procedures
  - Communication and reporting
  - Safe client management
  - Reimbursement

- What concerns/constraints do you have about the working practices of the independent midwives and their scope of practice, and can you identify benefits of collaborating with independent midwives?
  Probes:
  - Home births
  - Birthing units
  - malpractice insurance
  - Medical aid
  - Communication and reporting
  - Client satisfaction

  What solutions would you suggest for these challenges?

- Is there anything that you would like to add?

ANNEXURE 10 Hospital Manager request letter

Dear Sir/Madam

RE: Permission to interview the Labour Complex Manager at the hospital

My name is Jeanell du Plessis; I am a student at the University of the Witwatersrand, studying for a Master's Degree in Nursing Education. As part of the course requirements, I am expected to conduct a research report under supervision.

The title of my study is:

Collaborative Maternity Care: The Relationship between independent Midwives and the Interprofessional Care Providers in Johannesburg, South Africa.

The question that I aim to answer in the study is: How does the current relationship between the independent midwives in Johannesburg and the backup obstetricians as well as the referral facilities in the government sector influence the quality of collaborative maternity care?

I hope that the findings of this study may assist in the development of policies and guidelines between maternal care providers in order to facilitate collaborative care. I further hope that these findings may also aid nurse educators to identify the importance of introducing the topic of interprofessional collaboration within a South African context in current training programs.

I am requesting your approval to interview your Labour Complex Manager with regards to the research question above.

Due to our current challenges with the COVID 19 pandemic, interviews will be conducted electronically via the ZOOM application. The date and time will be agreed upon by both parties. The duration of the interview is scheduled to last 30-40 minutes.

Participation is voluntary and all information will be treated confidentially. Anonymity and confidentiality will be attained by not using full names of participants in the interviews. Reports of the research findings will not include any identifying information.

Participating in this study may not benefit you or your institution directly, but it will help us to understand and learn about collaboration in maternity care. No significant risks related to the participation in this study is envisioned.

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Dr Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Contact details of the researcher and supervisors:

Researcher: Jeanell du Plessis (083 552 8516) jeanellduplessis@gmail.com
Supervisors: Dr Sue Armstrong (011 488 4061) sue.armstrong@wits.ac.za
Dr. Barbara Hanrahan (011 488 4061) barbara.hanrahan@wits.ac.za

Thank you

Jeanell du Plessis

ANNEXURE 11 Title approval from Postgraduate Committee

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

16 July 2020
Person No: 1409448
PAG

Ms J Du Plessis
53 Rail Street
Johannesburg
Florida
1709
South Africa

Dear Ms Jeanell Du Plessis

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled *Colloborative maternity care: The relationship between independent midwives and interprofessional care providers in Johannesburg, South Africa.* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

ANNEXURE 12 Human Research Ethics Committee Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R49 Ms J du Plessis

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M200514

NAME: (Principal Investigator)	Ms J du Plessis
DEPARTMENT:	School of Therapeutic Sciences Department of Nursing Education Medical School University
PROJECT TITLE:	*Collaborative maternity care: exploring the relationship between independent midwives and interprofessional care providers in South Africa*
DATE CONSIDERED:	2020/06/29
DECISION:	Approved unconditionally
CONDITIONS:	Previous condition satisfied on 2021/09/08
NOTE:	If contact information regarding student study participants is required, please contact the Registrar's office - <Nicoleen.Potgieter@wits.ac.za>
SUPERVISOR:	Dr S Armstrong and Ms B Hanrahan
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	2020/12/11

This Clearance Certificate is valid for 5 years from the date of approval. An extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office secretariat on the 3rd floor, Philip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to submit details to the Committee. **I agree to submit a yearly progress report.** When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in **May** and therefore reports and re-certification will be due in the month of **May** each year. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

Signature of Principal Investigator

15/01/2021
Date

ANNEXURE 13 Hospital 1 approval

Anonymised. Original consent with researcher.

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

[redacted]

Enquiries : [redacted]
Tel : [redacted]
Email : [redacted]

TITLE OF RESEARCH PROJECT:
"COLLABORATIVE MATERNITY CARE: THE RELATIONSHIP BETWEEN INDEPENDENT MIDWIVES AND INTERPROFESSIONAL CARE PROVIDERS IN JOHANNESBURG, SOUTH AFRICA"

NAME OF SUPERVISORS:
Dr S Armstrong
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NAME OF RESEARCHER:
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School of Therapeutic Sciences
Faculty of Health Sciences
University of the Witwatersrand

NHRD REF NO: GP_202101_038

Dear Ms. Du Plessis,

Permission is granted for you to conduct the research as indicated in the title above.

The terms under which this permission is granted is contained in the Researcher Declaration form that you have signed. Failure to comply with these conditions will result in the withdrawal of such permission.

It is crucial for you to inform the Research Coordinator, [redacted] of the actual start and end dates of your study. This could be done by e-mail.

Should the study commence more than 12 months after receipt of this approval letter you will have to go through the process of applying again.

You are strongly advised to keep a signed copy of the declaration form to ensure that the terms of this agreement are always complied with.

Yours sincerely,

[redacted]

[redacted]
SENIOR CLINICAL EXECUTIVE
2021:03:23

ANNEXURE 14 Hospital 2 approval

Anonymised. Original consent with researcher.



[redacted]

Office of the Nursing Director
Enquiries [redacted]
Tel: [redacted]
Ema[redacted]
03 May 2022

GP_202101_038

Dear Jeanell Du Plessis

STUDY TITLE: Collaborative Maternity Care: Exploring the Relationship Between Independent Midwives and Interprofessional Care Providers in Johannesburg, South Africa

Permission is granted for you to conduct the above-mentioned study as described in your request provided:

1. [redacted] will not anyway incur or inherit costs as result of the said study.
2. Your study shall not disrupt services at the study sites.
3. Strict confidentiality shall be observed at all times.
4. Informed consent shall be solicited from patients participating in your study.

Please liaise with the HOD and Unit Manager or sister in charge to agree on the dates and time that would suit all parties.

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

Supported / ~~not supported~~

[redacted]

[redacted]
Nursing Director

Approved/~~not approved~~

[redacted]

[redacted]
Chief Executive Officer

ANNEXURE 15 A sample of an analysed interview section

	<u>RESEARCHER</u>: I think we can stay as we are. Maybe let's start with discussing the obstetricians? And you as an independent midwife, how do you go about setting up those relationships with the obstetricians, and then how do you go about keeping those relationships working with the obstetricians? Participant 1, do you want to start with that?	
P1	*<u>INTERVIEWEE</u>: I don't really know how; I kind of initiated and my relationships with the doctors; basically probably just referring patients to them. The ones that were working at (Private MOU 1) already so, yeah it's tough though to say like: what you're doing to keep the relationships good. I don't know. Basically just I think, the level of respect and but going like either way like they have to respect your opinion but you also have to respect their opinion, if you've referred a patient with a problem to them, and they're saying that this and this is, they're not fine with, that you go with what they say and not go and try and do your own thing because I think that's where they start losing trust in us.*	Setting up the relationship with Obstetricians Respect Losing trust
	<u>RESEARCHER</u>: Is it?	
P1	*<u>INTERVIEWEE:</u> If we're not taking in consideration what their worries and concerns regarding our clients are.*	
	<u>RESEARCHER</u>: Okay. INTERVIEWEE 2, do you want add?	
P2	*<u>INTERVIEWEE</u>: So yeah, so generally I well some of the OB's I have worked with at (private hospital 3), so that's where the relationship started. A lot of them, they're on the call roster or they're on the backup system so by referral, I do write a letter when I send my clients to them, and I give them an update and then I SMS them when or WhatsApp them when the moms are in labour. I WhatsApp them after the moms have given birth. I generally do everything in documentation. They seem to like that because they are kept in the loop and updated on what's happening. I do ask their preferences, so a lot of the gynaes I do know what their preferences are so I can respect that and know what their likes and their dislikes are and based on that, that's managed to keep it. I also, so for example, I do vbac's I don't advertise for vbac's and I don't like taking on vbac's. So there are selective patients, that they would send to me, and I'll do them, but they also know, what to send and what not to and to….when I say both ways,*	Initiating relationship with backup obstetricians Respect, knowing preferances Role clarification;

	I'm not happy continuing care with this client for me she is a high risk. They do kind of sometimes push that but I think we stand firm on that which is excellent, so they know that you're not willing to test the boundaries and once they know that, that's managed to keep the relationship going right through. *<u>RESEARCHER</u>: Okay. So, they need to trust you?* *<u>INTERVIEWEE</u>: Yeah.* *<u>RESEARCHER</u>: Do you think it's important to stay within your scope of practice? As a midwife.*	communication with obstetricians
P2	*<u>INTERVIEWEE</u>: Absolutely, I think that's what keeps us going, look, I must say that all of our OBGYN's, and all of the doctors don't know what's in our scope because sometimes they'd refer things that's out of our scope, so we have to remind them that it's not in our scope and in order to make them understand, and I think that's what they appreciate.* *<u>RESEARCHER</u>: Okay.*	Staying within scope of practice; safe practice
P3	*<u>INTERVIEWEE</u>: So, with me, with my gynaecologist, I must say that it also goes with history and whether you can trust them, I mean I've worked with several gynaecologists but in the end of the day, you sort of end up with whoever you trust, and also people who come out if you really need them. So, there's several gynaecologists that I just don't want to work with anymore but like INTERVIEWEE says, it's very; I think it's very important to know what the, what their suggestions are and what their preferences are, on when they want to see the patients, when would they like us to refer the patients and also not to refer the patients too late. I find that the gynaes gain quite a lot of respect for us, if we refer the patients in time, even though an antenatal patient that becomes a high risk, and some I mean I would contact the gynae and ask them, would you not want to want me to wake you up in the middle of the night, to prescribe Voltaren? And they would say no, so to know what they trust us to do do without their specific guidance or whatever and what we can prescribe without their consent, because it's very difficult you know there's some of the things, sometimes if you want to augment a labour in the middle of the night but you only need a little bit of synto, you're supposed to phone them but you also, it's a very difficult situation; and then yeah said.* *<u>RESEARCHER</u>: No, I'm hearing, Midwife participant 3, that I, these things take time. So, they need to learn how you work as a midwife and how you practice and but then you also need to, there's the relationship takes time to really build and so that*	Trust; knowing who to trust Choosing who to work with Respect; timeous referal Trust

	there's respect between the midwife and the obstetrician and there has to be some form of role clarification, am I hearing you right? Each one needs to know and INTERVIEWEE, you also said, I think you also said that they need to know, you've got to have clear boundaries. They need to know what you are comfortable with and but they'll also need to know that you will refer in time and I take it, that is both in antenatal, as well as in labour? *<u>INTERVIEWEE 1 & 3</u>: Yes.* *<u>RESEARCHER</u>: Okay.*	
P1	*<u>INTERVIEWEE</u>: If I can just make an example, some gynaes, a specific gynae would want us to inform them in the middle of the night, if the patient goes into labour, whereas another gynae only want us, if it's in the middle of the night, to let us know if there's emergency, or and then I won't wait for the emergency to happen, I will probably 4 or 5 hours before the time let them know listen, this lady is not progressing like it should, we might need a Caesar later on, whereas with that specific gynae, once the patient's birth, I will just wait for the morning to come, maybe 7:00 or 8:00 in the morning and then let him know that person is not doing very well.* *<u>RESEARCHER</u>: How do you agree upon these things with the gynaes or the obstetricians? Do you have a meeting with them? Do you have a specific contract, how do you come or is it just with time that you get to know each other?*	Communication with obstetricians
P3	*<u>INTERVIEWEE</u>: I ask them specifically. When I see them, I ask them, what are your preferences on this? Would you like me to let know in the middle of the night, if a patient is in labour and everything's going well, or you know and some of them do and some don't.* *<u>RESEARCHER</u>: Okay. INTERVIEWEE? Do you want to add?*	Agreement; preferances
P2	*<u>INTERVIEWEE</u>: So, I think a lot of the gynaes did on the M&M mention also what they wanted and not in one stage, so a lot of that was documented and yeah, when we work with them, generally in the past, if not specifically but in the passing, we generally chat and that's how we get to know what they want and not. It's very difficult to schedule a meeting with them because they also have extremely busy schedules, so we have to catch them when we can. A lot of my conversations is on WhatsApp actually. I WhatsApp them in the middle of the night because I ask them, if it's on silent and their WhatsApp's are…* *<u>RESEARCHER</u>: Yeah.*	Communication with obstetricians

P2	*INTERVIEWEE: …so I do send them WhatsApp and then I also if I want to know, I generally ask them that on you know, on WhatsApp as well, what would you like with this or not and take it from there.* *RESEARCHER: Okay. Communication, I think all of you have referred to communication in some form or other. That seems to be really important that you need to communicate with your obstetricians and in a timely fashion. I hear really, do you think then if, if we, we've kind of touched on things that work with the relationship. One of the things that would not work would you say is if a midwife would constantly or repeatedly or often only inform the obstetrician of an emergency, too late for when it's actually too late for them, it's and then they take on the responsibility or it links to malpractice. What do you think when it comes to that?*	
P3	*INTERVIEWEE: Yeah, it's right. I basically when I do my birth plan with my clients, I have a clause in there that says, like listen, I'm very conservative when it comes to things. If there's the smallest thing that I'm worried about, I'd rather cop out early on because I also want it to be, even if we have to end up in theatre with a procedure, I still want it to be kind of enjoyable to you. Not us all panicking and stressing: Is this baby going to be fine? Or is this mother going to live or whatever. So, they very much know from the onset that I'm not going to take chances with them and I think the doctors also kind of have figured that out over the years that I've worked with them, that I don't take unnecessary chances with clients. If I am in the least little bit worried about something, I rather just cop out. You know what, it's in the end of the day, I'm not going to compromise a mom and a baby just because I want them to have this normal birth and I want to side line the doctor. So…* *RESEARCHER: Yeah.*	Safe practice Safe practice
P3	*INTERVIEWEE: …yeah so I must [inaudible 11:27] definitely. I definitely let them know, even if it's not even, there's a lot of times that I would send a photo of a CTG with maybe a baseline of 110. I know it's fine but I want them to tell me that it's also fine with them...* *RESEARCHER: Yeah.*	Communication Photos
P3	*INTERVIEWEE: …you know and but a very reactive CTG, even if something is just a little bit off and I know that she can continue to go on labouring. I just want them to also know so I do let them know even long before I think there might be a Caesar, they always know about the patient, so I make sure that by*	Communication

	the time that there is an emergency, it's not the first time they hear from me. *MIDWIFE PARTICIPANT 1: But also, that it's not actually not such an emergency that everybody has to rush now and like panic.* *RESEARCHER: Yeah.*	Safe practice